

Humboldt Del Norte Foundation for Medical Care 2008 Utilization Management Policy

Reporting Structure and Content

The Chief Medical Officer is involved with key aspects of the utilization management (UM) program, such as setting policies, reviewing cases, participating on all UM committees and supervising the UM program. The medical director(s) and other Foundation staff are responsible for implementation of the UM program. The QMAC oversees the UM program (see Section II. Quality Management, C. Governing Body and Content). All physicians involved in the UM program must possess an unrestricted California medical license.

The Medical Management Committee (MMC) develops the annual Utilization Management Program (UMP) goals and presents the UMP to the QMAC for review, revision, and final approval. The annual UMP is developed using the ICE format. The QMAC reviews all recommendations and revisions before submitting the UMP to the Boards of Directors. The Boards of Directors of the Foundation and IPA conduct an annual review of the Foundation's UMP and periodically as needed.

Utilization Review Clinical Criteria and Decision Making

The Foundation adheres to State of California, NCQA and health plan mandated criteria for consistency of reviewing utilization. The Foundation's *Approved Resources* (see Appendix E) are objective and based on sound medical evidence. Additions to the Approved Resources are reviewed and approved by QMAC as needed. Appropriate, actively practicing medical and behavioral health practitioners are involved in development and adoption of standardized clinical criteria.

The Foundation's prior authorization requirements are based on the following general principles.

- Patient care should be coordinated by their primary care practitioner (PCP).
- Consultation services ordered from a PCP to a local IPA or Foundation member specialists do not require prior authorization.
- Services received by HMO plan members from non-contracted providers are not covered unless prior authorization process has determined the medical necessity of receiving care from a non-contracted provider.
- Prior authorization is required for services which are only covered when the health plan's medical necessity criteria are met.
- Prior authorization is required for all elective inpatient stays but, once admitted, the services provided during the hospital stay are affected only by claims review.
- Prior authorization is not required for services provided in a medically emergent situation.
- When PPO plan members access services from out of network providers without prior authorization, the services are covered at a reduced rate.

All information and rationale used during the utilization review process is disclosed upon written request to the Foundation from a practitioner, member or the public. The Foundation may charge a fee to cover the copying and postage expenses associated with the request for information. Disclosure notice sent with criteria or guidelines requested by members and the public include the following statement: "The materials provided to you are guidelines issued by the Foundation to authorize, modify or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under the member's contract."

The Foundation's UM responsibilities are allocated among staff based on the type of service being reviewed. The Foundation's Medical Management Department staff is delegated to approve some service requests for

approval following specific Foundation policies. Clinically competent licensed California IPA/Foundation physicians review all denials and modifications for services based on medical necessity. When a requested service is reviewed for potential denial for lack of medical necessity without a previously approved guideline, the Medical Director will initiate a clinical consult with a physician knowledgeable in the requested service for input. This consult is documented and included in the authorization documentation.

Reviewers must consider at least the following factors when applying criteria to a given individual:

- Age
- Progress of Treatment
- Member desires
- Co-morbidities
- Psychosocial situation
- Ethnic and Cultural beliefs and practices
- Complications
- Home environment
- Other as appropriate

Reviewers refer to the *Approved Resources* (Appendix E) and apply all the relevant criteria within the context of the local delivery system in making their decision. Reviewers also consult with appropriate board certified specialty providers as needed. (Note: To provide this resource, all IPA member physicians make themselves available for telephone consultations with the Foundation.) In compliance with DOL (ERISA) regulations the identity of experts whose advice was obtained in connection with an adverse determination is made available upon member's request (this must be done without regard to whether the advice was relied upon to make the determination).

The rationale for all authorization decisions, whether approved, denied or modified are noted on the *Authorization Tracking Form* by the reviewer(s) to ensure that subsequent reviewers will be able to clearly understand the decision made. When making a determination based on medical necessity, the Foundation staff obtains relevant clinical information and consults with the treating physician or clinician expert as necessary.

When the reviewer determines that an alternate treatment plan is more appropriate, the authorization request is denied with information recommending the alternate treatment plan. When a request for services by an out-of-plan provider is denied, the denial letter includes options for in-plan providers. When the reviewer is considering denial of concurrent inpatient care, the care will not be discontinued until the member's treating provider is contacted about the pending decision and the treating provider has agreed to a care plan.

Utilization Management Policies and Procedures

1. Authorization Process

The Foundation's customer service staff is available from 8:00 am to 5:00 pm on business days to assist providers and members with the UM process. The Foundation posts the status of authorization requests received within the past 90 days on the web site at www.hdnfmc.com. Providers interested in viewing authorizations, claims and PPO plan member eligibility can contact customer service for more information.

Providers and members are responsible for ensuring that prior authorization is obtained for services according to the requirements of their health plan (HMO or PPO). The Foundation may deny payment for any services requiring authorization that are rendered without prior authorization. All services, whether pre-authorized or not, are subject to post-service claims review for appropriate coding and documentation.

Local in-plan providers may directly refer to local in-plan specialists without prior authorization. Specifically, they may refer immediately to: Cardiology, Dermatology, Ear/Nose/Throat, Endocrinology, Gastroenterology, General Surgery, Hematology, Neurology, OB/GYN, Oncology, Ophthalmology, Orthopedic Surgery, Podiatry, Routine Laboratory, Routine X-ray, Urology, etc. Specialists must indicate the referring provider on the claim form.

Services Requiring Prior Authorization are listed in Appendices A and B. Emergent and urgent services do not require prior authorization so providers should not delay such treatment pending authorization. If any service being provided requires authorization, then all services for that visit will require authorization.

Approved authorizations are effective on the date received and expire in three months. If requested in advance of the expiration date, extensions are considered for approval on a case-by-case basis.

Secondary Insurance Authorizations are not required by the Foundation except when:

- The requested service is not a covered benefit under the primary insurance, and/or
- The benefits for the requested service have been exhausted under the primary insurance. In this case, evidence of the exhaustion of benefits will be required.

The Foundation does not authorize services denied as not medically necessary by the primary insurance.

Authorizations may be submitted by IPA member physicians (MD and DO), podiatrists and advanced practice clinicians who may generate authorization requests for services they are ordering for patients they are or will be seeing. Requests submitted by specialists must be related to the problem/condition they are managing. Optometrists must request prior authorization to diagnose or treat medical (not optometry) services for HMO members.

Authorization Request Forms (see Foundation Forms in back of this document) must include medical information necessary to establish the medical necessity of the requested services. The completed form can be faxed to (707) 442-2047 or mailed to the Foundation at P.O. Box 1395, Eureka, CA 95502.

- Incomplete Member or Provider Information – The Foundation returns requests that do not adequately identify the member or provider within one business day of receipt. The specific information missing is indicated on the *Notification of Incomplete Authorization Request* form, which is faxed with the returned incomplete request form.
- Incomplete Medical Necessity Information – The Foundation may delay processing (“pend”) a request if required information is not submitted (see Appendix C: Foundation Utilization Management Timeliness Standards) with the request. When requests are delayed, the notification includes the reason for pending, specific information needed, and the time frame for submitting the information.
- Multiple service locations - Complete a separate Authorization Request Form for each location of service.
- Multiple providers in a group - The requested provider must be indicated on the form but, the authorization will be valid for use by any provider within the group’s tax identification number.
- Professional and Technical components - Authorization for the technical or professional component of a procedure includes authorization for the technical and professional components of the procedure.
- Surgical Assists – Authorized surgeries include authorization for surgical assist when medically indicated.
- Second opinion requests with a non-contracted provider for HMO members are referred to the health plan for authorization and referral processing. Foundation staff process second opinion requests for all other health plans (see also separate Foundation Access Policy and Procedure.)
- Experimental or Investigational treatment requests for HMO plan members are referred immediately to the health plan for authorization and referral processing. The Foundation has adopted HMO Experimental and Investigational treatment guidelines for all health plans it administers.
- Unlisted Codes - Unlisted codes will not be authorized. If necessary, request authorization for the service most similar to the one being performed and submit documentation with the claim for post-service review.

Retroactive authorization requests are not generally approved by the Foundation. Retroactive authorization requests must be received within 90 days of the date of service to be considered for approval. Claims for services billed with an approved retroactive authorization must be submitted within 30 days of the date of the retroactive approval or they will be denied for claim timeliness.

Retroactive authorizations for the following services when they are deemed medically necessary per documentation received will be approved for payment:

- Emergent or urgent services
- Durable Medical Equipment ordered by an in-plan provider and dispensed by a non-contracted vendor when a contracted vendor was not available
- Procedures provided during the visit as a result of a decision made during that visit
- “First Contact” services when the requesting provider presents documentation showing that the member provided them with incorrect insurance information prior to the service being performed.
- Out of area services with a contracted provider
- Services that exceeded the primary payer’s benefit coverage when the Foundation-administered plan is secondary (documentation will be required).

All other retroactive authorization requests for medically necessary services that could have been authorized in advance or within days of the date of service will be considered for approval but, if approved, these services will be reimbursed at 50% of the regular contracted amount.

Emergency Services are authorized without review of medical necessity. Post emergency services are also authorized based on the treating practitioner’s determination of medical necessity for continued care.

Member eligibility is verified by the Foundation prior to processing authorization requests. If the member’s health plan eligibility is terminated prior to receiving the authorized services, the member may be responsible for the cost of those services.

Timeliness of the Foundation’s UM decisions is based on the Industry Collaborative Effort (ICE) timeliness standards, which apply turnaround times based on medical necessity (see Appendix C: Foundation Utilization Management Timeliness Guidelines). Urgent care services are assigned priority status and routine requests are processed within five days, unless additional information is necessary to process the request.

Notification of all UM decisions are sent to the requesting and requested providers via fax and to the member via mail. Denied and modified authorization notifications are written following ICE standards. Denied and modified letters include the specific reason for the denial or modification, an alternate treatment plan, information about the option to appeal the decision, and instructions on how to initiate an appeal. Denied and modified letters also include notification to practitioners that the Foundation’s reviewer is available to discuss the UM denial decision and the reviewer’s name and specific telephone number is provided as a method of contacting the reviewer.

Case Management

During the UM process, the member may be recommended by any Foundation staff to receive case management (CM) services. CM activities can improve medical outcomes, provide effective benefit management and increase member and provider satisfaction. CM activities are documented in the member’s CM file. Case Managers also assist high-risk patients who are affected when providers terminate from the Health Plan. See Case Management Policy and Procedure for more detail.

Utilization Management Quality Assurance Activities

The Foundation’s quality assurance activities are reported at least quarterly to the QMAC. The following reports are routinely reviewed.

Interrater reliability studies - The Foundation conducts interrater reliability studies at least quarterly to evaluate consistency in decision making between both physician and non-physician reviewers.

Denial letter reviews – The Foundation conducts monthly review of denial letters focusing on letter content and format, decision-making consistency and timeliness of decision.

Adverse outcomes – The Foundation staff investigates and reports all adverse outcomes to the Quality Management Administrative Committee (QMAC).

Turnaround time reports – The Medical Management Committee (MMC) reviews turnaround time reports and makes recommendations for change as needed.

Emergency Room and Urgent Care utilization – The QMAC compares emergency room and urgent care utilization against standards. Utilization patterns by members and providers are investigated and action plans initiated as needed.

Bed Days per 1000 member – The QMAC reviews inpatient utilization and compares against standards. High and low bed day rates are investigated and action plans initiated as needed.

Appendix A: Foundation HMO Authorization Requirements **Effective January 1, 2008**

- A. All services provided by out of plan (non-contracted) providers require prior authorization.
- B. All services provided outside of Humboldt or Del Norte County require prior authorization. HMO members must receive specialty services from local in-plan specialists when available before out-of-area services will be considered for approval, unless the requesting provider establishes the medical necessity for referring directly out-of-area.
- C. All the following general services require authorization.
- Acupuncture
 - Alcohol and Substance Abuse Treatment – inpatient and residential services
 - Biopharmaceuticals
 - Chiropractic Care
 - Durable Medical Equipment and related supplies > \$50
 - Genetic testing
 - Hearing Aids
 - Hospital - Inpatient Services (non-emergent only)
 - Infusion Therapy – ambulatory or home bound, any other than chemotherapy
 - Lupron for gynecological diagnosis
 - Mental Health- inpatient and residential services
 - Occupational Therapy
 - Orthotics and prostheses > \$50
 - Physical Therapy
 - Respiratory Care
 - Skilled Nursing Facility Services
 - Speech Therapy
 - Transplants
- D. Authorization requirements and potential benefit issues are available on the Foundation's website at www.hdnfmc.com. Search by CPT code or service description. Every CPT code is identified with one of the following indicators:
- | | |
|----|--|
| A | Authorization required |
| X | Does not require authorization |
| BA | Benefit issue for some plans and authorization required |
| BX | Benefit issue for some plans but does not required authorization |

Note: Primary Care Practitioners may refer immediately without prior authorization for consultation with the following contracted specialists: Cardiology, Dermatology, Ear/Nose/Throat, Endocrinology, Gastroenterology, General Surgery, Hematology, Neurology, OB/GYN, Oncology, Ophthalmology, Orthopedic Surgery, Podiatry, and Urology. They may also order Routine Laboratory, Routine X-ray without prior authorization.

Appendix B: Foundation PPO Health Plan Prior Authorization Requirements Effective January 1, 2008

The following services (marked with an X) require prior authorization to receive maximum financial coverage and to avoid any penalties for non-compliance, depending on the specifics of the health plan.

Services provided by out of plan (non-contracted) providers are covered at a reduced benefit level and incur a higher cost to the member.

Service	SJHS – Humboldt	PALCO	Trinidad Rancheria	Blue Lake Rancheria
Biopharmaceuticals	X	X	X	X
Durable Medical Equipment (DME) >\$250 (use purchase price if equipment will be rented)	X	X	X	X
Genetic Testing	Not Covered	X	X	Not Covered
Home Health Services	X	X	X	X
Hospital – Inpatient services (non-emergent only)	X	X	X	X
Hospital – Outpatient services, excluding lab and plain x-ray (non-emergent only) (lab & plain x-ray= no authorization required)	X	X	X	X
Imaging – CT, MRI, Pet Scans	X	X	X	X
Infusion Therapy (excluding chemotherapy)	All outpatient	Home only	All outpatient	All outpatient
Mental Health and Substance Abuse Treatment - Facility-based inpatient or outpatient	X	X	X	Not Covered
Rehabilitative Therapy Services: Acupuncture, Chiropractic Care, Physical Therapy, Speech Therapy & Occupational Therapy	Auth after 10 combined rehab visits	Auth after 14 combined rehab visits	Auth after 12 combined rehab visits	Auth after 12 combined rehab visits
Professional Services, over \$500 allowed by CPT code (includes professional & technical, if split billed)		X		
Transplants (organ and tissue), peripheral stem cell replacement, and similar procedures	X	X	X	X

Appendix C: Foundation Utilization Management Timeliness Standards

HMO HEALTH PLAN – ICE STANDARDS UM TIMELINESS STANDARDS AND NOTIFICATION REQUIREMENTS FOR PENDING PROCESS

	URGENT	NON-URGENT		POST-SERVICE	
	Additional Information Needed	Additional Information Needed	Consultation By Expert Reviewer Needed	Additional Information Needed	Consultation By Expert Reviewer Needed
Pend Notification Member & Practitioner	24 hrs of receipt of request (allow 48 hrs for submission of info)	5 business days of receipt of request (allow 45 calendar days for submission of info)	5 business days of receipt of request	30 calendar days of receipt of request (allow 45 calendar days for submission of info)	30 calendar days of receipt of request
Decision	48 hrs after info received, complete or incomplete OR 48 hrs after timeframe given to supply info if info not received	5 business days after info received, complete or incomplete OR 45 calendar days plus 5 business days if info not received	15 calendar days from date of pend notice	15 calendar days after info received, complete or incomplete OR 45 calendar days plus 15 calendar days if info not received	15 calendar days from date of pend notice
Initial Practitioner Notification (approvals & denials)	24 hrs of decision <i>not to exceed 48 hrs</i> after receipt of complete or incomplete info, or the timeframe given to supply info if info not received	24 hrs of decision	24 hrs of decision	N/A	N/A
Written Denial Notification Member & Practitioner	48 hrs after receipt of info complete or incomplete, or after the timeframe given to supply info if info not received	2 business days of decision	15 calendar days from date of pend notice	15 calendar days after receipt of info complete or incomplete, or after the timeframe given to supply info if info not received	15 calendar days from date of pend notice
Member Notification (approvals)	48 hrs after receipt of info complete or incomplete, or after the timeframe given to supply info if info not received	2 business days of decision	2 business days of decision	15 calendar days after receipt of info complete or incomplete, or after the timeframe given to supply info if info not received	15 calendar days from date of pend notice

PEND NOTIFICATION CONTENT REQUIREMENTS

	Additional Information Needed	Consultation By Expert Reviewer Needed
Reason for Pending	Required	Required
Specific Information Needed	Required	NA
Time Frame for Submission of Information	Required	NA
Expected Date of Decision	Required	Required
Type of Expert Reviewer	N/A	Required

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition <u>not to exceed 72 hours after receipt of the request.</u>	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials) Member: Within 72 hours of receipt of the request (for approval decisions) Document date and time of oral notifications.	Within 72 hours of receipt of the request Note: If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed <ul style="list-style-type: none"> Additional clinical information required 	Additional clinical information required: Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information. <u>Additional information received or incomplete:</u> If additional information is <u>received</u> , complete or not, decision must be made within 48 hours of receipt of information. Note: Decision must be made in a timely fashion appropriate for the member's condition <u>not to exceed 48 hours after receipt of information.</u>	<u>Additional information received or incomplete</u> Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials) Member: Within 48 hours after receipt of information (for approval decisions) Document date and time of oral notifications.	<u>Additional information received or incomplete</u> Within 48 hours after receipt of information Note: If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification
	<u>Additional information not received</u> If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. Note: Decision must be made in a timely fashion appropriate for the member's condition <u>not to exceed 48 hours after the deadline for extension has ended.</u>	<u>Additional information not received</u> Practitioner: Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials) Member: Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions) Document date and time of oral notifications.	<u>Additional information not received</u> Within 48 hours after the timeframe given to the practitioner & member to supply the information Note: If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
<p>Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services)</p> <p>Requests involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments.</p> <p>Exceptions:</p> <ul style="list-style-type: none"> • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to <u><i>Urgent Pre-service</i></u> category. • If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to <u><i>Non –urgent Pre-service</i></u> category. 	<p>Within 24 hours of receipt of the request</p>	<p><u>Practitioner</u>: Within 24 hours of receipt of the request (for approvals and denials)</p> <p><u>Member</u>: Within 24 hours of receipt of the request (for approval decisions)</p>	<p>Within 24 hours of receipt of the request</p> <p>Note: If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification</p>
<p>Non-urgent Pre-Service - All necessary information received at time of initial request</p>	<p>Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.</p>	<p><u>Practitioner</u>: Within 24 hours of the decision (for approvals and denials)</p> <p><u>Member</u>: Within 2 business days of the decision (for approval decisions)</p>	<p>Within 2 business days of making the decision</p>

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of <u>Denial</u> to Practitioner and Member
Non-urgent Pre-Service - Extension Needed <ul style="list-style-type: none"> • Additional clinical information required • Require consultation by an Expert Reviewer 	Additional clinical information required: Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	<u>Additional information received or incomplete:</u> If additional information is <u>received</u> , complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	Practitioner: Within 24 hours of the decision (for approvals and denials) Member: Within 2 business days of the decision (for approval decisions)	Within 2 business days of making the decision
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	Require consultation by an Expert Reviewer: Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered		
	<u>Require consultation by an Expert Reviewer:</u> Decision must be made in a timely fashion as appropriate for the member's condition not to exceed 15 calendar days from the date of the delay notice to the practitioner and member	<u>Require consultation by an Expert Reviewer:</u> Practitioner: Within 24 hours of the decision (for approvals and denials) Member: Within 2 business days of the decision (for approval decisions)	<u>Require consultation by an Expert Reviewer:</u> Within 15 calendar days from the date of the delay notice
Post-Service - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days of receipt of request	Practitioner: Within 30 calendar days of receipt of request (for approvals and denials) Member: Within 30 calendar days of receipt of request (for approvals)	Within 30 calendar days of receipt of request

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
Post-Service - Extension Needed <ul style="list-style-type: none"> • Additional clinical information required • Require consultation by an Expert Reviewer 	Additional clinical information required: Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	<u>Additional information received or incomplete</u> If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information	<u>Additional information received or incomplete</u> Practitioner: Within 15 calendar days of receipt of information (for approvals and denials) Member: Within 15 calendar days of receipt of information (for approvals)	<u>Additional information received or incomplete</u> Within 15 calendar days of receipt of information
	<u>Additional information not received</u> If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	<u>Additional information not received</u> Practitioner: Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals & denials) Member: Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions)	<u>Additional information not received</u> Within 15 calendar days after the timeframe given to the practitioner & member to supply the information
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered		
	<u>Require consultation by an Expert Reviewer:</u> Within 15 calendar days from the date of the delay notice	<u>Require consultation by an Expert Reviewer:</u> Practitioner: Within 15 calendar days from the date of the delay notice (for approvals & denials) Member: Within 15 calendar days from the date of the delay notice (for approval decisions)	<u>Require consultation by an Expert Reviewer:</u> Within 15 calendar days from the date of the delay notice

**Appendix D: St. Joseph Health System Health Plan
In-Office Laboratory Services
Renewed Effective January 1, 2008**

Only the following laboratory tests will be considered for payment when provided in a clinician's office for patients with the St. Joseph Health Plan. All other tests must be performed by St. Joseph Hospital or Redwood Memorial Hospital.

81000	Urinalysis	by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy
81001	Urinalysis	automated, with microscopy
81002	Urinalysis	non-automated, without microscopy
81003	Urinalysis	automated, without microscopy
81025	Urine Pregnancy	by visual color comparison methods
82270	Hemoccult	blood, occult; by peroxidase activity, qualitative; feces screening, 1-3 determinations
82565	Creatinine	blood
82947	Glucose	quantitative, blood (except reagent strip)
82948	Glucose	blood, reagent strip
84132	Potassium	serum
84520	Urea nitrogen	quantitative
84703	Pregnancy	gonadotropin, chorionic (hcg), qualitative
85007	Blood count	microscopic exam with manual differential WBC count
85014	Hematocrit	other than spun
85018	Hemoglobin	hemoglobin
85025	CBC	complete automated Hgb, Hct, RBC, WBC and platelet count
85610	Prothrombin time	prothrombin time
86403	Rapid Strep	particle agglutination; screen, each antibody
86580	PPD	tuberculosis, intrader mal
87081	Strep Culture	culture, presumptive, pathogenic organisms, screening only
87205	Gram Stain	smear, primary source, with interpretation; routine for bacteria, fungi, or cell types
87210	Wet Mount	for infectious agents (e.g., saline, India ink, KOH preps)
87220	KOH	tissue examination by KOH slide for fungi or ectoparasite ova or mites/scabies
87430	Streptococcus, A	infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method, adenovirus enteric types 40/41
87880	Streptococcus A	infectious agent detection by immunoassay with direct optical observation

Appendix E: Foundation Approved Resources

Updated Effective January 1, 2008

All medical management decisions are evidenced-based using “Approved Resources”. Every month, the Medical Management Committee (MMC) reviews the new and revised policies of the HMO Cross of California and Blue Shield of California HMO. The MMC will adopt and implement changes to said policies. The information resources for decision-making of the Medical Management staff include:

- Medical Management Policies and Guidelines of Commercial Health Plans
- Medical Guidelines adopted by the Foundation
- Clinical consultation with appropriate physicians

Additional approved resources include:

- American College of Radiology: Appropriateness Criteria
- Clinical Evidence, BMJ
- Cochrane Library (on-line)
- Complete Global Service Data-Ortho Surgery, AAOS
- Current Procedural Terminology Assistant, AMA
- Current Medical Diagnosis and Treatment
- Current Procedural Terminology (CPT), AMA
- Diagnostic & Statistical Manual of Mental Health Disorders (DSM-IV,) APA
- Durable Medical Equipment Billing Guide
- Epocrates
- Harrison’s Textbook for Medicine
- Healthcare Common Procedure Coding System (HCPCS), AMA
- Humboldt Breast Medicine Project Website, algorithms
- Institute for Clinical Systems Measurement (ICSI)
- International Classification of Diseases, Physician (ICD-9 CM), AMA
- Lange – Surgical Diagnosis & Treatment
- Lange - Basic & Clinical Endocrinology
- Lange – Clinical Neurology
- Lange – Diagnosis & Treatment in Psychiatry
- Lange – General Urology
- Medicare RBRVS, AMA
- National Institute for Health (NIH)
- National Imaging Associates, Inc.; “Guidelines for Radiology Procedures”
- National Osteoporosis Foundation
- National Quality Measure Clearinghouse - AHRQ
- Part B News, Centers for Medicare and Medicaid Services
- Physicians as Assistants at Surgery 2007
- Physicians’ Desk Reference
- Physicians’ Fee and Coding Guide
- Red Book Pharmacy’s Fundamental Reference
- Surgical Assistant
- U.S. Preventative Health Services Taskforce (on-line)
- Virtual Examiner (national correct coding guidelines)
- Websites of specialty organizations (e.g., ACOG)

Foundation Authorization Request Form

Fax completed form to 707-442-2047 or mail to the Foundation, P.O. Box 1395, Eureka, CA 95502

Incomplete request forms will be returned without being processed. A copy of this form should be kept in the patient's chart.
Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

Foundation Authorization Tracking #: _____

MEMBER INFORMATION

Patient Name: _____ Gender: M / F Date of Birth: _____

Patient's Address: _____
Street City Zip Phone

Health Plan: Blue Cross HMO/POS (CaliforniaCare) - Blue Shield HMO - Blue Lake Rancheria - PALCO - SJHS Humboldt - Trinidad Rancheria

Subscriber Name: _____ Group #: _____

Member's Primary Care Provider: _____ Subscriber #: _____

REQUESTING PROVIDER INFORMATION	PROPOSED PROVIDER & FACILITY INFORMATION
Name: _____	Name: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____
Contact Name: _____	Tax ID # (Out of Area Providers only): _____
Today's Date: _____	Place of Service: _____

REQUESTED SERVICES AND MEDICAL NECESSITY

Diagnosis Description: _____ ICD9(s): _____

Relevant Clinical Information (and/or send medical notes): _____

Requested Service:	Description: _____	CPT: _____	Quantity: _____
	Description: _____	CPT: _____	Quantity: _____
	Description: _____	CPT: _____	Quantity: _____
	Description: _____	CPT: _____	Quantity: _____

Check if requesting surgical assist

Type of Request (circle): Routine Outpatient Inpatient Date _____

Retroactive (include notes) Date _____ Emergent / Urgent (include notes)

- Authorizations are effective from the date they are received and expire three (3) months from the effective date.
- Authorizations are based on the member's current eligibility.
- Claims for services rendered without required prior authorization may be denied reimbursement.
- Claims for the above services must be submitted for the same service, CPT code and provider group (tax id #) as those approved or documentation must be submitted to explain the medical necessity of alternative and/or additional services.
- The requesting physician or the member may submit authorization appeals to The Foundation Medical Management Department.
- This is confidential and privileged information protected by California Civil Code § 43.97, Health & Safety Code §1370, and California Evidence Code §1157.

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Foundation Authorization Request For Continued PT & OT

Fax Completed Form to 707-442-2047 or Mail to: Foundation, P.O. Box 1395, Eureka, CA 95502

Incomplete request forms will be returned without being processed. A copy of this form should be kept in the patient's chart.
Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

Foundation Authorization Tracking Number:

MEMBER INFORMATION

Patient Name: _____ Gender: M / F Date of Birth: _____

Patient's Address: _____
Street City Zip Phone

Health Plan: Blue Cross HMO/POS (CaliforniaCare) – Blue Shield HMO - Blue Lake Rancheria - PALCO – SJHS Humboldt - Trinidad Rancheria

Subscriber Name: _____ Group #: _____

Member's Primary Care Provider: _____ Subscriber #: _____

REQUESTING PROVIDER INFORMATION

PROPOSED PROVIDER & FACILITY INFORMATION

Name:	Name:
Address:	Address:
City, State, ZIP:	City, State, ZIP:
Phone: Fax:	Phone: Fax:
Contact Name:	Tax ID # (Out of Area Providers only):
Request Date:	Place of Service: <input type="checkbox"/> Office <input type="checkbox"/> Outpatient Hosp <input type="checkbox"/> Inpatient Hosp

REQUEST FOR CONTINUATION OF PT & OT SERVICES – MEDICAL NECESSITY

Diagnosis: _____ ICD9(s): _____

Initial evaluation (Date) _____ Reassessment (Date) _____ Total visits to date: _____

Pain: Initial _____ /10 Current _____ /10 Goal _____ /10

Strength: Initial _____ Current _____ Goal _____

Flexibility: Initial _____ Current _____ Goal _____

Function: Initial _____ Current _____ Goal _____

Overall: Initial _____ Current _____ Goal _____

Barriers to patient transitioning to home/independent care, if any? _____

Request: _____ Visits/Week x _____ Weeks = _____ Total Visits CPT Code(s): _____

Therapist Comments: _____
Therapist Signature _____

Referring Provider Comments: _____
Referring Provider Signature _____

- Approved authorizations are effective from the date they are received and expire in three (3) months.
- Authorizations are based on the member's current eligibility.
- Claims for services rendered without required prior authorization may be denied reimbursement.
- Claims for the above services must be submitted using the same CPT code and provider group (tax id #) as those approved or include documentation to explain the medical necessity of alternative or additional services.
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