

**ALL PROGRAMS OTHER THAN MEDI-CAL (APOM)
UTILIZATION MANAGEMENT PROTOCOLS FOR HOSPITALS**

1 **INTRODUCTION**

This Utilization Management Protocol represents a compilation of criteria and procedures which apply to those medical and hospital services provided to Members under one of the following Programs that CenCal Health administers: Healthy Families (HF); Healthy Kids (HK); Prenatal PLUS 2 (PP2) and In-Home Supportive Services (IHSS). Collectively these shall be Members.

CenCal Health will only reimburse Hospital for those Covered Services provided to Members which are properly authorized by CenCal Health's Health Services Department. Authorization requirements are designed to ensure that CenCal Health funds are spent only on those services that are both covered by the Programs administered by CenCal Health and judged to be medically necessary in accordance with professional guidelines, CenCal Health contracts with the State or employer groups, and CenCal Health policies.

The criteria and procedures included in these Protocols have been developed by medical and medical administrative professionals who are fully aware of the vast range of medical and medical administrative problems that providers and Members encounter.

2 **REGULATORY AUTHORITY**

State and employer contracts allow CenCal Health to develop utilization processes to ensure that medically necessary services are being provided to Members. CenCal Health normally provides Utilization Management (UM) functions, including requiring Referral Authorization Forms (RAFs) or Authorization Forms (ARs), as required. (See also the AUTHORIZATIONS section of this Provider Manual).

3 **PROGRAM GOAL AND OBJECTIVES**

The goal of CenCal Health's UM program is to assure the provision of appropriate and cost-effective, high-quality patient care to Members who are residents of counties in which CenCal Health administers its programs. More specifically, the programs are designed to:

- 3.1 Monitor primary care case management;
- 3.2 Increase access to health care of acceptable quality to Members;
- 3.3 Increase physician participation;

- 3.4 Improve claims processing;
- 3.5 Reduce unnecessary paperwork; and
- 3.6 Establish local program administration.

4 CENCAL HEALTH STAFFING FOR REVIEW OF SERVICE AUTHORIZATION REQUESTS AND SERVICES RENDERED

All reviews of requests for service authorizations and medical appropriateness of services rendered or denied by the Hospital will be performed by CenCal Health's Health Services Department staffed by the Medical Director, or the Associate Medical Director, (hereafter both are "Medical Director") Director of Health Services, and professional Utilization Management Coordinators ("UMC"). The Medical Director is a physician with substantial experience in the administration of utilization management programs. The Director of Health Services and the UMCs are Registered Nurses or higher level medical professionals with broad backgrounds in the implementation of utilization management protocols. A UMC may approve any request for a prior service authorization. The Medical Director shall review any UMC recommendation regarding the denial of a request for a prior service authorization.

5 EFFECTS OF CENCAL HEALTH'S SERVICE AUTHORIZATIONS

Once a service has been authorized, CenCal Health shall not retroactively deny payment for said service, unless the Member was not eligible at the time their services were rendered, or Hospital failed to notify the Member's Primary Care Physician ("PCP") or CenCal Health in the case of an emergency admission, as required by Section 9.1 of this document.

6 GENERAL CRITERIA FOR ACUTE HOSPITAL CARE

A Member requires acute hospital care in the following general circumstances:

- 6.1 The Members require or will require the constant availability of a physician and/or other medical consulting staff;
- 6.2 The Members require immediate availability of other diagnostic and/or therapeutic services and equipment that are available in the acute care setting (i.e., intravenous fluids and medication therapy, intramuscular and subcutaneous injection of medication, operating room services, respiratory therapy, I.C.U. services, and certain laboratory and x-ray therapies and treatments); and

- 6.3 The Members require the constant availability of professional nursing services which are found in an acute hospital.

7 AUTHORIZATION OF ACUTE CARE HOSPITAL NON-EMERGENCY ADMISSIONS

- 7.1 Criteria and Procedures for Prior Authorization. The Member's PCP must request Hospital admission authorization through the Authorization Request (AR) process, or agree to permit another contracting physician to do so by executing a physician Referral Authorization Form, or RAF, prior to any elective admission of a Member when the procedure to be performed requires authorization. The procedures for elective admission authorizations are as follows:

7.1.1 The contracting physician shall request admission authorization through the AR process and shall provide all necessary medical information detailing the Member's medical need for inpatient services. This will be done on an AR (50-1 AR) sent to CenCal Health's Health Services Department by the contracting physician. (ARs may be mailed, faxed or sent electronically).

7.1.2 The contracting physician shall provide CenCal Health's Health Services Department with a descriptive diagnosis detailing of required services with appropriate procedure codes, and any appropriate additional information. This additional information shall include:

7.1.2.1 Chief complaint;

7.1.2.2 Relevant past medical history including previous episodes and treatment of present illness, hospitalization dates and duration;

7.1.2.3 Date of onset of present illness where the Member's prognosis for the present and foreseeable future may establish the need for service(s) requested;

7.1.2.4 Significant associated diagnoses;

7.1.2.5 Limitations of function due to illness, when the service requested is related to a functional limitation or such information would help establish the need for the requested service;

7.1.2.6 Treatment plan and expected duration, when the requested service is one that requires a treatment plan or the services are to be continuous, frequent, or periodic over an extended period;

- 7.1.2.7 Drug regimen when the drugs to be taken by the Members affect any of the above items; and
- 7.1.2.8 Specific goal of therapy, where appropriate.

7.1.3 The completed 50-1 AR Form, RAF from the PCP, if required, and attached medical information, as submitted by the contracting physician, shall be reviewed by Utilization Management Staff, and a decision to approve or defer for further information, or a decision by the Medical Director to approve with modification or deny the request will be made and conveyed to the contracting physician and Hospital in a time frame appropriate to the case.

7.1.4 After review of the medical information provided, a determination will be made on the facts of each specific case. The initial length of stay will be noted on the 50-1 AR Form.

8 GENERAL CRITERIA FOR ACUTE CARE HOSPITAL EMERGENCY ADMISSIONS

An emergency admission is one in which it is reasonable to expect that failure to admit will result in the death, disability, or continued suffering of a Member who is experiencing severe pain, as well as possibly causing the exacerbation of the Member's condition. Admissions to Hospital for any other reason are considered to be elective admissions and shall therefore require authorization.

9 AUTHORIZATION OF ACUTE CARE HOSPITAL EMERGENCY ADMISSIONS

9.1 Requirement for Notification of Emergency Admissions

In the event that Member's condition is an emergent condition as defined in Section 8 of this document, contact with the Member's PCP may be delayed until the Member's medical condition is stabilized. However, in any case, the Hospital shall use its best efforts to contact the Member's PCP regarding an emergency admission within twenty-four (24) hours of the time of admission. Failure of Hospital to use its best efforts to contact the Member's PCP and failure of the Hospital to document such efforts may result in CenCal Health's denial of payment for services rendered.

9.2 Procedures for Review of Emergency Admissions.

9.2.1 The Hospital shall present medical information either electronically or to the UMC at the next weekly UMC onsite review for each Member admitted to Hospital in an emergent condition. The UMC shall review the attached medical

information and shall make an appropriate recommendation, subject to review by the Medical Director.

- 9.2.2 Documentation required. UR staff at Hospital will document the Member's entire stay and provide the Member's medical record if such record is requested by the UMC.

11 AUTHORIZATION FOR EXTENSION OF STAY FOR ALL ACUTE CARE HOSPITAL ADMISSIONS

11.1 Documentation Required. Justification for extension of acute hospital stay beyond the initial length of stay authorized by CenCal Health's Health Services Department must be appropriately documented by the attending physician and entered into the Member's medical record. This applies to all admissions.

11.2 Required Procedures:

11.2.1 It is the responsibility of the Hospital to have its UR staff monitor a Member's level of care on a regular basis and for the UR staff to provide updated medical record information pertinent to the Member's medical condition as delineated in Section 11.1 above, for review by CenCal Health's Health Services Department.

11.2.2 After the medical information has been provided to the UMC, the UMC will approve, defer for further information, or recommend denial of further Hospital stay to the Medical Director at the time of the onsite review.

11.2.4 Recommended UMC denials will be subject to the review and approval or disapproval of the Medical Director.

11.2.5 A provider who disagrees with the decision of the Medical Director may appeal this decision in the manner set forth in the "Procedure for Appeal of Medical Director's Decision", at Section 15 of these Protocols.

12 ACUTE CARE HOSPITAL ONSITE REVIEW PROCEDURES

12.1 Hospital Requirements.

12.1.1 The Hospital shall identify one of its employees to act as a contact person and shall furnish the UMC with a work area and telephone space, preferably in the area where the contact person is located.

- 12.1.2 The contact person is responsible for submitting medical information to the UMC at scheduled weekly onsite reviews.
 - 12.1.3 The contact person shall make copies of hospital prior approved forms available to the UMC upon UMC request.
 - 12.1.4 The contact person is responsible for keeping Hospital administration, the attending physician(s), the Member, or the Member's designated representative apprised of extension of stay determinations.
- 12.2 Onsite Review Procedures.
- 12.2.1 CenCal Health's UMC shall travel to Hospital to review and make recommendations regarding requests for extensions of stay beyond the initial length of stay authorized for hospital admissions.
 - 12.2.2 The UMC reports to the designated work area in Hospital and meets with Hospital contact person. A schedule of onsite reviews is coordinated with the contact person.
 - 12.2.3 The Member's medical record may be reviewed by the UMC when deemed necessary by the UMC. Such review shall take place at a location determined appropriate for such review by the contact person.
 - 12.2.4 If continued stay is approved by the UMC, the UMC indicates at what level care is to be provided.
 - 12.2.5 One approval form shall be used for each acute inpatient stay.
 - 12.2.6 The UMC shall refer recommended denials to the Medical Director.
 - 12.2.7 The UMC shall inform Hospital contact person in writing of the UMC's extension of stay recommendation and the reason for said recommendation.
 - 12.2.8 The UMC shall document a UMC recommendation for the transfer of a Member to a different level of care.
 - 12.2.9 The UMC shall complete the required forms and shall leave the provider copy with the Hospital contact person.

12.3 Non-onsite acute hospital review process

- 12.3.1 Contact CenCal Health UM by phone when member is admitted to acute hospital
- 12.3.2 After member is discharged, please send medical record with completed inpatient authorization form to: CenCal Health UM, 110 Castilian Dr., Goleta, CA 93117-3028.
- 12.3.3 Provider will be notified of CenCal Health's determination per facsimile.

13 CRITERIA FOR AUTHORIZATION OF ACUTE ADMINISTRATIVE DAYS

13.1 Definition. Acute administrative days are those days approved in an acute care inpatient facility which provides a higher level of care than the facility care currently needed by the Member (i.e., licensed nursing facility care).

13.2 Procedures for Authorization of Acute Administrative Days.

- 13.2.1 The necessary documentation shall be presented to the UMC for review at the first onsite visit following the change in the Member's condition, making licensed nursing care appropriate, rather than acute level of care.
- 13.2.2 The Hospital UR staff will prepare any required forms, including all pertinent medical information.
- 13.2.3 Documentation of placement efforts, in accordance with Section 13.3 below shall be submitted along with the required forms.
- 13.2.4 At the time of the onsite visit, after review of the required forms, pertinent medical information, and documented placement efforts, the UMC will approve or defer for further information or will recommend denial of acute administrative days to the Medical Director.
- 13.2.5 Recommended denials of acute administrative days are subject to the approval of the Medical Director.
- 13.2.6 A provider who disagrees with the decision of the Medical Director may appeal the decision in the manner set forth in the "Procedure for Appeal of Medical Director's Decision", at Section 15 of these Protocols.

13.3 Required Placement Efforts. Acute administrative days may be authorized subject to the following:

- 13.3.1 The Hospital shall make five (5) calls per day for the first five (5) working days, to prospective placement facilities within a 60 minute drive of the Member's place of residence, or further at the Member's request or agreement. After the first five (5) working days, Hospital shall make at least two (2) calls per day for an additional twenty (20) days.
- 13.3.2 The calls being made under Subsection 13.3.1 above can cover any number of Members being placed provided that there is documentation in the record that each Member was discussed as a placement possibility.
- 13.3.3 Administrative days shall only be authorized on a day on which the required number of calls have been completed under Subsection 13.3.1 above and provided all other review requirements have been met.

14 PROCEDURES FOR OUTPATIENT SERVICE AUTHORIZATION

- 14.1 RAFs. All outpatient services for case-managed Members shall require prior authorization from the PCP by a RAF or prescription.
- 14.2 ARs. All outpatient services which require prior authorization by AR, as specified by CenCal Health, shall require ARs in order to be eligible for reimbursement by CenCal Health. See the Provider Agreement and RAF and AR Sections of this Provider Manual for additional information regarding authorization.

15 PROCEDURE FOR APPEAL OF MEDICAL DIRECTOR'S DECISION

The Hospital and/or the Member's physician may appeal a utilization review decision of the Medical Director pursuant to the provider appeals and grievance process policy, which is contained in this Provider Manual.

16 MODIFICATIONS OF UTILIZATION MANAGEMENT PROTOCOL

CenCal Health may modify this Utilization Management Protocol For Hospitals, as needed. CenCal Health shall provide Hospital forty five (45) days prior written notice of any proposed material modifications to the Protocols, unless changes are required due to regulatory changes. The Hospital may subsequently choose to accept the proposed modifications or may choose to terminate its Agreement with CenCal Health.