Humboldt IPA

UTILIZATION MANAGEMENT POLICY

Utilization Management (UM) Policy

Reporting Structure and Content

The Medical Director 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 and other IPA staff are responsible for implementation of the UM program. The Quality Management Administrative Committee (QMAC) oversees the UM program (see Section II. Quality Management, C. Governing Body, and Content). A QMAC physician member may act as an alternate Medical Director in the event of the Medical Director's absence. 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 at least annually. The UMP is developed using Health Industry Collaborative Effort (HICE) format. The QMAC reviews all recommendations and revisions before submitting the UMP to the Board of Directors. The Board of Directors of the IPA conducts an annual review of the IPA's UMP periodically and as needed.

Utilization Review Clinical Criteria and Decision Making

The IPA adheres to State of California, National Committee for Quality Assurance (NCQA) and health plan mandated criteria for consistency of reviewing utilization. The IPA's *Approved Resources* (see Appendix C) 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 the development and adoption of standardized clinical criteria.

The IPA's prior authorization requirements are based on the following general principles:

- Patient care should be coordinated by their primary care practitioner (PCP) including any coordination needed during an inpatient stay with the attending physician when specialist consultations and services are needed.
- Referrals for specialty services should be documented in the patient's medical record.
- All pertinent medical records or test results should be forwarded to the specialist.
- Consultation services ordered from an in-network provider to in-network specialists do not require prior authorization.
- Services received by HMO plan members from non-contracted providers are not covered unless pre-authorized as medically necessary from that 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 a PPO plan member accesses services from out-of-network providers without prior authorization, the services are covered at a reduced rate based on their plan coverage.
- A list of codes that require authorization can be found on our website https://humboldtipa.com/wrd-prs/for-providers/authorizations/
- A list of in-network providers can be found on our website https://humboldtipa.com/wrd-prs/provider-search-for-providers/

All information and rationale used during the utilization review process for all prior authorization requests is disclosed upon written request to the IPA from a practitioner, member, or the public. The IPA 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 IPA 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 IPA's UM responsibilities are allocated among staff based on the type of service being reviewed. The IPA's Medical Management Department staff is delegated to approve some service requests for approval following specific IPA policies. Clinically competent licensed California IPA physicians' review/issue all denials and modifications of services based on medical necessity. ''Medically necessary" services and procedures are those services that are "clinically appropriate and in accordance with generally accepted standards of medical practice." Such services shall not be primarily for the convenience of the patient or health care provider and shall not be more costly than an alternative service that is likely to produce equivalent therapeutic or diagnostic results. The use of out of network providers is considered medically necessary only for out of area emergencies OR when a qualified provider is not available in network. 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 C) 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 IPA.) In compliance with Department of Labor (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, including pharmacy/injectable infusions, whether approved, denied or modified, is noted in the electronic authorization by the reviewer(s) to ensure that subsequent reviewers will be able to clearly understand the decision made. All documentation in the system regarding the rationale for the authorization decision includes the identifying information of the reviewer(s) and the date of the review. When making a determination based on medical necessity, IPA staff obtains relevant clinical information and consults with the treating physician or clinician expert as necessary.

When the IPA MD reviewer determines that an alternate treatment plan is more appropriate, the authorization request is denied with information regarding 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. All denials are documented electronically in the system as denied by a licensed California IPA physician as evident by their electronic identifier and the date of the decision.

Humboldt IPA practitioners are ensured independence and impartiality in making referral decisions which will not influence:

Hiring

- Compensation
- Termination
- Promotion
- Any other similar matters

Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. The Humboldt IPA does not specifically reward practitioners or other individuals for issuing denials of coverage or services. The Humboldt IPA does not offer financial incentives to UM decision makers that encourage decisions that result in underutilization.

Utilization Management Policies and Procedures

Authorization Process

The IPA's customer service staff is available from 8:00 am to 4:30 pm on business days to answer questions from providers and members. Staff are identified by name, title and organization name when initiating of returning calls regarding UM issues. Authorization requests are processed each business day from 8:00am to 4:00pm. The processing of authorization requests ends at 4:00pm each day to ensure the necessary decision notifications can be processed prior to the end of each business day. Mail is picked up each day at 11:00am. After 11:00am when a notification letter needs to be mailed that same day, a staff member will take the notification to the post office to be mailed out that day. When this occurs a copy of the stamped letter envelope will be scanned into the system confirming date that it was mailed. Each day the IPA posts the status of all authorization requests received within the past 90 days on its web site at www.humboldtipa.com. Providers interested in viewing authorizations, claims and PPO plan member eligibility can contact customer service for more information. Staff can receive inbound communication regarding UM issues after normal hours. Communication received after normal business hours are returned on the next business day. Communication received after midnight on Monday-Friday are responded to on the same business day. After hours communication can be telephone, Electronic Portal, e-mail or fax.

Providers and members are responsible for ensuring that prior authorization is obtained for services according to the requirements of the member's health plan. The IPA will 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.

In-plan primary care providers may directly refer to in-plan specialists without prior authorization.

In compliance with the Confidential Health Information Act including the additions from AB 1184, prior auth for Sensitive Services (including abortion) is not required and parental consent is not required for children 12 years and older. Adult members may self-refer without prior auth for Sensitive Services except in cases where those services require hospitalization No disclosure of medical information related to sensitive services to anyone other than the Protected Individual/Enrollee (including the policyholder or parent of a minor patient without the Enrollees express written authorization.) All communications regarding sensitive services will be sent directly to the Enrollee at the current address on file unless the Enrollee has otherwise designated an alternative address. All communications regarding a Protected Individuals receipt of sensitive services to be sent directly to the Protected Individual when the following criteria apply:

1. There are communications (written, verbal or electronic communications) regarding the individual's receipt of sensitive services contain the name and address of a provider, description

of services provided, and other information related to a visit when the individual requests the confidential communication.
2. The communications contain protected health information. Provider Organization does not inform parents or legal guardians of a minor's Sensitive Services care and information without minors permission, except as Allowed by law.

All members have direct access to OB/GYN services under Federal Law without any requirement for authorization.

All in-plan providers may request prior authorization. Authorization requests received from non-contracted advanced practice clinicians working under a contracted physician will be accepted under the contracted supervising physician's name only. Authorization requests received from all other non-contracted providers will be returned.

Services Requiring Prior Authorization are described generally in Appendix A and more specific information is available on the IPA's website at www.humboldtipa.com. Emergent and urgent services that require prior authorization should be requested but not at the expense of delaying such treatment pending authorization. Requests cannot be denied for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the patient.

Prior authorization is designed to promote the medical necessity of service, to prevent unanticipated denials of coverage and to ensure that participating providers/practitioners are utilized and that all services are provided at the appropriate level of care for the member's needs. The following statements guide the authorization process:

- Medically necessary services and procedures are those services that are "clinically appropriate and in accordance with generally accepted standards of medical practice";
- Such services shall not be primarily for the convenience of the patient or health care provider; and
- Not be more costly than an alternative service that is likely to produce equivalent therapeutic or diagnostic results.

All medical management decisions including routine, urgent, and prescription injectable/Infusion drug requests are evidenced-based using "Approved Resources." Each month, the MMC reviews the new and revised policies of Anthem Blue Cross and Blue Shield of California HMO plans. The MMC will adopt and implement changes to said policies. The information resources for decision-making of the Medical Management staff include:

1. Federal and State Law Mandates (i.e. Code of Federal Regulations, Department of Managed HealthCare);
2. Medical Policies from Anthem and Blue Shield
3. Imaging guidelines published by Evolent (Blue Shield and self-funded plans) and Carelon Medical Benefits Management, Carelon Rx, (Anthem Blue Cross)
4. MCG 29th edition (formerly known as Milliman Care Guidelines)
5. Humboldt IPA policies (Blue Shield Only)
6. Evidence based clinical literature, i.e. Up to Date (Blue Shield Only) and NCCN
7. Member plan benefit statements
8. Anthem Policy: ADMIN.0006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline
9. Clinical consultation with appropriate Specialists/Physicians

Approved authorizations are effective on the Authorization Action date, which are entered into the system automatically through the authorization review process, and generally expire in three (3) months. Effective dates for retroactive authorization requests will be determined at the time of review (see Retroactive authorization requests below). If requested in advance of the expiration date, extensions may be granted by the IPA's UM staff.

Secondary Insurance Authorizations are not required by the IPA 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 IPA will not authorize services denied as not medically necessary by the primary insurance.

Authorizations may be submitted by IPA member physicians (MD and DO), podiatrists, advanced practice clinicians and optometrists. Requests submitted by specialists must be related to the problem/condition they are managing.

Authorization Request Forms

All authorizations must include medical information necessary to establish the medical necessity of the requested services in order to be considered for approval. Authorizations should be submitted thorough the provider portal found on our website (www.humboldtipa.com).

In the event that online submission through the provider portal is not possible paper-based authorization request forms are available on the IPA's website at www.humboldtipa.com, and can be submitted by mail or fax. Forms are also available upon request or see Appendix D. The completed form can be faxed to (707) 442-2047 or mailed to the IPA at 2315 Dean Street, Eureka, CA 95501.

Necessary Information Required:

- Patient Information
  - First and Last Name
  - Date of birth
  - Member health plan and ID number
- Requesting Provider
- Date of Request (the date you are submitting the authorization request)
- Proposed Provider / Facility
- Diagnosis = ICD-10
- Requested Service
  - CPT codes and
  - Quantity
  - Type of request
  - Urgent
  - Routine
  - Drug
  - Retroactive
  - Outpatient
  - Inpatient

- Incomplete Authorization Request forms – Requests that do not adequately identify the member or provider will be returned 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. Additional information requested will only be that which is reasonably necessary to make a decision per CA Health & Safety Code 1367.01(g)

- 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 Authorization Request Form, but the authorized service(s) may be provided by any provider within the group's tax identification number.
- Prescription injectable/Infusion Drugs – The requesting provider must submit a completed Prescription Drug Prior Authorization Request Form (Form No 61-211) per California State law (SB 866) for all medications requiring prior authorization. Injectable drug requests are not approved if a form other than Prescription Drug Prior Authorization Request form is used. Notification of authorization, denial, or denial for additional information will be communicated by fax to the requesting provider within 72 hours of receipt of request. If a denial notice is not sent within the required 72 hours, the request will be deemed approved. ***Urgent requests will be processed within 24 hours and notification of authorization denial, or denial for additional information will be communicated by fax to the requesting provider within 24 hours of receipt of request. If an urgent prescription injectable or infusion drug authorization comes in on a Friday, or the day before a holiday, the authorization will be processed on that day.***
- 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 – Requests for Surgical Assists must be included with the surgical request. Surgical assistants will be approved when medically indicated. MCG 29th Edition, will be utilized to determining if an assistant is medically necessary. The guidelines were developed with reference to the most recent (2011) American College of Surgeons study "Physicians as Assistants at Surgery". MCG, 29th Edition Assistants at Surgery will also be utilized for claims processing.
- Second opinion requests with a non-contracted provider for HMO members are referred to the health plan for authorization and referral processing. IPA staff process second opinion requests for PPO health plans (see also separate IPA 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 IPA has adopted HMO Experimental and Investigational treatment guidelines for all health plans it administers. Also see separate IPA policy, Investigational & Experimental Service Requests – HMO Health Plans ONLY
- Organ Transplant/Pre-Transplant Review requests for HMO plan members are referred immediately to the health plan for authorization and referral processing. Customer Service staff will notify the appropriate HMO health plan and will not be processed by the IPA. PPO plan member's authorizations requests requiring authorization are processed by the IPA.
- 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 IPA. 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 (see separate policy on Durable Medical Equipment)
- CT provided during the course of radiotherapy treatment.

- "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.
- Services provided when the IPA-administered plan is secondary to other coverage (no prior authorization is needed for services other than rehabilitative therapies).

Retroactive Authorizations will be considered for possible approval for the following services when they are deemed medically necessary:

- Procedures provided as a result of a decision made during an office visit when the procedure was carried out at the visit;
- Services requested within two (2) business days of receipt of the authorization request;
- Other exceptions presented to the Medical Management Committee for review.

Retroactively Approved, Non-urgent Services

Claims for services that are authorized retroactively for medically necessary services that could have been authorized prior to the date service will be allowed at 50% of the regular rate.

The Humboldt IPA conforms to Title 28, California Code of Regulations, 1300.71.4, Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services:

- Emergency Services are covered for screening, stabilization and post-stabilization of the member without prior approval at contracted and non-contracted facilities where a layperson, acting reasonably, would have believed that an emergency medical condition existed.

  A layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment.

  A layperson is considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms, that emergency medical treatment was necessary. Severe pain and other symptoms may constitute such emergency cases.

  Requests cannot be denied for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the claimant (e.g., the member is unconscious and in need of immediate care at the time medical treatment is required).

- Emergency Services are authorized/approved without review of medical necessity. Post-stabilization medical care requests are deemed to be authorized for contracted and non-contracted facilities. 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 IPA prior to processing authorization requests and must be verified by the provider at the time of service. If the member is not eligible on the date of service, the member is financially responsible for the cost of those services.

Timeliness of the IPA's UM decisions is based on HICE standards, which applies turnaround times based on medical necessity (see Appendix B: IPA Utilization Management Timeliness Guidelines). Urgent care services are assigned priority status and routine requests are processed within five (5) days, unless additional information is necessary to process the request.

At the time of the request, all necessary information must be in place; decision will be made in a timely fashion appropriate to the member's condition not to exceed 72 hours after receipt of the request. IPA strives to complete all urgent authorizations within 24 hours of receipt. When urgent authorization requests are received on a Friday or prior to a closed holiday, every effort will be made to complete the authorization request on that day.

Additionally, members will be notified by mail of all decisions regarding routine and urgent requests <72 hours of receipt of requests. Providers will be notified by fax of decisions regarding routine and urgent requests <24 hours of decision being made. Information regarding the status of an authorization request, including the decision, can also be found on the provider portal located on our website.

TAT: Turn Around Time is mandated by Department of Managed Health Care (DMHC), Patient Protection and Affordable Care Act (PPACA) and ICE; with very specific guidelines that the IPA must adhere to.

Routine Request/Non-urgent: All necessary information received at the time of the request; decision to be made in a timely fashion appropriate to the member's condition not to exceed five (5) business days of receipt of the request.

Routine Request/Non-urgent – Extension Needed: Additional clinical information required; see Pended Authorization Request information below.

Urgent Request: PPACA identifies urgent treatment as **treatment that is necessary to prevent jeopardizing a patient's life or treatment necessary to alleviate severe pain that cannot be adequately managed without the requested treatment,** in the opinion of a physician with knowledge of the member's medical condition.

Urgent request – Extension Needed: Additional clinical information required; see Pended Authorization Request information below.

Pended Authorization Request: Authorization request has been received and is insufficient to render a determination. Authorizations may be pended for:

- Additional clinical information was requested but has not been received
- Consultation with an expert reviewer is required and/or
- Additional examinations, treatments or test are required
- In cases where the Medical Director Pends an Authorization and documents the following: "if no additional clinical information is received than the decision is to Deny", the UM RN will wait the entire Pend period of 45 calendar days , as well as faxed reminder to the Provider allowing for an additional 5 business days for submission of additional clinical information. After the required Pend time period for submission of clinical information ends and UM Department has not received requested information, the request will be denied at the end of the 5 business days, per Medical Director.

Pended Routine Request/Non-urgent: Request for additional information is made within five (5) days of receipt of the request. Additional information to be submitted within 45 calendar days. A decision will be made within five (5) business days of receipt of the requested information.

Pended Urgent Request: Request for additional information is made within 24 hours of receipt of the request. Additional information to be submitted within 48 hours**.** A decision will be made within 48 hours of the receipt of the information.

Pended Retroactive/ Post-service Request: Additional information to be submitted within 45 calendar days. A decision will be made within 15 business days of receipt of the requested information.

Routine Prescription injectable/Infusion Drugs – Notification of authorization denial, or denial for additional information will be communicated to the requesting provider within 72 hours of receipt of request. If a denial notice is not sent within the required 72 hours, the request will be deemed approved.

Urgent Prescription injectable/Infusion - Notification of authorization denial, or denial for additional information will be communicated to the requesting provider within 24 hours of receipt of request. If an urgent prescription injectable or infusion drug authorization comes in on a Friday or the day before a holiday, the authorization will be processed on that day.

Notification of all UM decisions, including routine, urgent and prescription injectable/infusion drugs, are sent to the requesting and requested providers via fax and to the member via mail. Additionally information regarding the status of an authorization request, including the decision, can also be found on the provider portal located on our website. Requesting and requested providers can contact the IPA Medical Director by calling the IPA at (707) 443-4563.

All Denied and Modified authorization notifications, including Routine, Urgent and Prescription injectable/infusion drugs, are written following ICE standards. Denied and Modified letters include the following items:

- Notification to requesting providers regarding the availability of the Medical Director to discuss the denial/modification decision with contact information. Communication between requesting provider and physician reviewer may also take place pending the denial decision and/or con-currently.
- Specific reason for the denial that describes why the request does not meet the criteria using language that is easily understood by the member, using layman's terms and at or below the 8th grade reading level.
- Denial reason is specific to the member's condition.
- Citation of the source of the criteria used to determine the denial/modification. Sources include benefit provisions, clinical guidelines, clinical policies or protocols. As stated above, the denial must explain the criteria and why the request does not meet the criteria.
- Explanation of the appeal process.
    - Time frame for filing an appeal (180 days from the post marked date of denial/modified notice).
    - Member opportunity to submit written comments, documents or other information related to the appeal.
    - Description of both a standard appeal and an expedited appeal.
    - Notification that expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.
    - Time frame for decision from the organization/health plan based on type of appeal. (30 days for a standard appeal; 72 hours for an expedited appeal.)
- Member has the right to be represented by anyone they chose, including an attorney.
- Notification of member's right to contact the DMHC and/or Consumer Assistance Program is also included as well as how to contact these entities. (See denial letter template at the end of this document.)

Pended authorization notifications are written following ICE standards. Pended authorization notification letters include the following items:

- Reasons for pending requests includes but not limited to, consultation by an expert reviewer is required; or additional information regarding examination is required.
- Specific information needed.
- Time frame for submitting the information.
- Expected date of decision.
- Type of expert reviewer required, if applicable.

Notification documentation

Authorization notifications are sent to members and providers within 24 hours of the decision. Member notifications are mailed (see authorization process above for additional details) and provider notifications are faxed and are also available on via portal. When a decision is made the notifications are created and the system captures the date and time of notification. (See Appendix for NCQA Timeliness Standards/Written Notification Requirements).

Authorization System (EZCAP): Control, Documentation, Information Integrity

When an authorization request is received by fax or through the portal the system date and time stamps the authorization request, and the requested date and time cannot be edited. When an authorization is received through the mail on paper, all pages of the authorization request are date stamped with the date of receipt. The date the authorization is received is the "Requested" Date and this date is captured the system. All aspects of the submitted authorization requests including the following information: submitted clinical documentation, Humboldt IPA's decision maker (i.e., Utilization Management RNs or UM MD), data elements and contents of the notices are protected from alterations. Once an authorization is finalized (approved, modified, or denied), it is the policy of the IPA that changes are not made to system notes, notices, or other data elements in the authorization.

The EZCAP Authorization Action Date "Auth Action Date" should only be changed once. It is changed one time when the first determination is made on an authorization, i.e., approved, denied, modified, or cancelled. If the "Auth Action Date" is changed more than once, the Authorization Changes Report (see description below) will capture this change and the report is reviewed quarterly and explanation is documented as to why the "Auth Action Date" was changed. Once an authorization is finalized (approved, modified, or denied), it is the policy of the IPA that changes are not made to the system. Exceptions to this rule include: UM Staff (i.e. ,UM RNs, Customer Service Representative and Claims Manager) can extend the Authorization's Expiration Date (of an approved or modified authorization) when services have yet to be rendered and extension is needed and/or when a member's insurance plan terminates.

The EZCAP system maintains logs of any additions, deletions, or changes to the records in the system. The system does not allow authorized users to edit the notes of other authorized users at any point. The Authorization Changes Report captures and logs all modifications and is reviewed quarterly.

Authorization System Control: Authorization Changes Report and System Security

To ensure changes are not made to finalized authorizations, the Authorization System Changes Report is reviewed quarterly by the UM Department to ensure that any modifications adhere to UM Policy and Procedures. The Authorization Changes Report tracks all date modifications, when and who the data was changed by, as well as the new value and the old value. If inappropriate modifications are identified on the Authorization Changes Report, the UM Department Manager will initiate an investigation and take appropriate action when applicable.

Only UM staff (RNs, Customer Service Representative and Claims Manager have access to the operating environment/system (EZCAP) that houses the utilization management data and documentation. The Humboldt IPA's computer servers are maintained solely by the IPA's IT department and a security code is required for entry. See the following policies for more information:

- Building and Computer Access
- Workstation Use

Utilization Management Information Integrity

The following documentation and updates to UM information are inappropriate:

- Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
- Creating documents without performing the required activities.
- Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices).
- Attributing review to someone who did not perform the activity (e.g., appropriate practitioner review).
- Updates to information by unauthorized individuals.

In the event that the Humboldt IPA's CEO, UM Manager, and/ or UM staff discovers inappropriate documentation or fraudulent activity, the Humboldt IPA's CEO and Compliance Officer and Medical Director will be notified immediately. An investigation into the potential inappropriate documentation or fraudulent activity will proceed and if any fraud or misconduct is identified appropriate action will be taken. Appropriate action may include employee termination and reporting to the Health Plans' Delegation Oversight if fraud and misconduct are identified.

To ensure compliance, IPA's UM Manager will conduct annual training(s) with UM staff regarding appropriate conduct and documentation to ensure information integrity.

Specialty Referral Monitoring

On a monthly basis, a report of open authorizations from the previous 90 days is generated and sent to the UM Department for review. An "open" authorization is any authorization that has not had a claim(s) associated with it. The CSR team will contact the provider and/or the member to determine if the service(s) are still needed or if additional action is required.

Care Management

During the UM process, a member may be recommended by any IPA staff to receive care 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 EMR. 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 IPA's quality assurance activities are reported at least quarterly to the QMAC. The following reports are routinely reviewed:

Inter-rater Reliability Studies – The IPA conducts inter-rater reliability (IRR) studies at least quarterly to evaluate consistency in applying UM decision-making criteria between both physician and non-physician reviewers. Inter-rater reliability studies are conducted using the NCQA 8/30 methodology. The IPA will follow the NCQA 8/30 rule and will have an overall pass rate of 90% and that we will interpret a passing IRR as being 80% or greater of the reviewing committee agreeing with the original decision. If the overall pass rate is less than 90% a corrective action plan

is implemented. The goal of inter-rater reliability is to achieve pass rates of at least 90 percent and, if this threshold is not met, a corrective action plan is implemented if consistency is not maintained to act on opportunities to improve consistency. Inter-rater reliability testing is also conducted for all new non physician staff and must pass rates of at least 90 percent before they can conduct utilization review without supervision.

Denial Letter Reviews – The IPA conducts monthly review of denial letters focusing on letter content and format, decision-making consistency and timeliness of decision. One week's worth of denial letters (approximately 25% of all denied or modified authorizations) will be reviewed monthly by the Chief Executive Officer (CEO) for consistency criteria, including but not limited to dispute information, letter criteria, rationale and timeliness of decision and format.

Adverse Outcome – The IPA staff investigates and reports all adverse outcomes to the MMC.

Turnaround Time Reports – The MMC reviews turnaround time reports and makes recommendations for change as needed.

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

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

Resources: 29 CFR 2590.715-2719A(B), 29 CFR 2590.715-2719(b)(2)(ii)(D), 29 CFR 2560.503-1(b)(3), f)(2)(i); 29 CFR 2560.503-1(b)(1)(f)(2)(iii)(A); CA Health & Safety Code 1367.01(h)(5), AL. Ins. Code § 10123.135(h)(1); CAL. Health & Safety Code § 1367.01(h)(4); CAL. Ins. Code § 10123.135(h)(4) (f)(1) & (f)(2)(E), CA Health and Safety Code section 1371.4(a)(b) ; 29 CFR 2560-503-1(b)(3), AB 1194

Position Responsible for Implementing Procedure
UM Medical Director
Chief Executive Officer
UM Department Manager
Claims Manager

DOCUMENT HISTORY

Status	Date	Action
New	02/1996	Approved HDNFMC & IPA Board of Directors
Revised	12/1996	Approved HDNFMC & IPA Board of Directors
Revised	12/1998	Name changed to Medical Management Policy; Approved HDNFMC & IPA Board of Directors
Revised	12/1999	Approved HDNFMC & IPA Board of Directors
Revised	01/2000	Approved by HDNFMC & IPA Board of Directors, added TAT and Milliman Care Guidelines
Reviewed	12/2000	Approved HDNFMC & IPA Board of Directors
Revised	12/2001	Approved HDNFMC & IPA Board of Directors
Revised	09/2004	Approved QMAC
Reviewed	12/2005	Name changed to Utilization Management; Approved QMAC
Reviewed	12/2006	Approved QMAC
Revised	04/2007	Approved CMO & Executive Committee

Updated	04/2008	Authorization requirements updated; TAT; Approved QMAC
Updated	09/2008	Updated in-office lab services and approved UM resources; Approved QMAC
Reviewed	07/2009	Approved by QMAC
Reviewed	06/2010	Approved by QMAC
Updated	09/2010	TAT updated to reflect ICE; Approved by QMAC
Updated	02/2011	Approved by QMAC
Updated	08/2011	Updated routine, pended and urgent auth definitions; Approved by QMAC
Reviewed	10/2011	Approved MMC and QMAC
Reviewed	02/2012	Approved by QMAC
Updated	09/2012	Specialist list updated; Approved by QMAC
Updated	03/2013	TAT and addresses updated; Approved by QMAC
Updated	08/2013	Updated emergency service definition and pend timeliness standards; Approved by QMAC
Updated	12/2013	Added auth form requirements, ER post-stabilization process, denial letter components for member letters and removed footer and added document history; Approved MMC
Updated	2/2015	Approved at QMAC
Reviewed and updated	5/2016	Additional requirements regarding specialty referrals, Pg. 1, Added language regarding not requesting additional information that is not reasonably necessary to make a decision, Pg. 5. Added language regarding Organ Transplant Auth requests for HMO members, Pg. 5. Added language regarding prescription injectable/infusion drug prior Auth process changes per CA law SB 866. Pg. 5.
Updated	7/2016	Retro auth for non-emergent services will be allowed at 50% of regular rate.
Updated	9/20/16	TAT clarification for urgent and routine prescription injectable infusion drugs from 2-4 days to 24-72 hours respectively.
Updated	12/2/16	Include language on page 2 to include pharmacy/injectable infusions with regards to documentation on auth, denial letters.
Updated	2/14/17	Updated urgent notification for provider and member to reflect phone call of notification and documentation in EZ CAP of same.
Updated	12/26/17	To include MCG edition (currently using 24th ed.) and reference on page 3 to not offering financial incentives to UM decision makers that encourage decisions that result in underutilization.
Reviewed	2/2018	
Updated	8/2018	Approved at MMC
Updated	10/2018	Approved at QMAC
Reviewed	1/2019	
Updated	10/2019	Updated the following sections, documentation, specialty referral tracking and Pending authorization requests. Approved by MMC
Updated	1/2020	Added clarifying language regarding EZCAP editing ability and monitoring
Updated	12/2020	Updated MCG edition, ICE TAT grid to current version and documentation language on page 10
Updated	3/2021	Removed “prudent”, updated MCG 25th, and a few additions regarding the authorization process and customer service. Approved at QMAC
Updated	11/2021	Updated ICE Turnaround Grid
Updated	12/2021	Updated IRR to 90% Threshold for passing and added language clarified with Blue Shield Auditor regarding overall pass rate. Reviewed and approved at MMC. Reviewed and Approved at QMAC
Reviewed	1/2022	Review and approved by MMC 11/16/2022
Updated	11/2022	Updated MCG 26th edition
Reviewed	1/2023	MCG 27th edition and clinical resources used for decision making
Updated Updated	4/12/2024 4/30/25	Updated to reflect authorization requirements for out of area being removed Updated NCQA UM 12 Information Integrity and MCG 29th ed (approved by MMC 5/1/2025)

Appendix A: Humboldt IPA Authorization Requirements

Authorization requirements and potential benefit issues are available on the IPA's website at www.humboldtipa.com. PLEASE REFER TO OUR WEBSITE PRIOR TO SUBMITTING AN AUTHORIZATION REQUEST. Search by CPT code or service description. Updates and an Authorization Request form can be found at our website http://humboldtipa.com/ or phone Customer Service (707) 443-4563.

Note: HMO and PPO plans may have different criteria. Please refer to the table below:
HMO Specific Information:

- In-network providers may refer immediately without prior authorization for specialty consultations with in-network specialty providers.
- All services provided by out of plan (non-contracted) providers require prior authorization.

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

The following services require prior authorization to receive maximum financial coverage and to avoid any penalties for non-compliance, depending on the specifics of the health plan:

Service	HMO Plans Anthem & Blue Shield	Blue Lake Rancheria
Biopharmaceuticals / High cost injectable / Chemotherapy* HCPCS Codes requiring prior authorization can be found on our website.	Yes	Yes
DME – Durable Medical Equipment and related supplies Use purchase price if equipment will be rented	Yes > $50.00	Yes > $250
Genetic Testing	Yes	Yes
Hearing Aids Not all HMO members have this benefit; verify	Yes	Yes
Home Health Services	Yes	Yes
Hospital Inpatient Services (non-emergent only)	Yes	Yes
Hospital Outpatient Services (non-emergent only) Lab, plain x-ray and Ultrasounds are excluded, no auth required	Yes	Yes
Hospice	Yes	Yes
Imaging – includes CT, MRI, MRA, PET scans and DEXA scans	Yes	Yes
Infusion Therapy – ambulatory or home bound	Yes	Yes outpatient only
Mental Health Services and Substance Abuse Treatment Inpatient, outpatient, residential services	Contact Anthem or Blue Shield	Yes
Rehabilitative Therapy Services: Acupuncture, Chiropractic Care, Physical, Occupational and Speech Therapy. May not be a covered benefit; please verify. Benefit limitations may apply	Yes	Yes, Auth after 12 combined rehab visits
Respiratory Care May not be a covered benefit; please verify	Yes	Yes
Skilled Nursing Facility Services May not be a covered benefit; please verify	Yes	Yes
Transplants (organ and tissue), peripheral stem cell replacement and similar procedures	Yes	Yes

Utilization Management Timeliness Standards
(Commercial HMO - California)

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**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 **not to exceed 72 hours after receipt of the request.**	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 • 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.		
	Additional information received or incomplete: If additional information is received, 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 not to exceed 48 hours after receipt of information.	*Additional information received or incomplete* 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.	*Additional information received or incomplete* 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.
	Additional information not received: 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 not to exceed 48 hours after the deadline for extension has ended.	*Additional information not received* 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.	*Additional information not received* 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.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**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 Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request 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. **Exceptions:** • 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 *Urgent Pre-service* 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 *Non –urgent Pre-service* category.	Within 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request. **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.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Standing Referrals to Specialists / Specialty Care Centers **-** All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. **NOTE:** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.
Non-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 not to exceed 5 business days of receipt of request.	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.
Non-urgent Pre-Service - Extension Needed • 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.		
	Additional information received or incomplete: If additional information is received, 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.		

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
	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.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	*Require consultation by an Expert Reviewer:* Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 2 business days of making the decision.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**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 - 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). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
Post-Service - Extension Needed • 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.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	*Additional information received or incomplete* Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	*Additional information received or incomplete* Within 15 calendar days of receipt of information.
	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 within an additional 15 calendar days.	*Additional information not received* Practitioner: Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). Member: Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	*Additional information not received* 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.		

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
	Require consultation by an Expert Reviewer: Within 15 calendar days from the date of the delay notice.	*Require consultation by an Expert Reviewer:* Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 15 calendar days from the date of the delay notice.
Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity) 2. Non-Urgent (e.g., post-service pend or denial notifications)	*LAP Services Not Delegated:* All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request 2. Request forwarded within two (2) business days of member's request		*LAP Services Delegated/Health Plan:* All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.
Prescription Drugs CA Health & Safety Code section 1367.241 (CA SB 282; 2015-2016) **Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function **OR** when an insured is undergoing a current course of treatment using a non-formulary drug.*	▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	Practitioner: ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*	Practitioner: ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*

Appendix C: Humboldt IPA Approved Resources

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

1. Medical Policies from Anthem and Blue Shield
2. Federal and State Law Mandates (i.e. Code of Federal Regulations, Department of Managed HealthCare);
3. Imaging guidelines published by NIA (National Imaging Associates, Inc. – Blue Shield and self-funded plans), and Carelon, Carol Rx, Anthem Blue Cross)
4. MCG 27th edition(formerly known as Milliman Care Guidelines)
5. Humboldt IPA policies
6. Evidence based clinical literature
7. Member plan benefit statements
8. 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 Procedural Terminology (CPT), AMA
- Diagnostic & Statistical Manual of Mental Health Disorders (DSM-IV,) APA
- Durable Medical Equipment Billing Guide
- Epocrates
- 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
- Medicare RBRVS, AMA
- National Institute for Health (NIH)
- National Comprehensive Cancer Network (NCCN)
- National Osteoporosis Foundation
- National Quality Measure Clearinghouse - AHRQ
- Part B News, Centers for Medicare and Medicaid Services
- U.S. Preventative Health Services Taskforce (on-line)
- UpToDate (on-line subscription)
- Virtual Examiner (national correct coding guidelines)
- Websites of specialty organizations (e.g., ACOG)

Humboldt IPA Authorization Request Form

Fax completed form to 707-442-2047 or mail to the IPA, 2315 Dean St, Eureka, CA 95501

Incomplete request forms will be returned without being processed.

Notification will be sent to the member, the requesting provider, the member's PCP (if different than the requesting) and the proposed provider.

MEMBER INFORMATION	**Today's Date:**	
Patient's Name:		**Date of Birth:**
Gender: M / F	Patient's Address: _____ Street City Zip	
Phone #:	**Member ID#:**	
Health Plan	HMO: ☐ Anthem Blue Cross ☐ Blue Shield Cal PERs HMO	PPO: ☐ Blue Lake Rancheria ☐North Coast Co Op / PCP:

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):
	Facility Name:

REQUESTED SERVICES AND MEDICAL NECESSITY

TYPE of REQUEST (check one): ☐ Routine ☐ Urgent/Emergent ☐ Retroactive Date:

Diagnosis Description:

ICD(s):

Relevant Clinical Information (and/or attach current clinical notes): _____
_____

Requested Services

Description: _____ CPT: _____ Quantity : _____
Description: _____ CPT: _____ Quantity : _____
Description: _____ CPT: _____ Quantity : _____
Description: _____ CPT: _____ Quantity : _____

Are you also requesting a Surgical Assistant? ☐ Yes ☐ No

PLACE of SERVICE: ☐ Office ☐ Outpatient ☐ Inpatient Date: _____

- Approved authorizations are effective from the date they are received and expire three (3) months from the effective date and are based on the member's eligibility at the time the authorization is reviewed. Providers must verify member eligibility within 5 days of the date of service to ensure coverage..
- 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 IPA 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

HUMBOLDT INDEPENDENT PRACTICE ASSOCIATION
2315 DEAN ST STREET, EUREKA, CA 95501
PHONE: (707) 443-4563 FAX: (707) 443-2527
www.humboldtipa.com

Sample Template
Denial Letter

[Date]

[Member Name]
[or member's representative]
[Address]
[City, State, Zip]

Member Name:	Requested Provider:
DOB:	Requested Service: [use when specific provider requested]
Member ID#:	Requesting Provider/Physician:
Health Plan:	Authorization #:

Dear [Member Name]:

The requesting provider/physician has asked for the above referenced service. The service requested is being [*insert **one**: modified, **or** delayed in delivery, **or** denied*] by the Humboldt IPA because there is ***[insert only one:** lack of medical necessity **or** no covered benefit **or** lack of eligibility.*] This decision was based on your [***insert only one:** medical information **or** evidence of coverage **or** plan eligibility.*]

Insert a clear and concise explanation of the reasons for the decision. [***Medical necessity denials:** Insert description of the criteria or guidelines used to support the action and the clinical reasons in relation to member's health condition. **Conditions of coverage or benefit denials** should include a specific reference contained within the EOC/federal brochure, if possible. **Eligibility denials** should provide information specific to requested service or coverage. **Post-service (retro) denials should refer the member to the EOB for claim amounts.***] *Insert any alternative recommended treatment or service.*

You may obtain a free of charge copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request, by calling the Humboldt IPA at (707) 443-4563 ext. 154. You may contact your provider for detailed information about your diagnosis or treatment. This could include the detailed codes and their meanings.

[*Insert in Member letter:* The requesting provider/physician has been advised of this denial and given the opportunity to discuss this determination with Humboldt IPA physician reviewer.]

[*Insert in Provider letter:* If the treating physician would like to discuss this case with the physician or health care professional reviewer or obtain a copy of the criteria used to make this decision, please call Dr. Candy Stockton at (707) 443-4563 ext. 143.]

How to Dispute This Determination*

If you believe that this determination is not correct, you have the right to appeal the decision by filing a grievance with your health plan. Your health plan requests that you submit your grievance within 180

days from the postmark date of this notice. You, your provider, or an attorney or representative on your behalf may submit your grievance verbally or in writing. You may call your health plan to learn how to name your authorized representative.

There are two types of grievances: *standard and expedited*.

IV. Standard Grievance Process

A standard grievance will be resolved within 30 calendar days. Your health plan will notify you in writing of the decision within 30 calendar days of receiving your grievance.

Expedited/72 hour Grievance Process

You have the right to an expedited decision when the standard decision-making process might pose an imminent and serious threat to your health, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. Your health plan will evaluate your request and health condition to determine if it qualifies for an expedited decision, which will be processed as soon as possible to accommodate your condition, not to exceed 72 hours. To request an expedited decision, you or your physician on your behalf can call or write your health plan as listed at the end of this letter. Specifically state that you want an expedited decision, and that waiting for the standard process might seriously jeopardize your health. Expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.

Submitting Your Grievance

Please submit a copy of your denial notice and a brief explanation of your situation, or other relevant information to your health plan. Your health plan will document and process your standard or expedited grievance and provide you with written notification of the decision. You may write, call or fax your grievance to your health plan. Health plan address, telephone and FAX number is listed at the end of this letter.

Urgent Grievance

Urgent Grievance Request must be sent to the Health Plan within 1 hour of receipt.

Department of Managed Health Care Complaint Process

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **(800) 424-6521 or TTY/TDD line (800) 241-1823** and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. The DMHC also has a toll-free telephone number **(888) HMO-2219** and a TTY line **(877) 688-9891** for the hearing and speech-impaired. The DMHC's website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

Independent Medical Review through the DMHC – voluntary appeal procedure

Members have the right to request an IMR through the DMHC, as indicated in the above paragraph. Members may apply for an IMR if A) the member's provider has recommended a healthcare service as medically necessary, or B) the member has received urgent care or emergency services that a provider determined was medically necessary, or C) in the absence of a provider recommendation or the receipt of urgent care or emergency services, the member has been seen by an in-plan provider for the

diagnosis or treatment of the medical condition for which the member seeks independent review. Expedited external medical review can occur concurrently with the internal appeals process for urgent care. Members can contact the DMHC directly.

Employee Retirement Income Security Act (ERISA) notification

If your employer's health plan is governed by the Employee Retirement Income Security Act (ERISA), you may have the right to bring a civil action under Section 502(a) of the ERISA if all required reviews of your claim appeal have been completed and your claim has not been approved. Additionally, you and your health plan may have other voluntary alternative dispute resolution options, such as mediation.

You are entitled to, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Other resources to help you: Do you have questions about your appeal rights or this notice? Need help with an appeal? You can get help from the Consumer Assistance Program (CAP) in California.
California Department of Managed Health Care Help Center
Toll Free: 1-888-466-2219 TDD/TTY 1-877-688-9891
http://www.healthhelp.ca.gov .

Federal Employee Health Benefit Program (FEHBP) members: The preceding appeals information does not apply to participants of the FEHBP. If you are covered by the FEHBP, please refer to Section 8, *The Disputed Claims Process*, of your Federal Brochure, which explains the FEHBP appeals process.

Sincerely,

Humboldt IPA

cc: Member File
[Requesting Physician]
[PCP]
[Health Plan]
As indicated

Standard Grievance	Expedited Grievance
Health Plan Name Attn **Address** Telephone TTY/TDD: **Fax:** Internet:	**Health Plan Name** Attn **Address** Telephone TTY/TDD: **Fax:** Internet:

[Insert health plan LAP Notice of Translation]

Date

Member or Member's Representative
Address
City, State Zip

Sample Template
Pend Letter

Member Name: **Requested Provider:**
DOB: **Requested Service:**
Member ID#: **Requesting Provider:**
Health Plan: **Authorization #:**

Dear Member:

This correspondence is in response to your request or your physician's request received on [date] for the above referenced service. In some instances the Humboldt Independent Practice Association needs additional time in order to obtain all the necessary information to render a determination. This is not a DENIAL. Your request is pended for the following reasons:

Information received to date is insufficient to render a determination.

In the case of your request, the following extension is required:

We are requesting the additional information listed below be submitted within 45 calendar days.
A decision will be made within 5 business days of receipt of the requested information. The physician reviewer is unable to make a determination on the service request based on available information. If we do not obtain additional information by this deadline, we may have to issue a denial. Your physician can re-submit the request for authorization at a later date.

Specifically, we are requesting the following information from [provider/physician]:

We are requesting more information about your condition from your doctor. There is nothing that you, the patient, need to do during this time.

Thank you for your patience during this process. Please contact the Humboldt IPA if you have any questions or information.

(phone) 707-443-4563
(fax) 707-442-2047

Sincerely,

Humboldt IPA

cc: [Ordering Physician/Provider]
Member File