SAN FRANCISCO HEALTH PLAN

CO-01 - Utilization Management Notice of Action Letters

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: Nina Maruyama 9D4617B1400D431...	CCO	5/29/2024	Policy Update
DocuSigned by: Steve O'Brien 60DFB20814944C4...	CMO	6/4/2024	

SAN FRANCISCO HEALTH PLAN

SFHP POLICY AND PROCEDURE

Utilization Management Notice of Action Letters

Policy and Procedure Number:	CO-01
Department	Clinical Operations
Accountable Lead	Clinical Operations Analyst
Lines of Business and Coverage Programs Affected:	☒Medi-Cal ☒Healthy Workers HMO ☐Healthy SF ☐City Option ☐ All lines of business and coverage programs as listed above

POLICY STATEMENT

San Francisco Health Plan (SFHP) ensures members receive timely, consistent, and correct information regarding the management of their medical care, including information about their rights to appeal denials, modifications, or deferrals of care. SFHP sets standards for the content of Notice of Action (NOA) letters and establishes timeframes for notifying members and practitioners of the UM decisions as mandated by the appropriate regulations, Department of Managed Health Care (DMHC) and Department of Health Care Services (DHCS), and National Committee for Quality Assurance (NCQA) accreditation guidelines. SFHP follows NCQA guidelines, if not in conflict with current regulatory requirements, and DHCS required templates and standards for NOA letters. SFHP distributes NOA letter templates to its Delegated Medical Groups.

This policy pertains to services provided via the medical benefit, please refer to Pharm-02 for pharmacy authorizations and NOAs.

PROCEDURE

I. SFHP renders decisions to approve, defer, deny, or partially deny Preservice, Concurrent, and Post-service Requests. SFHP does not terminate, suspend, or reduce previously authorized services.

II. Decision notifications are provided to the member and provider using a written Notice of Action (NOA) letter. Approval determinations for concurrent requests are only communicated to the member's treating provider, in accordance with H&S Code 1367.01.

III. Required NOA letter contents, outlined below, vary between approvals and Adverse Benefit Determinations (i.e., denials, deferrals, and partial denials).

IV. All member NOA letters are accompanied with a DHCS approved nondiscrimination notice and language assistance taglines.

V. SFHP provides NOA letter templates to its delegated medical groups in its identified threshold languages. All NOA letters in English are written at the sixth (6^{th}) grade reading level.

VI. Approval NOA letters

A. The content of Approval NOA letters:

1. The template language of the Approval NOA letter, if appropriate, is fully translated in members' identified written threshold language or provided in members' preferred alternate format. Specific portions of the letter may be in English, as long as the letter is accompanied by the tagline document and nondiscrimination notice.
2. Date of decision.
3. Member name and identifying information.
4. Requesting provider name.
5. Service that was requested.
6. Approved service quantity.

VII. Denial, Partial Denial, and Deferral NOA letters

A. The content of Denial, Partial Denial, and Deferral NOA letters for members and their treating providers:

1. The template language as well as the decision rationale for denials, partial denials, and deferrals, are fully translated in the member's identified written threshold language or provided in the member's preferred alternate format.
2. Date of decision.
3. Member name and identifying information.
4. Requesting provider name.
5. Service that was requested.
6. Reason(s) for deferral, denial, or partial denial (e.g., benefit restriction or exclusion, medical necessity, etc.) are written in clear, concise, consumer-friendly language, absent of abbreviations and technical terms.
    a. Deferral NOA letters include:
        i. The specific information SFHP requested but did not receive, the expert reviewer consulted, or additional examinations or tests required before the service can be approved or denied.
        ii. The anticipated date on which a decision may be rendered.
    b. Denial/Partial Denial NOA letters include:
        i. A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision is based (e.g., EOC, Member Handbook, MCG criteria, SFHP Policy).
        ii. A statement that members can obtain a copy free of charge of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request.
        iii. Decision-Maker's signature.

    1. Medical necessity denials are determined by a physician (e.g., Medical Director, CMO, physician designee). The reviewing physician's signature is included in the NOA.
    2. Benefit/Administrative denials (e.g., benefit restrictions or exclusions, other primary health coverage, eligibility terminations), may be determined by a UM Nurse or physician. The decision-maker's signature is included on the NOA.
7. Instructions on how to contact SFHP.
    a. Provider NOA letters include the direct contact information of the decision maker (physician or UM Nurse) to ensure the treating provider has the opportunity to discuss the adverse decision.
8. Directions to the member concerning the next steps that should be taken. (e.g., "Please call your primary care provider at 415-XXX-XXXX for additional treatment options.")
9. Language explaining how the member or member's representative may appeal the decision. The "Your Rights" enclosure, in the members written threshold language, includes:
    a. A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.
    b. An explanation of the appeal process, including members' rights to representation and appeal timeframes.
    c. A description of the expedited appeal process for urgent preservice or urgent concurrent denials.
    d. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.
10. **Medi-Cal members** are informed of their right to, and method of, obtaining a DHCS State Fair Hearing. They are given State Ombudsman information as well as a State Fair Hearing form to contest the denial, deferral, or partial denial decision made by SFHP or its delegated medical group. Medi-Cal members are also informed that they may represent themselves at the State Fair Hearing or be represented by legal counsel, friend, or other spokesperson. The State toll-free telephone number for obtaining information on legal service organizations for representation is also included.
11. **Medi-Cal and Healthy Workers HMO members** are informed of their right to, and method of, obtaining a DMHC Independent Medical Review (IMR). If the requested service is denied as experimental or investigational, SFHP includes an IMR application and an envelope addressed to DMHC. See CO-59: Experimental or Investigational Service or http://www.dmhc.ca.gov/imr/.
12. Informing language that states eligibility is not affected by the denial or appeal process.
13. The DMHC mandated language located in Section 1368.02 of the Health and Safety Code.

SFHP ensures regulatory utilization management timeliness standards for decision making and member and provider notification are followed. The postmark on the notification is used to confirm compliance with timeliness standards. For purposes of calculating turnaround times, the receipt date of a provider request is considered to be "day zero (0)." SFHP turnaround times for decision making and member and provider notification are as stated CO-22: Authorization Requests. Delegated medical groups must follow SFHP turnaround times.

MONITORING

A. SFHP follows National Committee for Quality Assurance (NCQA) guidelines, if not in conflict with current regulatory requirements, and Department of Health Care Services (DHCS) required templates and standards for NOA letters. The Clinical Operations Department conducts a quarterly internal audit of approved, modified, partially-denied, and denied authorization files. The purpose of the internal audit is to ensure SFHP's Clinical Operations files (including NOAs) are meeting the statutory/regulatory requirements of DHCS and DMHC and the accreditation guidelines of NCQA. The audit follows NCQA's 8/30 audit sample methodology.

B. Medical groups delegated to perform utilization management are audited annually as outlined in DO-02 Oversight of Delegated Functions.

DEFINITIONS

Adverse Benefit Determination: any of the following actions taken by SFHP:

i. Denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
ii. Reduction, suspension, or termination of a previously authorized service.
iii. Denial, in whole or in part, of payment for a service.
iv. Failure to provide services in a timely manner.
v. Failure to act within required timeframes for resolution of Grievances and Appeals.
vi. Denial of a beneficiary's request to dispute financial liability.

Concurrent Request: A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if SFHP did not previously approve the earlier care.

Day Zero: Receipt date of a provider request

NCQA's 8/30 Methodology: Thirty files are randomly selected for review, along with 10 alternate records for a total of 40, in case one of the 30 records is not applicable/ineligible and must be replaced. Eight of the 30 for compliance, and if all eight are in compliance, the review is complete and compliant. If one or more of the

initial eight files is out of compliance, then the additional 22 files are reviewed for a total of 30 to assess compliance.

Notice of Action (NOA): A formal letter from SFHP informing a member of an "adverse benefit determination."

Notice of Adverse Benefit Determination (NABD): Same definition of NOA. DHCS has retained use of NOA for ease of understanding by members.

Preservice Request: A request for coverage of medical care or services that require advanced approval from SFHP before being rendered.

Post-service Request: A request for coverage of medical care or services that have been rendered (e.g., retrospective review).

AFFECTED DEPARTMENTS/PARTIES

Compliance and Regulatory Affairs
Delegated Groups
Delegation Oversight
Health Services -- Clinical Operations
Health Services -- Health Services Operations
Operations – Marketing & Communications
Operations -- Member Services
Operations -- Provider Network Operations

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. CO-22: Authorization Requests
2. CO-57: Clinical Criteria
3. CO-59: Investigational or Experimental Services
4. CRA-24: Responding to State Inquiries about Member Complaints
5. MC-03: Translation of Member Materials
6. Notice of Action (NOA) Letter Templates
7. Pharm-02: Pharmacy Prior Authorization
8. Pharm-08: Annual Review of Formulary, Prior Auth Criteria, and Policies
9. DO-01: Oversight of Delegates
10. GA-01: Clinical Member Grievances
11. GA-03: Member Appeals
12. Translation & Mail Process Flow Document

REVISION HISTORY

Effective Date: November 6, 2006

Revision Date(s): January 31, 2007; May 19, 2009; July 18, 2013; April 27, 2012; April 10, 2014; August 22, 2014; January 28, 2015; September 14, 2015; February 22, 2016; April 21, 2016; May 24, 2018; May 21, 2020; June 18, 2020; February 25, 2022; July 21, 2022, January 2024, May 23, 2024

REFERENCES

1. 28 CCR §1300.68
2. 42 CFR 438.210(c); 42 CFR 438.404
3. 22 CCR §§53858, 53893, 53894, 51014.1, and 51014.2
4. Health and Safety Code §§1363.5, 1367.01,1368, 1368.01, 1368.02, 1368.03, 1368.04, 1370.4, 1374.30, 1374.31, 1374.32, 1374.33, 1374.35, and 1374.36
5. Welfare and Institutions Code §10961
6. DHCS Contract, Exhibit A, Attachment 3, Subsection 5.1.5,Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests
7. NCQA Standard UM 5: Timeliness of UM Decisions
8. NCQA Standard UM 7: Denial Notices
9. DHCS APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
10. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and “Your Rights” Templates DHCS APL 22-002 Alternative Format Selection for Members with Visual Impairments