SAN FRANCISCO HEALTH PLAN

CO-57: UM Clinical Criteria

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: John Grgurina 5BD8B5B0FBA7424...	CEO	12/7/2020	Biennial Review
DocuSigned by: Jim Glauber 2C964B5A45074F7...	CMO	12/4/2020	

SFHP POLICY AND PROCEDURE

Utilization Management Clinical Criteria

Policy and Procedure Number:	CO-57
Department Owner:	Clinical Operations
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) conducts utilization management (UM) to manage covered benefits through the consistent application of medical necessity criteria used in a systematic hierarchy. For services subject to Clinical Operations' medical benefit, UM review is performed through the evaluation of a member's relevant clinical information against established clinical criteria that meet professional standards of care.

SFHP uses external criteria MCG care guidelines, State/Federal (Medi-Cal/CMS) and when available and, in limited circumstances, internally developed and approved criteria.

SFHP internally reviews and recommends changes to its clinical and level of care criteria through the UM Committee (UMC) to ensure they continue meeting professional standards of care. Annually, the UMC approves each set of clinical criteria with oversight and consensus from the Quality Improvement Committee (QIC).

Procedures for pharmacy criteria are addressed in Pharm-01 (Pharmacy and Therapeutics Committee, Pharm-02 Pharmacy Prior Authorization, and Pharm-08 (Pharmacy Formulary, Prior Authorization Criteria, and Policy Review).

PROCEDURE

I. Criteria Hierarchy

Resources are used to assist the Clinical Operations Nurse and Medical Director staff (hereafter referred as UM staff) in determining the medical necessity of requested services. SFHP's clinical criteria hierarchy in order includes:

A. SFHP internally developed and approved criteria

1. Genital Gender Confirmation Services
2. Non-Genital Gender Confirmation Services
3. EPSDT Private Duty Nursing

B. MCG Care Guidelines
C. State/Federal (Medi-Cal/CMS) criteria – (Medi-Cal only)
    1. If no Medi-Cal Criteria is available, Medicare/CMS criteria can be consulted on a case by case basis.
D. Chief Medical Officer (CMO) or physician designee (MD) review of the evidence in consultation with relevant external, independent specialty expertise obtained from SFHP's Independent Review Organization when there are no available external or internally developed and approved criteria.

II. Application of Criteria

A. SFHP and its Delegated Medical Group (DMG) UM staff, including Beacon for non-specialty mental health services, must use professionally accepted evidence-based criteria. UM staff is required to apply criteria in the order of the hierarchy. If a service is not addressed in the primary criteria, UM staff consults subsequent criteria in order until finding the relevant criteria.
B. Clinical information evaluated with reference to these criteria may include, but are not limited to:
    1. Office and hospital records
    2. History of the presenting problem
    3. Physical examination results
    4. Diagnostic testing results
    5. Treatment plans and progress notes
    6. Information on consultations with the treating practitioner
    7. Evaluations from any other health care practitioners and providers
    8. Any operative and pathological reports
    9. Rehabilitation evaluations
    10. Patient characteristics and information
    11. Treating physician statements of medical necessity
C. Criteria must be applied in conjunction with consideration of the individual member needs and characteristics such as age, cultural and linguistic needs, comorbidities, complications, progress of treatment, psychosocial needs, and the home and/or work environment. In addition, characteristics of the local delivery system available to the individual, including aspects such as the availability of alternative levels of care, timely accessibility of covered services, cultural preferences for treatment modalities, availability of specialty providers, access to community resources, familial influences and supports, benefit coverage for the available alternatives, and ability of local providers to provide all recommended services within the required access standards must also be considered.

III. Review and Approval of Criteria

A. The UMC review clinical criteria as needed, but at least annually to ensure that they are current. Information sources to gather data on potential changes to clinical criteria include, but are not limited to:
   1. Evaluation of member complaints, grievances, and appeals.
   2. Frequent and consistent overturns of SFHP denials through Independent Medical Review (IMR).
   3. New and/or revised statutory or regulatory requirements, including DHCS directives and All Plan Letter or Policy Letters.
   4. Changes to guidelines or practice protocols.
   5. Increased volume or rate of denied authorization requests.
   6. Availability of new technologies and/or treatments.
   7. Addition of new benefits or services.
   8. Concerns raised through the Member Advisory Committee (MAC), Pharmacy and Therapeutics Committee (P&T), or QIC.
   9. Provider or member input/feedback.

B. In considering the development of and/or changes to clinical criteria, the UMC considers the following:
   1. New technologies (See CO-54 Evaluation of New Technology).
   2. Other health plans' criteria – reflecting community standards of care.
   3. Evidence-based clinical practice guidelines produced by specialist associations, U.S. government agencies, and health care organizations.
   4. Medicare and Medicaid (Medi-Cal) guidelines.
   5. Benefit changes.
   6. Statutory and regulatory changes.

C. The UMC and QIC both review and approve the criteria hierarchy and adopt SFHP-developed and vendor purchased criteria annually.

IV. Communication of UM Criteria

Practitioners and enrollees are informed how they may obtain copies of UM criteria utilized for decision-making, and are provided upon on request. SFHP also communicates with practitioners through the Network Operations Manual (NOM) and the SFHP website to ensure their awareness of prior authorization procedures and timeframes. The public may obtain the relevant UM criteria for specific medical procedures or conditions on request. If there is a charge, the charge may not exceed the cost of copying and postage. When disclosed to the public, the notice that accompanies the criteria says, "The materials provided to you are criteria used by this plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

MONITORING

A. SFHP's Clinical Operations Department performs inter-rater reliability (IRR) audits at least annually for both physicians and nurse reviewers to evaluate the consistency and accuracy with which its reviewers apply UM criteria. The assessment is a standard IRR tool created by MCG using hypothetical case scenarios and multiple

choice answers to assess the accurate and consistent application of patient clinical presentations against medical necessity criteria. Reviewers are allowed two opportunities to reach the passing threshold of 80 percent. Reviewers who are unable to reach a 80 percent threshold are placed on an educational corrective action, which may include but is not limited to attendance of an internal MCG care guidelines training session, more frequent case review, supervisor feedback, and IRR reassessment.

SFHP's Clinical Operations Department also audits ten randomly selected medical necessity denials per quarter utilizing a proprietary audit tool, which includes NCQA, DHCS, and DMHC requirements. These include administrative requirements (turnaround time, Notice of Action readability, inclusion of appropriate appeal and grievance rights language) and clinical requirements (accurate criteria selection, accurate application of clinical information).

Results of the IRR assessment and denial audit are presented to the UMC and discussed for potential improvements. Final versions are submitted to QIC for review and comment.

B. SFHP's Clinical Operations Department reviews this policy and procedure to evaluate the utilization management guidelines at least annually and more frequently if necessary. Any changes to the guidelines are reviewed by SFHP's Utilization Management Committee (UMC) for consistency with sound clinical principles. UMC approves each set of clinical criteria with annual oversight and consensus from the Quality Improvement Committee (QIC).

C. SFHP employs the following monitoring mechanisms to reevaluate an existing or identify the need to develop new UM criteria:
    1. Medical record audits by SFHP's Clinical Operations Department.
    2. Review of member and provider satisfaction surveys, complaints, grievances, and appeals by SFHP's Health Outcomes Improvement Department.
    3. Overturns of medical necessity denials, especially overturns in which additional clinical information was not needed to reach the alternative determination by SFHP's UMC.
    4. Reports of cases sent for external medical review due to no criteria available by SFHP's UMC.
    5. Review of Clinical Operations utilization reports by SFHP's UMC.

D. When SFHP delegates UM to a contracted medical group, SFHP is accountable for assuring that the delegated medical group conducts UM according to SFHP's standards, which incorporate applicable DMHC, DHCS, and NCQA requirements. For each delegated medical group, SFHP's Clinical Operations and Compliance and Regulatory Affairs:
    1. Review the UM program to identify if the medical group is following the standards of application, approval, and evaluation of medical necessity criteria.

2. Review a sample of UM denial files to evaluate compliance with the use of relevant criteria and clinical information, as well as, the availability of criteria to practitioners.

DEFINITIONS

Medical Necessity: The Medi-Cal definition of Medical Necessity is reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. For members who are eligible for EPSDT services, services are determined to be medically necessary when needed to correct or ameliorate defects and physical and mental illnesses or conditions.

AFFECTED DEPARTMENTS/PARTIES

Compliance and Regulatory Affairs
Health Services -- Health Outcomes Improvement
Medical Directors
Quality Improvement Committee (QIC)
Utilization Management Committee (UMC)

RELATED POLICIES & PROCEDURES, DESKTOP PROCESS & PROCESS MAPS

1. CO-22: Authorization Requests
2. CO-33: EPSDT and EPSDT Supplemental Services
3. CO-54: Evaluation of New Technology
4. DO-02: Oversight of Delegated Functions
5. Pharm-08: Pharmacy Formulary, Prior Authorization Criteria, and Policy Annual Review
6. UM Criteria for EPSDT Private Duty Nursing
7. UM Criteria for Genital Gender Confirmation Services
8. UM Criteria for Non-Genital Gender Confirmation Services

REVISION HISTORY

Effective Date:	August 20, 2015
Revision Date(s):	February 17, 2017; April 20, 2017; September 21, 2017; April 19, 2018; November 21, 2019; December 12, 2019; May 21, 2020, November 19, 2020

REFERENCES

1. DHCS/SFHP Contract Exhibit A, Attachment 5, Provisions 1, 2
2. H&S Code §§1363.3, 1367.01
3. W&I Code §14059.5

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
sfhp.org

Date

FirstName LastName

1234 Address Street
San Francisco, CA 94110

RE: Request for Criteria

Dear [member or provider],

This letter is in response to your request for the criteria used to make our authorization decision for [requested procedure or service.]

The materials provided to you are criteria used by this plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered for [Medi-Cal HMO or Healthy Workers HMO].

If you have any questions, please contact xxx at (415) xxxx

Sincerely,

San Francisco Health Plan

Clinical Operations