

SAN FRANCISCO HEALTH PLAN**CO-01: Utilization Management Notice of Action Letters**

APPROVAL/REVIEW/REVISION HISTORY			
Signature	Title	Date	Action
<p>DocuSigned by: <i>John Grigurina</i> 5BD8B5B0FBA7424...</p>	CEO	6/30/2020	Biennial Review
<p>DocuSigned by: <i>Jim Glauber</i> 2C964B5A45074F7...</p>	CMO	6/30/2020	



SFHP POLICY AND PROCEDURE

Utilization Management Notice of Action Letters

Policy and Procedure Number:	CO-01
Department Owner:	Clinical Operations
Lines of Business and Coverage Programs Affected:	<input checked="" type="checkbox"/> Medi-Cal <input checked="" type="checkbox"/> Healthy Workers HMO <input type="checkbox"/> Healthy SF <input type="checkbox"/> City Option <input type="checkbox"/> 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 also 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 notifies members of a decision to approve, deny, defer, or partially deny requests for Prior Authorization by providing written notification (Notice of Action Letters or "NOA") to members and/or their authorized representative. 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 (6th) grade reading level. The review and signature of a licensed physician is required for all denials involving medical necessity determinations. NOA letters addressing benefit restrictions or exclusions may be signed by a UM Nurse or Medical Director.

In the event other coverage (e.g., Medicare, commercial) is confirmed as primary, SFHP issues a written NOA informing the member and/or the member's authorized

representative of the denial of coverage. Such denials are considered benefit exclusions and may be signed by a UM Nurse or Medical Director.

Members receives notification of any provider-requested modification that has been approved.

II. 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 the member's identified threshold language. Specific portions of the letter may be in English, as long as the letter is accompanied by a statement that informs the member of the availability of language assistance services. The statement reads "If you need assistance to translate this letter in another language, please call San Francisco Health Plan (or medical group) at 1-800-288-5555."
2. Date of decision.
3. Member name and identifying information.
4. Requesting provider name.
5. Service that was requested.
6. Approved service quantity.

III. Denial, Partial Denial, and Deferral NOA letters

A. The content of Denial, Partial Denial, and Deferral NOA letters:

1. The template language of the Denial, Partial Denial, and Deferral NOA letters if appropriate are fully translated in the member's identified threshold language. Specific portions of the letter, viz., the free text fields in the template, (e.g., reason for denial, etc.) may be in English only, as long as the letter is accompanied by a statement that informs the member of the availability of language assistance services. The statement reads "If you need assistance to translate this letter in another language, please call San Francisco Health Plan (or medical group) at 1-800-288-5555."
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 modification (e.g., benefit restriction or exclusion, medical necessity, etc.) written in clear, concise, consumer-friendly language, absent abbreviations and technical terms.
7. Specific language explaining the reason(s) for denial or modification from the EOC and/or Member Handbook in easily understandable language; and may include medical necessity and appropriateness criteria used in making the determination. (MCG care guidelines are one source for decision-making by a SFHP Medical Director or designee.) The letter includes notification that the member can obtain a copy of the criteria upon request.
8. Instructions on how to contact SFHP.

9. 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.")
10. Language explaining how the member or member's representative may appeal the decision, including the process for requesting an expedited review.
11. An enclosure in threshold languages explaining a member's appeal rights in the member's threshold language. Medi-Cal members are informed of their right to, and method of, obtaining a State Fair Hearing. They are given the State Ombudsman information 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.
12. Language informing the member about DMHC's Independent Medical Review (IMR) process is included if authorization is denied for medical necessity or experimental or investigational treatments. Application and other forms must be included when the member reaches the final level of appeal or the appeal has been opened for 30 days. See SFHP policy CO-59: Experimental or Investigational Service or <http://www.dmhc.ca.gov/imr/>.
13. Informing language that states eligibility is not affected by the denial or appeal process.
14. The DMHC mandated language found in Section 1368.02 of the Health and Safety Code at <http://www.leginfo.ca.gov/>.
15. Informing language on appeal rights and how to gain assistance in the member's primary language.

IV. SFHP ensures regulatory utilization management timeliness standards for decision making and member and provider notification are followed. 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.

- V.** Advanced Notice of NOA for termination, suspension, or reduction of previously authorized covered services:
- A. At least ten (10) days advanced notice is given to a member when a Notice of Action results in a termination, suspension, or reduction of previously authorized covered services. This may be shortened to five (5) days if probable recipient fraud has been verified.
 - B. Advance notice of a termination, suspension, reduction of services, or reduction of previously authorized covered service is not required when the following conditions apply:
 1. Death of a member.

2. Member provides a written statement requesting service termination or giving information requiring termination or reduction of services.
3. Member admission into an institution that makes the member ineligible for further services.
4. Member's address is unknown and mail directed to the member has no forwarding address.
5. Member has been accepted for Medi-Cal services by another local jurisdiction.
6. Member's Primary Care Provider prescribes a change in the level of medical care.
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions.
8. Safety or health of individuals in a facility would be endangered.
9. Member's health improves sufficiently to allow a more immediate transfer or discharge.
10. An immediate transfer or discharge is required by the member's urgent medical needs.
11. Member has not resided in the nursing facility for a minimum of 30 days.
12. Member is disenrolled for any other reason.

When UM is delegated, SFHP oversight is conducted in accordance with the Delegation Agreement and the Responsibilities and Reporting Requirements grid with each delegated medical group. The Clinical Operations and Delegation Oversight Teams conduct an annual UM audit of the performance at each delegated medical group. This audit includes a review of all denial, modification and appeal files, and a review of NOA letters. If deficiencies are found, the medical group has 30 days to take corrective action

MONITORING

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.

DEFINITIONS

Business Day: Every official working day of the week. The days between and including Monday to Friday, and do not include federal holidays (as defined by the U.S. Office of Personnel Management) or weekends.

Calendar Day: All the days in a week, month, or year, including weekends and holidays.

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 + 10 files are reviewed 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.

Post Service: A service or procedure that has already been rendered.

AFFECTED DEPARTMENTS/PARTIES

Compliance and Regulatory Affairs
Delegated Groups
Delegation Oversight
Health Services -- Clinical Operations
Health Services -- Health Outcomes Improvement
Operations -- Customer Service
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. PR-12: Oversight of Delegated Functions to Medical Groups
10. QI-06: Clinical Member-Grievances
11. QI-17: Member Appeals

REVISION HISTORY

Effective Date: November 6, 2006
Revisoin 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

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. Medi-Cal Managed Care Division All Plan Letters 17-006 (5.9.17)
7. DHCS Contract, Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests
8. NCQA Standard UM 5: Timeliness of UM Decisions