No. UM-009	Referral Management	
Effective Date: 01/01/2020	POLICY AND PROCEDURE	
Previous Versions: see revision history on last page		
DMHC TAGs: Utilization Management, Terminal Illness Requirement and Compliance NCQA UM Standard 2-7		

REFERRAL MANAGEMENT

Hierarchy of criteria applied to Utilization Management decisions, both outpatient and inpatient, (in this order):

1. Health Plan eligibility and coverage (benefits)
2. Medicare Advantage – CMS Criteria
   a. National Coverage Determination (NCD)
   b. Local Coverage Determination (LCD) used only for the area specified in LCD
   c. Local Coverage Medical Policy Article (LCA)
   d. Medicare Benefit Policy Manual
3. Federal or State Mandate;
4. Upstream Health Plan Medical Policy or Clinical Guideline;
5. Standardized Criteria (MCG® or InterQual®);
6. Standardized Behavioral Health Criteria (DSM-V® or VI-TR®);
7. Provider Group Criteria or Guideline;
8. Community Resources (peer reviewed journals or published resources);
9. If none apply, professional judgment is used.

Delegated Medical Groups and IPAs

A complete listing of Canopy Health's delegated medical groups and IPAs is located at https://findadoctor.canopyhealth.com/#!/network

Contracted Hospitals

A complete list of Canopy Health 's contracted hospitals is located at https://findadoctor.canopyhealth.com/#!/hospitals

Member Eligibility Verification

Canopy Health's delegated medical groups/IPAs encourage their contracted providers to verify members' insurance eligibility within two working days before the expected date of service. Concordant with California AB1324, if the provider has provided the authorized treatment in good faith, the member's Canopy Health delegated medical group/IPA Utilization Management department and parent Health Plan may not rescind previously issued authorizations for any reason, such as the Parent Plan's subsequent rescission, cancellation, contract modification, or a post-service determination that the member's eligibility for services was inaccurately interpreted.

Benefit Verification for Dual Coverage: Canopy Health and Medicare

When an authorization request is received by the delegated medical group/IPA UM staff and the patient has dual coverage with both commercial and Medicare health insurance, the Utilization Management staff must check service coverage under the Medicare benefits first. If the services are covered benefits under Medicare, the referral request is reviewed for medical necessity and processed accordingly. If the service(s) being requested is/are not covered by Medicare and the member has commercial HMO as secondary insurance, then the commercial HMO benefits must be verified before a determination is made.

The Utilization Management staff will flag the referral for health plan verification. The UM Coordinators verify the health plan coverage for this requested service and documents information in the referral notes. The Utilization Management staff processes the authorization request under the appropriate benefit. This request is processed based on medical necessity using the Canopy Health member ID.

Prior authorization requirements based on types of benefitted services

No prior authorization required: when offered within a member's home medical group/IPA

Canopy Health and its delegated medical groups/IPAs and other contracted providers follow requirements detailed in California AB 1954, Health Care Coverage for Reproductive Health Services. This covers OB – GYN self-referrals and Minor Consent Services. Specifically:

OB/GYN Self-Referrals

Canopy Health members have direct access to participating women's health specialists for routine and preventive health care services provided as basic benefits. If a member needs obstetrics and gynecology (OB/GYN) preventive care, is pregnant or has a gynecological concern, the member may self-refer to an OB/GYN or family practice physician who provides such services within the member's home medical group/IPA. If these services are not available within the home medical group/IPA, the member may go to another of Canopy Health's delegated medical group/IPA's referred physicians who provide OB/GYN services. Each medical group must be able to assist members by maintaining a list of its specialty physicians. The OB/GYN consults with the member's primary care physician (PCP) regarding the member's condition, treatment and needs for follow-up care.

MINOR CONSENT SERVICES

Under California state law, minor consent services are those covered services of a sensitive nature that minors do not need parental consent to access or obtain. The health care provider is not permitted to inform a parent or legal guardian without the minor's consent. Minors under age 18 may consent to medical care related to:

- Prevention or treatment of pregnancy (except sterilization) – California Family
- Code (CFC) §6925.
- Family planning services, including the right to receive birth control – CFC §6925.
- Abortion services (without parental consent or court permission) – CFC §6925 and HSC §123450 and American Academy of Pediatrics (AAP) v. Lungren, 16 Cal. 4th 307 (1997).
- Sexual assault, including rape diagnosis, treatment and collection of medical

evidence. However, the treating provider must attempt to contact the minor's parent or legal guardian and note in the minor's treatment record the date and time of the attempted contact and whether it was successful. This provision does not apply if the treating provider reasonably believes that the minor's parent or guardian committed the sexual assault on the minor or if the minor is over age 12 and treated for rape – CFC §6927 and CFC §6928.

- HIV testing and counseling for children ages 12 and older – CFC §6926.
- Infectious, contagious, communicable, and sexually transmitted diseases diagnosis and treatment for children ages 12 and older – CFC §6926.
- Drug or alcohol abuse treatment and counseling for children ages 12 and older, except for replacement narcotic abuse treatment – CFC §6926(b).
- Outpatient behavioral health treatment or counseling services for children ages 12 and older under the following conditions:
  - In the opinion of the attending provider, the minor is mature enough to participate intelligently in the outpatient or residential shelter services.
  - The minor would present a danger of serious physical or mental harm to himself or herself or to others without the behavioral health treatment, counseling or residential shelter services, or is the alleged victim of incest or child abuse - CFC §6924.
  - Skeletal X-ray – A health care provider may take skeletal X-rays of a child without the consent of the child's parent or legal guardian, but only for the purposes of diagnosing the case as one of possible child abuse or neglect and determining the extent of the abuse or neglect –CFC §11171.

- General medical, psychiatric or dental care if all the following conditions are satisfied:
  - The minor is age 15 or older.
  - The minor is living separate and apart from his or her parents or guardian, whether with or without the consent of a parent or guardian and regardless of the duration of the separate residence.
  - The minor is managing his or her own financial affairs, regardless of the source of the minor's income.

- If the minor is an emancipated minor, he or she may consent to medical, dental and psychiatric care – CFC § 6922(a) and § 7050(e).

No Prior Authorization Requirements

Automatic Adjudication: Benefited services provided by any Canopy Health delegated medical group/IPA provider that do not require a referral form or prior authorization include the following:

- Emergency services
- Basic prenatal care
- Family Planning services
- Sexually Transmitted Disease services
- Preventive services
- HIV testing
- Involuntary Psychiatric Inpatient Admission
- Self-referral for behavioral health
- Services provided by the PCP (except procedures requiring prior authorization as listed below).

Prior Authorization Required

All referrals to non-contracted Canopy Health providers and facilities require prior authorization by the home delegated medical group/IPA. Referrals within the home medical group/IPA referrals do not require prior authorization. Providers may request authorization for care and service for members by telephoning the home delegated medical group/IPA UM department. Referrals for the following services require prior authorization (note: this list is not all inclusive; members should be referred to their benefit plan for more detail):

- Bariatric-related services
- Behavioral health and substance abuse inpatient services as specified by the behavioral health provider network
- Clinical trials
- Durable Medical Equipment ("DME")
- Experimental/investigational services and new technologies
- Home health and infusion services

- Elective interventional cardiology procedures including cardiac catheterization and procedures requiring contrast
- Non-emergent inpatient medical and mental health admissions
- Rehabilitation therapies: such as physical, occupational, and speech therapy
- Pain management procedures
- Prosthetics
- Elective interventional radiology procedures requiring contrast administration
- Self–Injectable medications
- Surgical procedures, including biopsies
- Transplant-related services.

Authorization of Out of Network Services

When medically necessary services are not available within the Canopy Health alliance network, authorization is issued by the member's home medical group/IPA for the most appropriate, accessible and available provider within 30 miles or 60 minutes of the member's primary residence or workplace.

Cancellation of Referral Request

When a decision to cancel a utilization request is made, the delegated medical group or IPA ensures the following per NCQA UM 4.F.3 policy:

- No interruption in patient care
- No delay in patient care
- No under-utilization of medically necessary services
- Approval by the referring provider is documented

Examples of cancelled requests may include the following:

- Already approved authorization present in the system
- Expired referral request
- Coverage terminated with parent health plan or the delegated medical group/IPA
- Duplicate requests when received on the same day
- Addition or change in diagnosis or procedure codes

Requesting practitioners will be notified of the cancelled request through standard communication channels within each medical group/IPA.

Cancelled referral requests are tracked and monitored according to the delegated medical group/IPA UM policies and procedures.

CLINICAL TRIALS AND EXPERIMENTAL OR INVESTIGATIONAL THERAPIES

Members with a life-threatening or seriously debilitating condition or terminal illness may seek care through clinical trials or experimental or investigational therapies outside of clinical trials. "Life threatening condition" means either or both of the following: a) disease or conditions where the likelihood of death is high unless the course of the disease is interrupted, b) diseases or conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

Clinical Trials

Before clinical trial enrollment: Canopy Health's delegated medical groups/IPAs are responsible for members' medical management, including referrals and authorizations for the clinical work up before clinical trial enrollment.

Authorization and financial responsibility for Canopy Health members for clinical trials varies by parent health plan.

When the parent health plan retains authorization and financial responsibility for clinical trials, Canopy Health's delegated medical groups/IPAs who receive requests for clinical trial enrollment will refer those requests to the member's full-service parent health plan for its determination, regardless of possible benefit exclusion. Parent health plan responsibility also includes request for the initial visit with the clinical trial physician to determine the member's eligibility for the trial. Once a member is accepted into the clinical trial, the treating clinical trial providers communicates directly with the member's health plan to review and authorize all care through the clinical trial.

When Canopy Health retains financial responsibility for clinical trials, the Canopy Health member's home medical group/IPA Utilization Management department reviews these requests, including requests to assess a member's eligibility for enrollment in the clinical trial. Utilization Management departments will authorize clinical trials, based on medically necessity.

Investigational or Experimental Treatments Outside of Clinical Trials

Treating physicians may request experimental or investigational treatments if standard therapies have not been effective, or standard therapies are not medically appropriate, or there are no more beneficial standards therapies covered. Such requests are forwarded immediately to the member's parent health plan for its review.

Parent health plans vary regarding whether they cover investigational or experimental treatments but regardless of coverage, these health plans must review, process and communicate their decisions about all such requests.

When the parent health plan retains authorization and financial responsibility for investigational or experimental treatments, that responsibility also pertains to the initial visit with the physician to determine the member's eligibility for that treatment. Once a member is accepted for the investigational or experimental treatment, the treating providers communicates directly with the member's health plan to review and authorize the investigational or experimental treatment. When the parent health plan denies a member's request for investigational or experimental treatments outside of clinical trials, the parent health plan issues the denial, along with detailed information about how the member may appeal this decision by contacting the health plan directly (see contact information below).

United Healthcare members may contact the UHC Authorization Intake Department at 800-762-8456.

Health Net members may contact the Health Net Customer Contact Center at 800-539-4072.

Alternatively, members may submit an appeal of the denial and request for an independent medical review directly through the DMHC, via the "Independent Medical Review Application/Complaint Form", available at: https://wpso.dmhc.ca.gov/imrcomplaint/complaintform.aspx

Special Circumstance: Terminally Ill Members Requesting Investigational or Experimental Treatments

Because Canopy Health is not delegated to review requests for investigational or experimental treatments, all such requests are forwarded to the member's parent health plan. If that request is denied, the parent plan must include of the following information to the member within five (5) business days of receiving the request:

- a statement setting forth the specific medical and scientific reasons for denying coverage;
- a description of alternative treatment, services, or supplies covered, if any; and
- copies of the issuing UM department's grievance procedures; and
- a Department of Managed Health Care (DMHC) Independent Medical Review Application/Complaint Form. The DMHC Complaint Form provides an opportunity for the member to request a conference as part of the grievance system. Complaint forms are completed online at https://wpso.dmhc.ca.gov/imrcomplaint/complaintform.aspx

If the member with a terminal illness wishes to submit an appeal for services denied by a Canopy Health delegated medical group/IPA or PBM Utilization Management department, the member may submit a grievance and appeal form directly to the parent health plan. Alternatively, the member may submit a request to DMHC for independent medical review, via the "Independent Medical Review Application/Complaint Form", which is available at: https://wpso.dmhc.ca.gov/imrcomplaint/complaintform.aspx

The parent health plan must offer to this member with terminal illness the opportunity to attend a conference to discuss the reasons for denial. The conference date must be offered within 30 calendar days after the health plan receives the grievance and appeal form; but it may be held within five (5) business days if the treating participating physician determines that a sooner review is needed, after consultation with the issuing UM Medical Director and based on standard medical practice. Reasons for sooner conference include concern that further delay would decrease the material effectiveness of the proposed treatment, services, or supplies or any alternative treatment, services, or supplies that are covered by the Network. The following people are permitted to attend the conference: the member, a designee of the member, or both; or the parent, guardian, or conservator of the member if the member is a minor or is incompetent.

SECOND AND THIRD OPINIONS

Second Opinions

Canopy Health ensures that members have access to a second and third medical opinion by a qualified health care professional when medically necessary and appropriate in accordance with Section 1383.1 and 1383.15 of the California Health and Safety Code.

Reasons that members may request second opinions include but are not limited to the following:

- to determine the advisability of undergoing surgery or other major procedure, even when the considered surgery or procedure is not a covered benefit

- questions about a diagnosis or plan of care for a serious condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition;

- uncertainty about a diagnosis: clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition;

- treatment plan for a medical condition that is not improving: if the treatment plan in progress but the medical condition is not improving within a time frame appropriate given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment; or

- serious concerns about the diagnosis or plan of care if the member has attempted to follow the plan of care or consulted with the initial provider;

Third Opinions

Members may request a third opinion and this is considered medically necessary if the recommendations of the first and second physician differ regarding the need for surgery or other major procedure.

Second or third opinion encounters may include but are not limited to the following procedures:

- A history and physical examination
- Any diagnostic testing required to determine the need for surgery or a procedure.

Providers available to offer second and third opinions: Members requesting a second or third opinions may choose to seek this from any provider participating in the Canopy Health Network of the same or equivalent specialty as the one who offered the first or second opinion. If the member or treating physician requests a second or third opinion from a provider not contracted to participate in the Network and there is no Network provider medically qualified to offer the second or third opinion, then the delegated Medical Group or IPA shall approve and incur the costs or negotiate the fee arrangement for the second or third opinion, beyond the applicable cost-sharing paid by the member.

Non-Network second and third opinion requests: If Canopy Health has a provider in the network or contracted with the network who is qualified to offer a second or

third opinion but the member requests to see a provider outside the Network for such opinion, the medical group/IPA will forward that request to the Health Plan for its authorization determination. In this circumstance, the Health Plan bears financial risk for the second opinion services.

Options for members if a second or third opinion request is denied: If the Utilization Management department of the member's home IPA denies a member's request for a second opinion, that department shall notify the member of the denial in writing, as required by HSC 1368.02(b). Such members have the right to file an appeal with the applicable parent Health Plan, since Canopy Health is not delegated to manage appeals and grievances.

Revision History:

Version Date	Edited By	Reason for Change
7/26/16	M. Stevens	Creation date
7/25/17	M. Durbin	Health Net 2017 UM audit updates re: Prior authorization requirements based on types of benefitted services, Clinical Reviews and reflecting language re: contracted health plans as part of the CH network
11/8/17	A. Kmetz	Health Net 2017 UM audit CAP updates re: incorporating RNs in Clinical Review, updating language to reflect "qualified" professionals
12/19/17	A. Kmetz	Updated in response to the WHA pre-delegation audit re: aligning to NCQA standards.
12/27/17	M. Durbin	Minor wordsmithing and some brief clarification added.
02/12/2018	A. Kmetz	Renamed policy. Removed any language that is addressed in UM-008. Reviewed NCQA standards to ensure that none are applicable to this policy. Added investigational and experimental and second opinion language. Aligned font and spacing.
2/15/2018	M. Durbin	Removed cardiac and pulmonary rehabilitation therapies from the list of services needing prior authorization since not all our IPAs require this.

4/14/2018	**M. Durbin**	**Separated description for how referrals are managed for 1) clinical trials and 2) investigational and experimental treatments. Added wording about these referrals from now retired Utilization Management policy 006**
1/1/2020	R. Scott	Inclusion of Medicare Advantage requirements and end of Western Health Advantage contract.