

# UTILIZATION MANAGEMENT

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The philosophy at VOC is to provide a care management system that offers easy and immediate access to the most appropriate, quality mental health and/or substance abuse services for members along with a utilization management system that supports providers in delivering clinically necessary and effective care with minimal administrative barriers.

The utilization management program encompasses management of care from the point of entry through discharge. VOC believes in macro-management of care as much as possible through the use of objective, standardized, widely-distributed clinical protocols and outlier management programs. Intensive utilization management is reserved for high-cost, highly restrictive levels of care and cases that represent clinical complexity and risk.

VOC Clinical Care Managers (CCMs) base their reviews on clear and concise criteria developed and/or adopted by VOC specifically to guide level of care, treatment and length of stay determinations. CCMs are trained to match the needs of patients to appropriate services, levels of care and community supports. This requires careful consideration of the intensity and severity of clinical data presented, with the goal of quality treatment in the least restrictive environment. The clinical integrity of the utilization management program ensures that members who present for care are appropriately monitored and that comprehensive reviews of care are provided. Comprehensive reviews are provided for care in other settings. Those cases that appear to be outside of best practice guidelines are referred for specialized reviews. These may include evaluation for intensive care management, clinical rounds, Peer Advisor review or more frequent care manager (CCM) review.

VOC has designed a system of care that is based on principles of quality care, and one that maintains flexibility in meeting the needs of diverse populations, communities and customers. The VOC system:

- Provides easy and early access to appropriate treatment
- Works collaboratively with providers in delivering quality care according to accepted best-practice standards
- Addresses the needs of special populations, such as children and the elderly
- Identifies common illnesses or trends of illness
- Targets high-risk cases for intensive care management
- Emphasizes prevention, education and outreach

## **Organizational Structure and Staff Accountability**

VOC places a high value on the selection, training and performance evaluation of clinical staff performing utilization management services. All staff involved in clinical care management activities hold terminal degrees and licensure in their field. VOC physician Peer Advisors and the Medical Director are experienced, senior level clinicians, many of whom remain active in private practice. Most are Board-certified in their specialty areas and are required to maintain a current knowledge of behavioral health research findings and nationally recognized practice guidelines. Licensed Clinical Psychologists provide peer reviews for psychological testing and outpatient treatment.

The clinical utilization management staff is multidisciplinary and able to manage care in all general psychiatric, psychiatric subspecialty and substance abuse areas. VOC requires that Clinical Care Managers (CCM's) be fully licensed mental health professionals with a minimum of three years' prior clinical experience in a mental health/substance abuse setting providing direct patient care. First-level review is conducted by nurses (RN or MSN) masters-level or doctoral-prepared licensed behavioral healthcare clinicians. These reviewers complete all types of reviews for higher levels of care and complex outpatient reviews, including pre-certification, concurrent review, discharge planning and care management.

The VOC Board of Directors has ultimate accountability for the oversight and effectiveness of the UM Program. The Board has delegated authority for UM Program direction and monitoring to the multi-disciplinary VOC Quality Management (QM) Committee.

The Board of Directors reviews and approves the UM Program Description and UM work plan at least annually and at the time of any revision. The Board receives, at a minimum, a quarterly summary of all UM activities, including findings and actions taken by the QM Committee. An annual UM Program evaluation is also prepared and submitted to the Board for review.

The VOC Executive Director has over-all responsibility for all operations and reports to the Board. The VOC Medical Director/Vice President of Medical Affairs reports to the Executive Director. The VOC Director of Clinical Operations oversees clinical activities under the direction of the Medical Director and reports administratively to the VOC Vice President of Operations. Peer Advisors are responsible to the Medical Director.

*All providers are required to comply with the review process.*

### **Medical Necessity**

It is VOC policy to authorize payment only for services that are medically necessary and provided for the identification or treatment of a member's illness. Medically Necessary means those services or supplies for the treatment of an active Mental Disorder or Substance Abuse Condition which, consistent with professionally recognized standards of practice, are determined by the VOC Medical Director or designee to be:

- (i) Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) that threatens life, causes pain or suffering, or results in illness or infirmity.
- (ii) Expected to improve an individual's condition or level of functioning.
- (iii) Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
- (iv) Consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
- (v) Reflective of a level of service that is safe, where no equally effective, more conservative, and less costly treatment is available.

- (vi) Not primarily intended for the convenience of the recipient, caretaker, or provider.
- (vii) No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- (viii) Not a substitute for non-treatment services provided for the enrichment of a patient's environment such as the provision of custodial or housing services that may otherwise enhance patient wellness.

## **Clinical Criteria**

The clinical criteria used by VOC to make admission, level of care and continuing treatment decisions reflect VOC philosophy and clinical values. Sources for various criteria include:

- The American Psychiatric Association Manual for Peer Review
- The Diagnostic and Statistical Manual IV-TR
- The American Accreditation HealthCare Commission/URAC standards
- The American Society of Addiction Medicine standards
- Health Management Strategies International Mental Health Review Criteria
- Discussions with senior consultants in the field
- Various criteria sets from other utilization management firms and third party payers

A core set of criteria has been approved and adopted by the VOC UM and/or QM Committees. In addition VOC has also adopted for use the ASAM PPC-2R criteria published by the American Society for Addiction Medicine (ASAM).

To determine the appropriate level of care, the Clinical Care Manager (CCM) evaluates the clinical information relative to the levels of care criteria. A full set of the core criteria is included in the Clinical Criteria section of this Handbook.

## **Medical Necessity Determination/Referral Decision**

VOC care management system provides multiple channels of access to care for members. Ease of access to appropriate care is central to our philosophy and clinical values. A member or provider may access the care system through any of the following avenues:

- 24-hour toll-free emergency care/clinical referral line
- Direct certification of all levels of care through referral by a VOC Clinical Care Manager (CCM)
- In-person evaluations by network providers
- Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms or crisis response teams

Prior to initial determination of medical necessity, the CCM or customer service staff checks the member's eligibility status and benefit plan. If eligibility information is not available, in non-urgent/emergent situations the care manager will complete the screening assessment and pend the certification awaiting eligibility verification.

*CCMs will work with members who are in need of urgent/emergent care regardless of eligibility status.*

If a member's benefits have been exhausted, the CCM will refer the member to appropriate community supports and programs, such as local or state-funded agencies or facilities, sliding scale discounts for continuation in outpatient therapy, or explore benefit exchanges with the insurer/payer. This coordination is intended to appropriately transition the member to other care and guard against patient abandonment.

When a CCM receives a call from a provider requesting a medical necessity determination for services, clinical information is obtained from the provider or designee in a prescribed format. This format is shared with all VOC providers at the time of initial orientation and is subsequently included in this Handbook.

Upon confirmation that the member is eligible for benefits under the identified plan, the clinical data is reviewed to determine whether the patient's severity of symptoms meets criteria for the requested level of care. This is done through the use of standardized criteria, which specifically outlines the level of care appropriate for a particular constellation of symptoms. Requests for medical necessity determinations for higher levels of care come from providers who also are requesting a specific program, facility or service site. If this service site is a contracted provider and appropriate to the member's needs, then a determination confirming medical necessity is made. If the service site is not appropriate or if the provider has no specific site to request, then the CCM selects an appropriate program that matches the member's clinical needs, demographics, provider preferences and cultural preferences.

If the call is received from a member requesting care, the CCM conducts a brief assessment to ensure that the member does not meet the criteria for urgent or emergent care. VOC staff makes referrals to appropriate Providers, taking into account member preferences such as geographic location, hours of service, cultural or language requirements, ethnicity, type of degree the Provider holds and gender. Additionally, the member may require a Provider with a specialty such as treatment of eating disorders. The provider search will identify Providers that fit the requested profile in a random order. In all cases, where available, the CCM will provide the member with the name, location and phone number of at least three providers.

### **Pre-certification**

Reviews cannot be successfully conducted if medical necessity determinations are made retrospectively. Our partnership with Providers is dependent upon a cooperative effort to review care prospectively. **Providers must notify VOC prior to admitting a member to any level of care with the exception of outpatient where there may be a "pass-through" benefit (i.e. a designated number of outpatient sessions that do not require pre-certification under certain benefit plans).** Without prior certification there is a risk of denial and a denial of certification may be based on a failure to comply with administrative requirements. Examples include but are not limited to lack of pre-certification, failure to submit timely Outpatient Request Forms (ORFs) and failure to participate in the review process. Providers may not bill the member when a denial is for one of these administrative reasons.

### **Concurrent Review**

Ongoing concurrent review of treatment is essential to determine the continuing medical necessity of care. The concurrent review process is accomplished in clinically focused discussions between the Provider and a VOC clinician or through a review of an Outpatient Treatment Report.

### **Required Member Clinical Information**

The Provider must be prepared to provide VOC with the following information at the time of the review, as necessary and appropriate:

- Diagnosis (DSM-IV-TR, Axes I-V; for GAF score, note current, highest in past year and score expected at discharge)
- Reason for admission
- Suicidal/homicidal
  - ⇒ ideation
  - ⇒ plan
  - ⇒ intent
  - ⇒ psychotic/non-psychotic (e.g., command hallucinations, paranoid delusions)
- Chemical Dependency/Substance Abuse history
  - ⇒ type
  - ⇒ amount
  - ⇒ withdrawal symptoms
  - ⇒ vital signs
  - ⇒ date(s) of initial use and last use
  - ⇒ date(s) of periods of sobriety
- Medical problems
  - ⇒ medical history
  - ⇒ organic cause of psychiatric symptoms/behaviors
  - ⇒ medical problems which exacerbate psychiatric or substance abuse symptoms/behaviors
- Current medications
  - ⇒ types(s)
  - ⇒ dosage(s)
  - ⇒ date(s)
  - ⇒ duration
  - ⇒ response
  - ⇒ Provider(s)
- Primary care physician (PCP) interface, if applicable
- General level of functioning

- ⇒ sleep, appetite
- ⇒ mental status
- ⇒ ADLs
- Job/school functioning
  - ⇒ Job/role category (e.g., employed/number years of service; student, volunteer, full or part-time, homemaker, retired, special education)
  - ⇒ Job/school status (e.g., active, suspended, expelled, medical leave of absence/disability/worker's comp, violations, mandatory referral, rule or disciplinary, positive drug screen, job performance, supervisor referral, furloughed)
  - ⇒ Job/role issues (e.g., safety sensitive, regulatory compliance, treatment scheduling, supervisory or EAP involvement, situational workplace factors, level of job satisfaction)
- Psychological stressors and supports
  - ⇒ socioeconomic
  - ⇒ family
  - ⇒ legal
  - ⇒ social
  - ⇒ abuse, neglect, domestic violence (as appropriate)
- Response to previous treatment
  - ⇒ previous treatment history, most recent treatment, past treatment failures
  - ⇒ relapse/recidivism, motivation for treatment
  - ⇒ indications of compliance with treatment recommendations
- Treatment plan
  - ⇒ estimated length of stay
  - ⇒ treatment goals
  - ⇒ specific planned interventions
  - ⇒ family involvement
  - ⇒ precautions for specific risk behaviors
  - ⇒ educational component for regulatory compliance and substance abuse situations
- Discharge plan
  - ⇒ Is it anticipated that alternative level of care will be required upon discharge
  - ⇒ Obstacles to discharge

CCMs obtain clinical data from the Provider or designee relating to the need for care and treatment planning. The CCM evaluates this information, referencing clinical criteria, to determine whether the requested level of care or service meets criteria and a determination

confirming medical necessity can be made. Care is pre-certified for a specific number of services/days for a specific time period, based on the needs of the member.

### **Discharge Plan Documentation Outline**

Discharge planning is an integral part of good treatment planning and begins with the initial review. As a patient is transitioned from inpatient levels of care, the CCM will discuss with the Provider the discharge plan for the patient. The following information may be requested and must be documented.

- Discharge date
- Follow-up care
  - ⇒ Date of first post-discharge appointment (must occur within 7 days of discharge)
  - ⇒ With whom (name, credentials)
  - ⇒ Where (level of care, program/facility name)
- Other treatment resources to be utilized: types, frequency
- Medications
  - ⇒ Patient/family education regarding purpose and possible side effects
  - ⇒ Medication plan including responsible parties
- Support systems
  - ⇒ familial, occupational and social support systems available to the patient. If key supports are absent or problematic, how has this been addressed?
  - ⇒ community resources/self-help groups recommended
- EAP linkage
  - ⇒ if indicated (e.g., for substance abuse follow-up, workplace issues, enhanced wrap-around services) specify how this will occur
- Medical follow-up (specify plan, if indicated)
- Family/work community preparation
  - ⇒ Family illness education, work or school coordination, (e.g., Fitness for Duty evaluation, EAP and return to work conference) or other preparation done to support successful community reintegration.
- Specifics of plan including responsible parties and their understanding of the plan

When a Provider receives a pre-certification for treatment, specific treatment goals and objectives are agreed upon with the CCM to serve as the focus of the next concurrent review. Provider should make every effort to include significant others, such as spouses, guardians/conservators, etc., as appropriate, in the treatment planning process and when significant changes are made to the treatment plan. The Provider is instructed to contact the CCM prior to the certification

expiration date, leaving enough time for concurrent review and recertification so as not to interrupt the patient's treatment services. The CCM conducts the continued stay review with a focus on continued severity of symptoms, appropriateness and intensity of treatment plan, patient progress and discharge planning. This is accomplished through review of the member's case records and discussions with the Provider or appropriate facility or EAP staff, or other behavioral health providers. Cases not meeting clinical criteria require Peer Advisor intervention. Any questionable or absent treatment plans, discharge plans or questions related to the quality and appropriateness of care being delivered are referred to Peer Advisor review.

The CCM assesses the need for specialized discharge planning at the time of the initial review and informs the Provider or hospital utilization review department of any contractual limitations/benefits which may apply.

If a member does not have available benefits for a certain level of care, it is the CCM's responsibility to ensure that alternative treatment planning within available benefits takes place.

Initial utilization reviews of treatment are conducted telephonically or, for outpatient services, may be performed through review of a provider-submitted Outpatient Request Form (ORFs) after a pass-through sessions are completed.. When all needed clinical information is provided during the course of the telephonic reviews and there are no questions related to the quality and appropriateness of care, certification determinations are made by the end of the telephonic review and communicated to the provider at that time. If a case needs to be referred to a Peer Advisor, then the response standards for that process apply. (See "Peer Review/Consultation" later in this section.) The concurrent review process for outpatient care is typically done through a review of provider-submitted Outpatient Request Forms (ORFs).

### **Review of Inpatient or Higher Levels of Care**

All inpatient and alternative level of care programs (this does not include outpatient therapy rendered in a provider's office or outpatient therapy in a clinic or hospital setting) will be subject to the review requirements described in this section.

Prior to beginning treatment, the provider must call VOC:

- For notification
- To confirm benefits and eligibility
- To provide clinical information regarding the patient's condition and proposed treatment
- For authorizations or certifications

CCMs/Direct Referral Line Clinicians are available 7 days a week, 24 hours a day, 365 days a year to provide assessment and referral and conduct certification review. Pre-certifications are the preferred type of review for higher levels of care; however, providers are expected to ensure the safety of patients and may request certification of emergency care within 48 hours of an admission to an inpatient unit. Pre-certification review is conducted with the requesting provider or his/her delegate, and decisions are based on the VOC approved clinical criteria for the specified level of care. If a course of treatment is determined to be medically necessary, the certification will be for a specific period of time and level of care commensurate with the member's clinical condition. If prior to the end of the initial or any subsequent certification, the provider proposes to continue treatment, he or she must call VOC for a review and recertification

of medical necessity. It is important that this review process be completed more than 24 hours prior to the end of the current certification period.

The CCM conducts the continued stay review with a focus on continued severity of symptoms, appropriateness and intensity of treatment plan, patient progress and discharge planning. This is accomplished by reviewing client case records and discussions with the provider or appropriate facility staff, EAP staff or other behavioral health providers. The clinical information is documented and certified according to VOC or ASAM clinical criteria. Cases not meeting clinical criteria require Peer Advisor (PA) intervention via the peer review process. Any questionable or absent treatment plans, discharge plans or questions related to the quality and appropriateness of care being delivered are also referred to a Peer Advisor for review.

### **Retrospective Review**

A retrospective review of the relevant portion of a medical record will be provided when the patient has been discharged prior to the request for review of the complete episode of care. The provider or facility must submit a request for a retrospective review within 90 calendar days from the first day of non-reviewed care; this may be by letter, fax or telephone. Retrospective reviews are conducted within 30 calendar days of the receipt of the request. A clinical supervisor may review the case if the care is determined to be medically necessary. If there are questions of medical necessity, the case must be referred to a Peer Advisor for review. Decisions are communicated to the member, provider and facility in writing. If a determination of no medical necessity is made, the member, hospital or facility-rendering service and attending provider (if one can be identified) shall receive written notification that includes the clinical rationale for the determination and a statement of the method and timeframes for submitting an appeal.

In cases other than emergency admissions, where there was no clinical pre-certification, services may be reviewed and administratively denied. Administrative Exceptions to this policy may be made for extenuating circumstances, determined on a case-by-case basis, upon review through the VOC provider Dispute or Grievance process as applicable. If the admission meets the criteria for emergency admission, VOC will provide coverage for up to the first 48 hours of the admission (possibly longer, if a member's medical incapacity reasonably prevents notification to VOC within 48 hours, and notification is made within a reasonable period of time thereafter in order for the post stabilization services to be considered as covered services). A medical necessity determination can be obtained retroactively for the period of time following the initial 48 hours of the admission following VOC retrospective review guidelines.

### **Psychological Testing**

If psychological testing is deemed necessary, you must call VOC to pre-certify.

Any facility that does not include psychological testing in its per diem rate must call VOC for certification prior to conducting such tests.

See Request for Certification for Psychological Testing form at [www.valueoptions.com](http://www.valueoptions.com).

### **Electroconvulsive Therapy**

Prior to conducting Electroconvulsive therapy (ECT), providers must contact VOC for pre-certification of such therapy.

**Note:** Failure to follow the inpatient review and certification requirement may result in a non-certification and require that the member be held harmless from any financial responsibility for the provider's charges.

### **Outpatient Request Form**

Providers requesting outpatient treatment certification beyond the initial certification or pass-through visits must either submit an outpatient Request Form (ORF), or call the toll-free number on the member's ID card for a telephonic review. After the clinical needs are assessed and the course of treatment is reviewed, the reviewing staff member either issues a certification of care or the ORF is referred to peer review. When a certification is issued, it specifies both the length of certified treatment as well as the category of clinical services. If benefits are exhausted while a member is in treatment, the CCM will assist the provider in identifying alternatives for care.

### **Peer Review/Consultation**

Peer Advisors provide clinical case review of those cases that do not appear to meet medical necessity criteria, or that present quality of care issues. VOC has a Medical Director who is responsible for the clinical decisions. Medical directors are board-certified psychiatrists who provide case consultation in general adult psychiatry, adult chemical dependency, child and adolescent psychiatry and adolescent chemical dependency, at all levels of care. Peer Advisors use the clinical criteria adopted by VOC for determining medical necessity decisions. Specialists are available for adult, child/adolescent and addictive medicine to assist in the determination of clinical appropriateness. Clinical psychologist Peer Advisors provide review of requests for psychological testing and outpatient care.

Resources utilized by the Utilization Management Program include the following:

- daily, informal discussions with the medical director or the VOC Peer Advisors
- weekly case rounds for case review and monthly in-service training
- review of "outlier" cases on every level of care

### **After-Hours Services**

VOC has arrangements with clinical and administrative staff that provide after hours clinical and customer service to members. The after-hours staff utilize the same administrative and clinical policies and procedures as the daytime VOC staff and are updated and trained on any changes to our policies and procedures. After hours staff are also trained on our procedures for handling urgent and emergency cases and transferring these cases to the attention of VOC staff the next day for any required follow-up. California licensed Registered Nurses perform the after hours clinical assessment and referral process for VOC business. For after hour's coverage, a VOC clinician and Medical Director or designee are on call via a back-up contact system to deal with any emergencies.

### **Determination of No Medical Necessity Process**

CCMs can only certify care and may not deny care based on medical necessity reasons. Only a Peer Advisor can make an adverse determination to deny a request for care. If a CCM questions the medical necessity and/or appropriateness of the recommended treatment as outlined in VOC clinical criteria (or if there are quality of care concerns), the case is referred to a Peer Advisor

(PA). The Peer Advisor reviews the available information and, if no further information is needed, makes a decision as to the medical necessity of requested care.

### **Lack of Information (LOI) Process**

If there is a Lack of Information (LOI) to make a medical necessity decision, as part of the Peer Review Process, VOC will notify the provider of the required information within specified timeframes depending on the type of request. The needed information could require submission of documents or a peer-to-peer conversation. The notification will include a description of the information needed, the timeframe to submit, and how to submit the additional information for the review to be completed. Once the information has been received, VOC will make a determination and issue notification within the timeframes specified for the type of request. If the additional information is not received within the specified timeframe for submission, either an administrative or clinical denial will be issued within the timeframe appropriate for the type of request.

When a determination of no medical necessity is made, the treating Provider (and facility, if applicable) is notified telephonically of the decision. Written notification of a determination of no medical necessity is sent to the patient, provider, if one can be identified, and facility/program (if any) within the decision timeframe for the type of care requested. For substance abuse treatment of minors, VOC follows federal and state guidelines regarding release of information. VOC does not deny, delay, or modify services based on findings that a device, procedure, or other therapy is investigational or experimental.

For VOC members, the notification letter specifies the decision, the level of care/type of service for which a determination of no medical necessity has been made, and includes the following information:

- A clear and concise explanation of the reasons for the decision,
- A description of the criteria or guidelines used in making the decision,
- The clinical reasons for the decision,
- Information regarding how the member may file a grievance or appeal with VOC
- Information regarding the member's right to file a complaint with the Department of Managed Health Care,
- Disclosures required by Sections 1368.01, 1368.02, (Grievance rights) and 1374.30 (Independent Medical Review process) of the Knox-Keene Act, and
- Letters to providers will include the name and direct telephone number of the health care professional responsible for the denial.

VOC CCMs always work with providers in finding alternatives when a given level or type of care is determined not to be medically necessary.

When the determination that there is no medical necessity has been made without a peer-to-peer conversation having taken place, the provider may request peer-to-peer conversation within three (3) business days of receiving the notification. If this reconsideration is requested, VOC will make a Peer Advisor available within one (1) business day to conduct the peer-to-peer conversation. If this reconsideration results in change in the original no medical necessity determination, notice of the new decision will be issued immediately. If the conversation does not result in a change in the original decision, no additional notification will be issued.

A complete description of the ValueOptions of California medical necessity review process and timeframes for making decisions and issuing notifications is included in our policies and procedures. You may obtain a copy of these policies by contacting our Provider Relations Department.

## **Certification for Secondary Coverage**

Providers must follow all of VOC review procedures for certification even when the VOC-administered plan is the secondary payer.

## **Appeal (Grievance) Process**

VOC has an established system to allow for appeals of determinations of no medical necessity. Appeals for members are considered to be a form of grievance and subject to the requirements of Section 1368 et seq. of the California Knox-Keene Health Care Service Plan Act of 1975 as amended and Rules 1300.68 and 1300.68.01 of Title 28 of the California Code of Regulations.

VOC allows the member, member's representative, provider or facility rendering services at least 180 calendar days after the receipt of a non-certification to initiate the appeal process by telephone, by facsimile, in person, by mail, by e-mail, by an on-line member grievance submission process at the [valueoptions.com](http://valueoptions.com) web site.

### **A. Non-Urgent Appeals**

All non-urgent appeals (grievances) will be resolved and responded to within 30 calendar days (or sooner) of VOC receipt of the appeal/grievance. This 30 calendar day time period includes completion of any/all multiple internal/external levels of review that we may need to utilize due to the nature of an appeal/grievance. Example: The Plan Medical Director may review a clinical appeal/grievance but may determine a committee or external review is needed due to the nature of the issues involved.

## B. Urgent Appeals

All urgent appeals (grievances) will be resolved and responded to within 72 hours or less of receipt of the appeal/grievance by VOC. An urgent appeal/grievance is a case requiring expedited review because it involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function.

## C. Additional Appeal (Grievance) Rights

1. Review by Department of Managed Health Care: After completing the appeal (grievance) process as described in our policies and procedures or after participating in the process for at least 30 calendar days (the 30 days period is not required if the case meets the urgent definition above) or after completing voluntary mediation the member or member's representative may submit their grievance/appeal to the DMHC. The DMHC has a toll-free telephone number (**1-888-HMO-2219**) and a **TDD** line (**1-877-688-9891**) for the hearing and speech impaired. The DMHC's Internet web site ([www.hmohelp.ca.gov](http://www.hmohelp.ca.gov)) has complaint forms, IMR application forms and instructions online.
2. Independent Medical Review. Under California law, the member may be entitled to an external, independent medical review ("IMR") when a determination for a member's health care service has been denied, delayed, or modified by VOC in whole or in part due to a determination that the service is not medically necessary. If the member is 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. If the case meets these criteria, the written notification responding to the grievance/appeal request will advise the member of the availability of an independent review and how to request such a review.

## D. Provider Disputes

VOC has established a system to provide a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted provider disputes. Any provider dispute submitted on behalf of a member or a group of members treated by the provider (e.g. a clinical appeal of a UM certification decision, a clinical dispute during the concurrent care review process, provider is attempting to get an expedited review on behalf of a member meeting the urgent grievance definition, etc.) will be handled in the VOC grievance process as described above and not in our provider dispute resolution process. When a provider submits a dispute on behalf of a member or a group of members, the provider shall be deemed to be joining with or assisting the member within the meaning of Section 1368 (grievance regulations) of the Health and Safety Code.

## Appeal Notification Requirements

For VOC members, written notification of the clinical appeal decision rendered is sent to the member, provider, and facility (if appropriate) as soon as the review is completed and a

determination is made but no later than within 30 calendar days after receipt of a non-urgent request or 72 hours from receipt of an urgent request.

***NOTE: IN CALIFORNIA THERE ARE EXTENSIVE RULES AND REGULATIONS THAT PERTAIN TO UM REVIEW, DENIAL, AND APPEAL (GRIEVANCE AND PROVIDER DISPUTE) PROCESSES WHICH APPLY TO VOC AND PROVIDERS. THESE REQUIREMENTS, ADDITIONAL INFORMATION ABOUT MEMBER APPEAL RIGHTS, AND IMR GUIDELINES ARE DESCRIBED IN VOC POLICIES AND PROCEDURES. YOU CAN OBTAIN A COPY OF THESE POLICIES BY CONTACTING VOC AT THE NUMBER ON THE MEMBER'S IDENTIFICATION CARD AND SOME POLICIES CAN BE OBTAINED BY ACCESSING OUR LIST OF POLICIES AND PROCEDURES AT OUR WEB SITE AT [WWW.VALUEOPTIONS.COM/PROVIDER/CONTRACTSPECIFIC/VOC.HTM](http://WWW.VALUEOPTIONS.COM/PROVIDER/CONTRACTSPECIFIC/VOC.HTM).***

### **Hold Harmless Requirement**

The provider is contractually responsible to hold the member harmless for any charges incurred until the entire appeals process is completed. If a member wishes to continue treatment once the appeals process is completed, the provider must obtain the member's written consent to be financially responsible for any care thereafter. The member's consent must be signed and dated on or after the date that the appeals process is completed. VOC may request a copy of this consent form.

### **Confidentiality**

VOC maintains the confidentiality of all sensitive information in accordance with the requirements of state and federal laws and regulations including HIPAA, and the Confidentiality of Medical Information Act, California Civil Code 56 et seq., and in accordance with sound business professional principles. VOC recognizes the sensitive nature of the information gathered and developed in business operations, such as:

- Member-specific information, including confirmation or acknowledgement that treatment or care management records may exist
- Provider information related to quantity or quality of a provider's performance or to a provider's interactions in providing service to members

VOC provides training to employees on their responsibilities regarding confidential information. All employees sign a confidentiality agreement upon employment and annually thereafter, attesting that they have read, understand and abide by confidentiality policies.

VOC recognizes that members have a basic right to privacy of their personal information and records. Access to member information lies solely with the member except in the case of a parent or guardian with legal custody of a minor child, or a person with legal authority to act on behalf of an adult or emancipated minor in making decisions related to health care. VOC and providers must ensure that each member's Individually Identifiable Medical Information will be treated as confidential so as to comply with all state and federal laws and regulations regarding the confidentiality of patient records.

VOC honors members' privacy unless waived by the member or in rare instances of strongly countervailing public interest or as required by law. When information is disclosed, it is limited to what is necessary to fulfill the immediate and specific purpose.

All requests for release of information are review by management staff and responded to in accordance with VOC policy. The service center Medical Director screens all requests for clinical information prior to disclosure.

## **CLINICAL CRITERIA**

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**[LINK TO CLINICAL CRITERIA FOUND ONLINE IN VOI PROVIDER HANDBOOK](#)**

## **PRACTICE GUIDELINES**

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**[LINK TO TREATMENT GUIDELINES FOUND ONLINE IN VOI PROVIDER HANDBOOK](#)**