UTILIZATION MANAGEMENT

The philosophy at ValueOptions® of California (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. In addition, ValueOptions® of California has adopted 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. ValueOptions® of California 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.

Our Clinical Care Managers (CCMs) at ValueOptions® of California base their reviews on clear and concise criteria developed and/or adopted by ValueOptions® of California specifically to guide level of care, treatment and length of stay determinations. CCMs are trained to match the needs of members 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 all levels of care are provided. 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 CCM review.

ValueOptions® of California 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 ValueOptions® of California 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; and
- Emphasizes prevention, education and outreach.

Organizational Structure and Staff Accountability

ValueOptions® of California 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. The ValueOptions® of California physician Peer Advisors (PA) and the Medical Director are experienced, senior level clinicians, many of whom remain active in private practice. The majority 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 care management staff is multidisciplinary and able to manage care in all general psychiatric, psychiatric subspecialty and substance abuse areas. ValueOptions® of California requires that CCMs be fully licensed mental health professionals with a minimum of three years prior clinical experience in a mental health/substance abuse setting providing direct member care. First-level reviews are generally conducted by nurses (RN or MSN), masters-level, or doctoral-prepared licensed behavioral healthcare clinicians. These clinicians complete all types of reviews for higher levels of care and complex outpatient cases, including precertification, notification, 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 overall responsibility for all operations and reports to the VOC Board of Directors. The VOC Medical Director reports to the VOC Executive Director, while the VOC Director of Clinical Operations oversees clinical activities under the direction of the VOC Medical Director. Peer Advisors are responsible to the Medical Director.

Medical Necessity

It is the policy at ValueOptions® of California 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:

- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (ICD-9 or DSM-IV-TR) that threatens life, causes pain or suffering, or results in illness or infirmity
- Expected to improve an individual's condition or level of functioning

- Individualized, specific and consistent with symptoms and diagnosis, and not in excess of patient's needs
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications
- Reflective of a level of service that is safe, where no equally effective, more conservative and less costly treatment is available
- Not primarily intended for the convenience of the recipient, caretaker or provider
- No more intensive or restrictive than necessary to balance safety, effectiveness and efficiency
- Not a substitute for non-treatment services addressing environmental factors

Clinical Criteria

The clinical criteria used by ValueOptions® of California to make admission, level of care and continuing treatment decisions reflect ValueOptions® of California's 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 (ASAM);
- Health Management Strategies International Mental Health Review Criteria;
- Discussions with senior consultants in the field; and
- Various criteria sets from other utilization management firms and third party payers.

A core set of criteria has been developed, approved and adopted by the VOC Quality Management Committee. In addition, ValueOptions® of California 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 during a review the CCM evaluates the pertinent 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. The clinical criteria are updated annually.

Treatment Guidelines

In addition to clinical criteria, ValueOptions® of California has a set of Diagnosis-Based Treatment Guidelines. These guidelines are used in collaboration with providers to help guide appropriate and clinically effective care for a variety of complex psychiatric conditions. These guidelines represent standards of best practice for treating these complex conditions and can be referred to by Clinical Care Managers (CCM) and Peer Advisors (PA) during reviews. ValueOptions® of California seeks input from providers, consultants, and other expert clinicians to develop some of the guidelines, but for the most part ValueOptions® of California generally

adopts guidelines existent in the professional literature such as those developed by the American Psychiatric Association (e.g., Bipolar, Major Depression, Schizophrenia, Eating Disorder and ECT).

Access to Care/Referral Decision

ValueOptions® of California's 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 ValueOptions® of California CCM
- Emergency services through freestanding psychiatric hospitals, medical hospitals with psychiatric units, emergency rooms or crisis response teams
- Web-based applications (e.g., ProviderConnect)

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/non-emergent situations the CCM will complete a 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 that might provide 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.

If a call is received from a member requesting care, the CCM conducts a brief screening to assess whether there is a need for urgent or emergent care. The ValueOptions® of California staff makes referrals to appropriate network 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 in a random order network providers that fit the requested profile. In all cases, where available, the CCM will provide the member with the name, location and phone number of at least three network providers.

ValueOptions® of California has established the following standards for access to initial appointments for care:

- **Emergency Care Requests** – A situation where there is a caller-identified emergency, or the CCM assesses the situation as having a high risk of danger to the member's life, another person's life or property. In these instances, the CCM assures immediate emergency intervention or, if the situation is non-life-threatening, the CCM arranges for appropriate psychiatric, medical or substance abuse assessment within six (6) hours.

- **Urgent Care Requests** – A situation in which the provider or the CCM assesses that the member's condition presents a substantial risk to the member's life or health, or his/her ability to regain maximum function if not treated promptly. For prospective urgent requests, a medical necessity determination is made within three (3) calendar days, and the CCM arranges for face-to-face assessment by a licensed mental health provider within 48 hours for ValueOptions® of California members.

- **Routine or non-urgent care requests** – These involve a condition that causes some discomfort or subjective distress, but does not appear to jeopardize the member's life or health. Once authorization is made, the required care should be available to the member within ten (10) business days for ValueOptions® of California members.

There is a specialized access unit within ValueOptions® of California that assists members with locating available providers, in their geographical location, whose specialty matches the clinical needs of our members. In many cases where there is a clinical urgency for an immediate appointment, our Access Specialist will secure an appointment on behalf of the member. The access unit is responsible for performing post referral satisfaction outreach calls to members to ensure they were satisfied with their provider selection and appointment and to inquire as to whether or not the member needs additional services, assistance or referrals.

After-Hours Services

ValueOptions® of California 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 ValueOptions® of California 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 ValueOptions® of California staff the next day for any required follow-up. California licensed Registered Nurses perform the after hours clinical assessment and referral process for ValueOptions® of California business. For after hour's coverage, a ValueOptions® of California clinician and the VOC Medical Director or designee is on call via a back-up contact system to deal with any emergencies.

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 contact ValueOptions® of California:

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

CCMs/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 members and may notify ValueOptions® of California of the admission and request certification of emergency care within 24 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 ValueOptions® of California's 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 ValueOptions® of California 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, member 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 ValueOptions® of California 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.

Clinical Review Process

Our partnership with providers is dependent upon a cooperative effort to review care prospectively. **Providers must notify ValueOptions® of California of the admission of 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), or no pre-authorization requirement**. In all cases, providers are encouraged to contact ValueOptions® of California prior to initiating any treatment to verify member eligibility and to satisfy preauthorization requirements.

When a request for services is received, once it is established that the member is eligible for benefits under the identified plan, the CCM gathers the required clinical information, references the appropriate criteria set, and determines whether the requested care meets medical necessity criteria. The CCM may certify levels of care and treatment services that are specified as available under the specific benefit plan (e.g., acute inpatient, residential, partial hospitalization, intensive outpatient, or outpatient). Care is certified for a specific number of services/days for a specific time period.

As indicated above, the policy at ValueOptions® of California is to prospectively review and approve all requests for services. We recognize that under some circumstances providers may deliver care before requesting a review by ValueOptions® of California. When a provider requests a review for services that have already been delivered (retrospective review), ValueOptions® of California will first determine whether such a retrospective review (e.g., emergency admission, members failure to indicate appropriate benefit coverage) is necessary and appropriate, and if so, the CCM may request needed medical records from the provider.

In cases where a retrospective review request is not justified, 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 ValueOptions® of California Provider Dispute or grievance process, as applicable. If the admission meets the criteria for emergency admission, a medical necessity determination can be obtained retroactively within 24 hours of the admission.

Note: Failure to follow 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 Review Form

Pre-authorization is not required for outpatient services. During the course of treatment providers may receive a request for additional clinical information to review outpatient services for continued medical necessity. Providers are requested to either submit an Outpatient Review Form or call the toll-free number on the member's insurance card for a telephonic review. ValueOptions® of California encourages outpatient providers to request authorization for services electronically through our ProviderConnect website. This process generally takes less than 3-4 minutes per request and most authorization determinations can be made immediately. After the clinical needs are assessed and the course of treatment is reviewed, the reviewing staff member either issues a certification or refers the request to peer review. When a certification is issued, it specifies both the length and amount of certified treatment. If benefits are exhausted while a member is in treatment, the CCM will assist the provider in identifying alternatives for care.

Financial Incentives

The ValueOptions® of California Utilization Management staff base utilization-related decisions on the clinical needs of members, benefit availability and appropriateness of care. Objective, scientifically based clinical criteria and treatment guidelines, in the context of provider or member-supplied clinical information, guide the decision-making process.

ValueOptions® of California offers no rewards or incentives, financial or otherwise, to practitioners, utilization reviewers, Clinical Care Managers (CCMs), Physician Advisors or other individuals involved in conducting utilization review for issuing denials of coverage or service, or inappropriately restricting care.

Required Member Clinical Information

The provider must be prepared to provide ValueOptions® of California with the following information at the time of the review, as necessary and appropriate:

- Demographics
- Diagnosis (DSM-IV-TR or ICD-9, Axes I-V; for GAF score, note current, highest in past year and score expected at discharge)
- Reason for admission/precipitant
- Suicidal/homicidal risk, including
  - 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
- Other behavioral health care provider interface, if applicable
- General level of functioning
    - sleep, appetite
    - mental status
    - ADLs (Activities of Daily Living)
- 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
    - aftercare required upon discharge
    - Barriers 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 at a specific level of care, based on the needs of the member.

Treatment Planning

ValueOptions® of California providers are required to develop individualized treatment plans that utilize assessment data, address the member's current problems related to the DSM-IV TR diagnosis, and actively include the member and significant other, as appropriate, in the treatment planning process. ValueOptions® of California CCMs review the treatment plans with the providers to ensure that they include:

1. Specific measurable goals and objectives,
2. Reflect the use of relevant therapies,
3. Show appropriate involvement of pertinent community agencies,
4. Demonstrate discharge planning from the time of admission, and
5. Reflect active involvement of the member and significant others as appropriate.

Providers are expected to document progress toward meeting goals and objectives in the medical record and to review and revise treatment plans as appropriate.

Discharge Plan Documentation Outline

Discharge planning is an integral part of good treatment planning and begins with the initial review. As a member 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
- Aftercare date
    - 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 (note purpose)
- EAP linkage
    - if indicated (e.g., for substance abuse aftercare, workplace issues, such as Return-to-Work Conference, enhanced wrap-around services) indicate how this will occur
- Medical aftercare (if indicated, note plan, including responsible parties)
- Family/work community preparation
    - Family illness education, work or school coordination, (e.g., EAP and Return-to-Work Conference) or other preparation done to support successful community reintegration. Note specific plan, including responsible parties and their understanding of the plan.

Adverse Clinical Determination/ Peer Review

If a case does not meet medical necessity criteria at the requested level of care, the CCM discusses the member's needs with the provider and works collaboratively with the provider to find an appropriate alternative level of care. If no alternative seems appropriate, the CCM

cannot deny a request for services. Requests that do not meet medical necessity criteria or present quality of care issues are referred to a Peer Advisor (PA) for second level review. It is important to note that only a doctoral level Peer Advisor can clinically deny a request for services. The PA reviews the available information and may elect to conduct a Peer-to-Peer Review, which involves a direct telephone conversation with the attending or primary provider to discuss the case. Through this communication, the PA may obtain clinical data that were not available to the CCM at the time of the review. This collegial clinical discussion allows the PA the opportunity to explore alternative treatment plans with the provider and to gain insight into the attending provider's anticipated goals, interventions and timeframes. The PA may request more information from the provider to support specific treatment protocols and ask about treatment alternatives.

When an adverse determination is made, the treating provider (and hospital, if applicable) is notified telephonically of the decision and asked to notify the member. Written notification of an adverse determination is issued to member, member representative, practitioner, and facility within decision timeframes. If an adverse decision is rendered, the provider has the right to speak with the Peer Reviewer who made the adverse determination by calling ValueOptions® of California at the toll free phone number of the member's plan. For substance abuse treatment of minors, ValueOptions® of California follows Federal and State guidelines regarding release of information in determining the distribution of adverse decision letters.

All written or electronic adverse determination notices include:

- the principal reason(s) for the determination not to certify,
- a statement that the clinical rationale (or copy of the relevant clinical criteria), guidelines, or protocols used to make the decision will be provided, in writing, upon request,
- information regarding how the member may file a grievance or appeal with ValueOptions® of California,
- 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,
- the name and direct telephone number of the health care professional responsible for the denial, and
- the right of the provider to request a reconsideration within three (3) business days of receipt of the notice when a medical necessity denial is issued without a Peer-to-Peer conversation having taken place, or when an administrative denial is issued because of the failure of a provider to respond to a request for Peer-to-Peer conversation within a specified timeframe.

Lack of Information (LOI) Process

When there is insufficient information to make a medical necessity determination, the PA may elect to make the decision based on the information that has been received, or may invoke the LOI process. If the decision is made based on available information, written notification is issued within the determination timeframe for the type of care request (e.g. urgent, non-urgent). If the PA invokes the LOI process, the provider is notified of the information needed within prescribed timeframes based on the type of care requested. A minimum period of time is given for the provider to furnish the necessary information. A Peer-to-Peer conversation may be initiated by either the PA or the provider in order to discuss the needed information. Once information is received, or the time period for furnishing the information has expired, the decision and notice must be issued within the specified timeframe for the type of care requested. See the LOI chart below for a listing of all relevant timeframes by type of request.

Type of Review	**Urgency of Case**	**Timeframe to make over all decision ***	**Timelines for reviews when there is a lack of information to make a decision[1]**			**Timeframe to provide notification**	
			Timeframe to notify provider/ member that information is not sufficient to conduct review	**Timeframe to allow provider/ member to provide information**	**When information obtained, timeframe to make decision**	**Certification**	**Non-Certification[2]**
Prospective	Urgent (e.g. Emergency Services, Inpatient, Observation Holding Beds) Cases meeting expedited definition (Knox-Keene)	Seventy-two (72) hours after receipt of request for services	Within twenty-four (24) hours from request for services	At least two (2) calendar days after notification; time frame given must be documented	Two (2) calendar days from the earlier of receipt of specified information, or the end of the period allowed to supply the necessary information. The total process is to be completed within seventy-two (72) hours of the initial request for services.	Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the decision on the same day. Written or electronic notice issued to member, provider, and facility within seventy-two (72) hours of receipt of the request for	Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the decision on the same day Written or electronic notice issued to member, provider, and facility within seventy-two (72) hours of receipt of the request for

						services	services
	Non-urgent (i.e. RTC, Partial Hospitalization and Outpatient)	Five (5) business days after receipt of request for services	Within five (5) business days after request for services	At least 45 calendar days after notification; time frame given must be documented	Five (5) business days from receipt or the required information.	Telephonic or facsimile notification to provider on the same day the determination is made Written notice issued to member, provider, and facility within two (2) business days of the determination	Telephonic or facsimile notification to provider on the same day the determination is made Written notice issued to member, provider, and facility within two (2) business days of the determination
Continued Stay (Concurrent)	Urgent	Twenty-four (24) hours after receipt of request for services	Within twenty-four (24) hours from request for services	At least two (2) calendar days from request for services; time frame given must be documented	Twenty-four (24) hours from the earlier of receipt of specified information, or the end of the period allowed to supply the necessary	Telephonic or facsimile notification to provider on the same day as the determination; provider must agree to notify the member of the decision on the same day	Telephonic or facsimile notification to provider on the same day as the determination; provider must agree to notify the member of the decision on the same day

					information	Written or electronic notice issued to member, provider, and facility within twenty-four (24) hours of receipt of the request for services	Written or electronic notice issued to member, provider, and facility within twenty-four (24) hours of receipt of the request for services
	Non-urgent (i.e. RTC, Partial Hospitalization and Outpatient)	Five (5) business days after receipt of request	Notice to member and provider within five (5) business days from request for services	At least 45 calendar days after notification; time frame given must be documented	Five (5) business days from receipt or the request for services	Telephonic or facsimile notification to provider within twenty-four (24) hours of the determination Written notice issued to member, provider, and facility within two (2) business days of the determination	Telephonic or facsimile notification to provider within twenty-four (24) hours of the determination Written notice issued to member, provider, and facility within two (2) business days of the determination
Retrospective	Non-urgent (all levels of care)	Thirty (30) calendar days after receipt of request for retrospective review.	Notice to member and provider within fifteen (15) calendar days after request for services.	At least 45 calendar days from notification; time frame given must be documented	Fifteen (15) calendar days from the earlier of receipt of the required information, or the end of the period allowed to submit the necessary information	Written notice to member, provider, and facility within the over all determination timeframe of thirty (30) calendar days from receipt or the request for review	Written notice to member, provider, and facility within the over all determination timeframe of thirty (30) calendar days from receipt or the request for review

(1) Extensions are one-time only per request for services (i.e. a concurrent review would constitute a new request for services). Lack of information extension is one type of extension. In addition, if a lack of information extension is not used; non-urgent claims may be extended by ValueOptions® of California for "reasons beyond the control of the Plan" other than for lack of information (as shown above). Extensions are also subject to Knox-Keene requirements. ValueOptions® of California must notify the member and provider before the end of the determination time frame of the reasons for the delay and the date by which the decision will be made.

*Example of notification time calculation: a non-urgent initial request must be decided within five (5) business days of receipt of request. ValueOptions® of California may notify the member and provider on or before the 5th business day that it is extending the time-frame and why. The decision must then be made and a determination notice issued by the end of the five (5) business day of the extension, or twenty (20) days from receipt of the request for services (initial 5 business day determination date + the 15 day extension). **For urgent care claims, there is no provision for extension other than for lack of information.**

(2) Per Knox-Keene regulations-In the case of concurrent review, care shall not be discontinued due to a denial or a modification of service until the member's treating provider has been notified of ValueOptions® of California's decisions and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient.

Appeal (Grievance) Process

ValueOptions® of California has an established system to allow for appeals of determinations of no medical necessity. Appeals for ValueOptions® of California 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. The ValueOptions® of California process allows for a review subsequent to a no medical necessity determination, with the review being conducted by health professionals who are clinical peers to the provider of the services being appealed, hold active, unrestricted license to practice medicine or a health profession, are board-certified if applicable, are in the same profession and in a similar specialty as typically manages the clinical condition, procedure or treatment, and is neither the individual who made the original non-certification, nor the subordinate of such an individual. Appeals are conducted, as appropriate to the nature of the case, by a Peer Advisor, committee, or external reviewer having the qualifications stated above. This allows for objectivity and impartiality.

ValueOptions® of California 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 e-mail, by an on-line member grievance submission process at ValueOptions® of California's web site, or in writing. The member, member's representative, or provider may submit any information they feel is pertinent to their appeal request and all such information is considered in the appeals review, whether or not such information was available to ValueOptions® of California reviewers during the initial consideration.

Non-Urgent Appeals

All non-urgent appeals (grievances) will be resolved and responded to within 30 calendar days (or sooner) of ValueOptions® of California's receipt of the appeal/grievance. This 30 calendar day time period includes completion of any/all multiple internal/external levels of review that ValueOptions® of California may need to utilize due to the nature of an appeal/grievance. For example, the ValueOptions® of California 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.

Urgent Appeals

All urgent appeals (grievances) will be resolved and responded to within three (3) calendar days or less of receipt of the appeal/grievance by ValueOptions® of California. This three calendar day time period includes completion of any/all multiple internal/external levels of review that ValueOptions® of California may need to utilize due to the nature of an appeal/grievance. 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.

Additional Appeal (Grievance) Rights

- **Review by Department of Managed Health Care (DMHC)**
  After completing the appeal (grievance) process as described in ValueOptions® of California 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 **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

- **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 ValueOptions® of California 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 must advise the member of the availability of an independent review and how to request such a review.

- **Voluntary Mediation**
  In the event the member is dissatisfied with the ValueOptions® of California appeal/grievance process determination, the member may request voluntary mediation (process required to be available by California law) with ValueOptions® of California prior to exercising the right to submit a grievance to the DMHC as described above. The request must be made within sixty (60) calendar days of the ValueOptions® of California determination.

- **Arbitration**

If the member is not satisfied with ValueOptions® of California's response to an appeal/ grievance, the member may submit a request to ValueOptions® of California for binding arbitration within sixty (60) calendar days of receipt of ValueOptions® of California's response. However, in the case of binding arbitration, if the member has legitimate health or other reasons which would prevent the member from electing binding arbitration within sixty (60) calendar days, the member may have as long as reasonably necessary to accommodate special needs in order to elect binding arbitration.

- **ERISA appeals**

  The member may also have the right to challenge an adverse benefit determination on review by bringing a civil action under the provisions of the Employee Retirement Income Security Act of 1974 (ERISA). This act governs some health benefits that are obtained through a non-government employer.

ValueOptions® of California does not make appeal decisions based on findings that a device, procedure, or other therapy is investigational or experimental.

Provider Disputes

ValueOptions® of California 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. The ValueOptions® of California provider dispute resolution process is available for claims and other types of billing and contract disputes and is used to resolve MHSA and EAP disputes from all provider types (practitioners, facilities, and provider organizations).

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 ValueOptions® of California grievance process as described above and not in the ValueOptions® of California provider dispute resolution mechanism. ValueOptions® of California may verify the member's authorization to proceed with the grievance prior to submitting the complaint to ValueOptions® of California grievance 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.

Additional information regarding the provider dispute resolution process is available under the *Provider Disputes and Member Grievances* section of this same Handbook.

Appeal Notification Requirements

For ValueOptions® of California members, written notification of the clinical appeal decision rendered is sent to the member, practitioner, 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 appeal request or three (3) calendar days from receipt of an urgent appeal request.

VOC Timelines for Reviews

Type of Review	Urgency of Case	Timeframe to make decision	Timeframe to provide notification	
			Certifications	**Non-Certifications**
Prospective	Urgent (e.g. Emergency Services, Inpatient, Observation Holding Beds) Cases meeting expedited definition (Knox-Keene)	Seventy-two (72) hours after receipt of request for services	Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the determination on the same day Written or electronic notice issued to member, provider, and facility within seventy-two (72) hours of receipt of the request for services	Telephonic or facsimile notification to provider on the same day the determination is made; provider must agree to notify the member of the determination on the same day. Written or electronic notice issued to member, provider, and facility within seventy-two (72) hours of receipt of the request for services
	Non-urgent (i.e. RTC, Partial Hospitalization and Outpatient)	Five (5) business days after receipt of request for services.	Telephonic or facsimile notification to provider on the same day the determination is made. Written notice issued to member, provider, and facility within two (2) business days of the determination	Telephonic or facsimile notification to provider on the same day the determination is made. Written notice issued to member, provider, and facility within two (2) business days of the determination
Concurrent (Continued Stay)	Urgent (e.g. Inpatient)	Twenty-four (24) hours after receipt of request for services if the concurrent review request defaults to an urgent prospective review request.	Telephonic notification or facsimile to provider on the same day as the determination; provider must agree to notify the member of the decision on the same day Written notice to member, provider, and facility within twenty-four (24) hours of request	Telephonic notification or facsimile to provider on the same day as the determination; provider must agree to notify the member of the decision on the same day Written notice to member, provider, and facility within t twenty-four (24) hours of request
	Non-urgent (e.g., RTC, Partial Hospitalization and Outpatient)	Five (5) business days after receipt of request for services	Telephonic or facsimile notification to provider within twenty-four (24) of the determination Written notification to member, provider, and facility within two (2) business days of the	Telephonic or facsimile notification to provider within twenty-four (24) of the determination Written notification to member, provider, and facility within two (2) business days of the

			determination	determination
Retrospective	Non-urgent (all levels of care)	Thirty (30) calendar days after receipt of request for retrospective review.	Written notice to member, provider, and facility within the overall time frame of thirty (30) calendar days of request for retrospective review	Written notice to member, provider, and facility within the overall time frame of thirty (30) calendar days of request for retrospective review

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. ValueOptions® of California may request a copy of this consent form.

Health Plan Employer Data and Information Set (HEDIS)

On an annual basis, ValueOptions® of California participates with our client organizations in the collection of Health Plan Employer Data and Information Set (HEDIS) data. HEDIS is the most widely used set of performance measures in the managed care industry and is maintained by the National Committee for Quality Assurance (NCQA) that accredits the behavioral health industry. The most current set of HEDIS measures includes 71 measures across 8 domains of care. Only a few of these measures pertain to behavioral health, but over the last few years increasing attention has been paid to developing new measures for behavioral health.

Network providers play a critical role in ValueOptions® of California HEDIS measure performance. The behavioral health indicators primarily address either the number or the timeliness of visits following a diagnosis of certain behavioral health disorders or treatment at specific levels of care. Thus, it is important that providers be aware of the standards set by these measures so as to adjust practice standards accordingly.

Below is a brief description of the HEDIS measures that apply to the behavioral health field and the timeframes and numbers of sessions associated with each:

For detailed information regarding these measures, definitions and national averages, go to http://www.health.state.mn.us/divs/hpsc/mcs/hedishome.htm

1. Follow-up after Hospitalization for Mental Illness

This measure is described as the percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected **mental health** disorders, who were seen

on an ambulatory basis or who were in intermediate treatment with a mental health provider within 7 and/or 30 calendar days of discharge.

This HEDIS measure was the first behavioral health measure included in HEDIS. The critical pieces of this measure for providers are:

- **Inpatient facilities need to:**
    - **Use accurate diagnoses when submitting claims for inpatient treatment.** If the diagnosis on admission is a mental health diagnosis but subsequent evaluation during the stay confirms that the primary diagnosis is substance abuse, please use the substance abuse diagnosis on the claim submitted at discharge.

    - Assist in scheduling or ensure that follow-up visits are within seven (7) calendar days of discharge. **NOTE:** It is important to notify the provider that the appointment is post hospital discharge and that an appointment is needed in seven (7) calendar days.

- **Outpatient providers need to** make every attempt to schedule appointments within 7 calendar days for members being discharged from inpatient care. Providers are encouraged to contact those members who are "no show" and reschedule another appointment. Claims for these visits should be submitted in a timely fashion.

2. Initiation and Engagement of Alcohol and other Drug Dependence Treatment

This measure calculates two rates using the same population of members with Alcohol and Other Drug (AOD) dependence:

Initiation of AOD Dependence Treatment: The percentage of adults diagnosed with AOD dependence who initiate treatment through either:

- An inpatient AOD admission, or
- An outpatient service for AOD (that can include an ER visit) AND an additional AOD service within 14 calendar days

Engagement of AOD Treatment: An intermediate step between initially accessing care and completing a full course of treatment. This measure is designed to assess the degree to which the members engage in treatment with two (2) additional AOD services within 30 calendar days after initiation phase ends. The services that count as additional AOD services include IOP, Partial Hospital, or outpatient treatment billed with CPT 4 or revenue codes associated with substance abuse treatment.

3. Antidepressant Medication Management

The components of this measure assess different facets of pharmacological management of depression.

Optimal Practitioner Contacts for Medication Management. This process measure assesses the adequacy of clinical management of new treatment episodes for adult members with a major depressive disorder.

The measure is defined as the percentage of members, 18 years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of depression and treated with antidepressant medication, and who had at least three follow-up contacts with a non-mental-health practitioner or mental health practitioner coded with a mental health diagnosis during the 84-day (12-week) Acute Treatment Phase.

At least one of the three follow-up contacts must be with a prescribing practitioner (e.g., licensed physician, physician assistant or other practitioner with prescribing privileges).

Effective Acute Phase Treatment: This intermediate-outcome measure assesses the percentage of adult members initiated on an antidepressant drug who received a continuous trial of medication treatment during the Acute Treatment Phase.

The percentage is determined by the number of members, 18 years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of depression, were treated with antidepressant medication and remained on an antidepressant drug during the entire 84-day (12-week) Acute Treatment Phase.

Effective Continuation Phase Treatment: This intermediate-outcome measure assesses the effectiveness of clinical management in achieving medication compliance and the likely effectiveness of the established dosage regimen.

The percentage is determined by the number of members, 18 years of age and older as of April 30th of the measurement year, who were diagnosed with a new episode of depression and treated with antidepressant medication and who remained on an antidepressant drug for at least 180 days (6 months).

4. Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

The following two rates in the measure assess follow-up care for children prescribed a medication to treat ADD or ADHD. Examples of the antidepressant medications included in this measure are:

- Tricyclic antidepressants (TCA) and other cyclic antidepressants
- Selective serotonin reuptake inhibitors (SSRI)

- Monoamine oxidase inhibitors (MAOI)
- Serotonin-norepinepherine reuptake inhibitors (SNRI), and
- Other antidepressants

Initiation Phase: Defined as the percentage of members, 6–12 years of age as of the prescription start date, with an ambulatory prescription dispensed for ADHD/ADD medication and who had one follow-up visit with practitioner with prescriptive authority during the 30-day Initiation Phase.

Continuation and Maintenance (C&M) Phase: Defined as the percentage of members, 6–12 years of age as of the prescription start date, with an ambulatory prescription dispensed for ADHD/ADD medication who remained on the medication for at least 210 days and had at least two additional follow-up visits with a practitioner within 9 months after the Initiation Phase ends.

Electroconvulsive Therapy

Prior to conducting Electroconvulsive Therapy (ECT), providers must contact ValueOptions® of California for pre-certification of such therapy. All requests for ECT are reviewed by a member of our medical staff.

Certification for Secondary Coverage

Providers must follow all of ValueOptions® of California's review procedures for certification even when the ValueOptions® of California administered plan is the secondary payer.

ValueOptions® of California, at times, is both the primary and secondary payer. To avoid duplication of the review process in these cases, the primary ValueOptions® of California office will manage the care until primary coverage ends, at which time the ValueOptions® of California office with secondary coverage will assume management. Providers can assist ValueOptions® of California in the management of these cases by notifying ValueOptions® of California of all pertinent employer and insurance information for the ValueOptions® of California member being treated.

Confidentiality

ValueOptions® of California defines confidentiality under the *Quality Management Program* section of this same Handbook.

New Service Technologies

ValueOptions® of California recognizes the need for knowledge of emerging technologies to provide optimum care to members. ValueOptions® of California evaluates these technologies in

terms of their overall potential benefits to members and recommends these technologies to clients for inclusion in their benefit packages. Examples of new technologies are psychotropic medications or new, approved uses of current medications, innovative community service programs and new approaches to provision of psychotherapy and treatment. ValueOptions® of California has established committees that conduct formal reviews of potential new technologies. The effectiveness of new service technologies will be considered in our medical necessity decisions.

Mechanisms to Evaluate the Effects of the Utilization Management Program

Effectiveness of the Utilization Management Program is evaluated in part by:

1) **Member Satisfaction Surveys –** ValueOptions® of California continuously conducts member satisfaction surveys. On a semi-annual basis, results are summarized and distributed to the VOC Quality Management Committee where corrective action plans, where appropriate, are developed.

2) **Provider Satisfaction Surveys –** ValueOptions® of California also conducts an annual provider satisfaction survey. This survey measures providers' opinions regarding ValueOptions® of California clinical and administrative services. Data is aggregated, trended and used to identify improvement opportunities. Results are shared with providers through the VOC Quality Management Committee, Clinical Advisory Committees, and provider newsletters.