SECTION 5

REFERRAL AND AUTHORIZATION PROCESS

Primary Care Physician Referral Process

Members of CCHP are required to select a primary physician (PCP) from the CCHP Provider Directory. All primary care physicians are part of the Chinese Community Health Care Association (CCHCA) medical group. Family members may select different primary care physicians. The primary care physician is responsible for:

1. Assuring reasonable access and availability to primary care services,
2. Making referrals to specialists and other plan providers,
3. Providing 24 hour coverage for advice and access to care, and
4. Communicating authorization decisions to the health plan member.

Chinese Community Health Plan (CCHP) members may require services that go beyond the scope of their primary care physician (PCP). When this occurs, the PCP refers the member to an appropriate participating specialist using the Specialty Consultation Referral process.

In the event the CCHCA medical group or CCHP does not have a needed provider or consultant, the member's primary physician or attending physician or other CCHCA/CCHP specialist must request prior authorization from the Utilization Management Department to use a non-contracted, out-of-network specialist.

Referral from PCP to Participating Specialists

The Specialty Consultation Referral Process enables a Primary Care Physician (PCP) to coordinate the process by which their patients receive care from Chinese Community Health Care Association (CCHCA) medical group specialist physicians, behavioral heath specialists and other CCHP/CCHCA participating health care providers. When a CCHP primary care physician identifies the need for a referral, the PCP may refer patients to CCHCA specialist physicians, including behavioral health specialists as medically appropriate by completing a CCHCA/CCHP Consultation Referral Form.

- A referral is good for 4 visits in a calendar year for the **same diagnosis** to the same specialist. Referrals submitted in December are also valid for the following year up to a maximum of four visits.
- CCHCA specialist visits for a different diagnosis require a new and separate Consultation Referral Form from the PCP with the specific diagnosis.
- Additional visits beyond 4 for the same diagnosis range require prior authorization.
- Services exceeding $500 (of Medicare allowable) require prior authorization.

- If a patient self-refers to a CCHCA OB/GYN specialist for women's health services a referral is not required. For self referred services, the OB/GYN must complete a CCHCA Direct Access Report Form. One copy is submitted to the PCP and another copy is attached to a paper claim. For electronic claims CCHP will audit medical records to verify that the Report Form is in the PCP's file.
- **The Consultation Referral Form cannot be used for non-CCHCA physicians or non-CCHCA behavioral health specialists. All services from non-CCHCA physicians and non-CCHCA behavioral health specialists require prior authorization by the CCHP Utilization Management Department.**

Referral from Participating Specialist to Participating Specialist

With PCP concurrence, for those services or providers not requiring prior authorization, a CCHCA specialist physician may refer to another CCHCA specialist as medically appropriate by completing a CCHCA/CCHP Consultation Referral Form.

Referral to Non-Participating Specialists

Prior Authorization is required to refer members to non-participating specialists. Non-participating specialists are physicians who are not contracted with Chinese Community Health Plan or Chinese Community Health Care Association.

Consultation Referral Forms

The Consultation Referral Form is to be used for referring patients to participating CCHCA physicians or participating behavioral health specialists only. It cannot be used for referring to non-CCHCA or non-CCHP physicians or providers, nor can it be used to request services that require prior authorization; (for these services, the Service Authorization Form must be used).

Consultation Referral Procedure

To refer a patient to a CCHCA/CCHP specialist physician or CCHCA/CCHP behavioral health specialist:

1. Complete a CCHCA/CCHP Consultation Referral Form.

   The primary or referring physician should complete all pertinent information on the top half of the Consultation Referral Form, including the reason for consultation. If the referring physician is not the primary physician, the referring physician should obtain consent from the primary physician and check mark the

box “If referring MD is not the PCP, has PCP consent”. The referring physician shall keep the white copy for his/her records.

2. After completing the Referral Form, the referring physician should keep the white copy for his/her records and give the remaining copies to the patient who should be told to bring the Referral Form to the CCHCA/CCHP specialist physician or CCHCA/CCHP behavioral health specialist (consultant).

3. **Following consultation, the specialist will fill out the bottom half of the Consultation Referral Form and send a copy of the form/report to the referring physician and primary physician**. Consulting physicians and behavioral health specialists must send a written communication to the referring physician.

4. The specialist physician shall keep a copy of the form for his/her records.

5. For electronic claims, the CCHCA specialist physician or behavioral health specialist (consultant) must indicate the name of the referring CCHCA physician on the electronic claim. For paper claims, the specialist (consultant) physician or behavioral health specialist must submit a copy of the CCHCA Referral Form with the claim.

6. If the specialist physician determines the patient needs a procedure that is an office procedure and the procedure does not require prior authorization, the treating specialist may perform the procedure after consultation with the primary physician.

7. If the procedure requires authorization then the specialist must request prior authorization from the Utilization Management Department by completing and submitting a Service Authorization Form (SAF) by fax. If the request is urgent, mark “URGENT” at the top of the SAF.

Continuity of Care by a Specialist

(For more than 4 visits in a Calendar Year)

The specialist, in consultation with the primary physician, may need to see a patient beyond the primary physician's referral (**valid for 4 office visits per calendar year for the same diagnosis**; prior approval is required for further visits). The specialist is required to submit a Service Authorization Form (SAF) to the Utilization Management Department to request additional office visits. The SAF must include the diagnosis, medical justification for additional visits, and treatment plan (i.e., frequency and duration of visits). **The boxes on the top of the SAF "services provided by" and "has primary physician approval" MUST also be filled out**.

Mental Health Parity

Please refer to Section 6, "Mental Health Parity" to review the coordination of care and documentation requirements for Primary Care Physicians, Specialist Physicians and Behavioral Health Specialists.

Prior Authorization

Prior Authorization is intended to ensure that the requested service is covered by the member's benefit, that the provider of the service is participating, and that the services are medically necessary. Services will also be reviewed to ensure that the most appropriate setting is being utilized and to identify those members who may benefit from our case management programs. Prior Authorization is subject to a member's eligibility and covered benefits at the time of service.

Utilization Management Department

The Utilization Management Department is responsible for the prior authorization process, which includes monitoring inpatient hospitalizations and patients in skilled nursing facilities as well as working with physicians for those patients in need of case management services.

CCHP uses evidence-based clinical guidelines developed by Milliman Care Guidelines, LLC. The Care Guidelines identify benchmark patient care and recovery stages to enhance health care services delivery, resource management and patient outcomes. This approach can reduce unnecessary variation in health care delivery and health care disparities in our community. The Care Guidelines provide health care professionals with evidence-based clinical guidelines at the point of care. They also support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives.

Notice of Utilization Management Decision-Making

Utilization Management (UM) decision-making is based on medical necessity and appropriateness of service in conjunction with eligibility and covered benefits. Chinese Community Health Plan does not reward practitioners or other individuals for issuing denials of coverage or services. There are no financial incentives for UM decision makers to encourage decisions that result in denial of care.

Services Requiring Prior Authorization

The following contains a summary of services requiring prior authorization. CCHCA Physicians should consult the CCHCA Physician Handbook for more detailed information. Please refer to the Covered Services and Exclusions section of a member's Evidence of Coverage for more information on services that require a prior authorization. **Please note that our prior authorization requirements are subject to change**. If you have questions about services requiring prior authorization, contact the Utilization Management Department.

Service (in alphabetical order)

- All services from Non-Participating Providers
- Acupuncture services
- Acute Rehabilitation Facilities
- Ambulatory surgery
- Amniocentesis
- Durable Medical Equipment
- Epidural blocks for pain management
- Fetal testing, stress and non-stress **after the first test** (No authorization needed for the first test)
- Home Health Care Services
- Hospitalizations (Elective)
- Mammograms **for 2nd or more in a year**. (No authorization required for first mammogram in year)
- Nuclear cardiograms, cardiac imaging
- Nuclear Medicine Studies: Bone, Heart, Liver/spleen, Lung, Thyroid
- Occupational Therapy
- Out-of-Plan Providers (also referred to as non-plan or non-contracted or out-of-network providers)
- Outpatient Services from Non-Preferred Providers (as indicated on the Outpatient Services List in this Section)
- PCP referrals in excess of four visits to specialist physicians in a calendar year
- Physical Therapy **after initial consultation visit**
- Radiology Scans: CAT, MRI, PET
- Services, procedures or supplies over $500 allowable (according to the Medicare Fee Schedule)
- Skilled Nursing Facility (SNF)
- Speech Therapy
- Transportation (Non-emergency medically necessary ambulance, wheelchair, medi-van, air ambulance)
- Ultrasound for pregnancy and Gyn studies **after the first two tests** (No approval needed for the first two tests, except for Gyn studies for infertility)

How to Request Prior Authorization

The **CCHCA Service Authorization Form (SAF)** is used to request prior authorization from the Utilization Management Department. If the SAF is being submitted by a CCHCA referral specialist, he/she may submit an SAF after approval from the primary physician.

To request prior authorization:

1. Complete a CCHCA Service Authorization Form (SAF). **Be sure to include**:

   a) The diagnosis and treatment plan,
   b) CPT and ICD 9 Codes (when applicable), and
   c) **Adequate clinical information that supports the medical necessity of the services requested. Requests for services that do not meet Milliman Care Guidelines and requests submitted without adequate clinical information may be denied or returned for additional clinical information**.

   - Please allow up to 14 calendar days to process authorization requests for routine, non-urgent services.
   - For urgent services, please write "URGENT" at the top of the SAF for priority processing.

2. **Fax** the completed Service Authorization Form **and** supporting clinical information to the UM Department at: **415-398-3669.**

3. Once a determination is made you will receive an approval (or denial) notice via fax. You can also view authorized services at **www.cchphmo.com/eligibility_inquiry.**

   - **When services are approved**, the reference number is written on the SAF and it is returned by fax to the requesting physician, the primary physician and the provider of the service. It is the responsibility of the requesting provider to communicate to the member the specific health care service(s) that was approved and document that the approved service was communicated to the member. Patients may be notified by telephone, written notice, email or in person.
   - **When services are denied**, a denial letter is faxed to the requesting provider and the primary physician.

4. After rendering the service be sure the claim includes:
   a) The procedure code(s) that was authorized on the SAF matches the code on the claim form,
   b) The reference number for the authorization,
   c) And, when submitting a paper claim, attach a copy of the SAF.

Retroactive Authorizations

For services requiring authorization, the request must be submitted prior to rendering the service, to:

1. Verify medical necessity,
2. Verify the service requested is a covered benefit,
3. Verify member eligibility and enrollment, and
4. Verify the provider and location of service is in network.

Requests for retroactive authorizations will not be approved for any elective and non-emergent services.

NOTE: Claims received for elective and non-emergent services without the required prior authorization by the Utilization Management Department will be denied.

Urgent Authorizations

Urgent requests receive special attention. The UM Department makes every effort to return authorization determinations in a timely manner. Urgent or emergent care should never be delayed while awaiting prior authorization. Please do not hesitate to ask to speak directly to the UM Manager if you have concerns that the process may interfere with the care your patient requires.

During Business Hours: Monday – Friday, 9:00 am to 5:00 pm

Outpatient:
If a situation is urgent, submit an SAF marked "URGENT" at the top and it will be given priority processing.

Inpatient:
If there is an urgent need for an inpatient authorization, call the UM Manager at 415-955-8800, ext. 3260.

Weekends, After Hours, Holidays

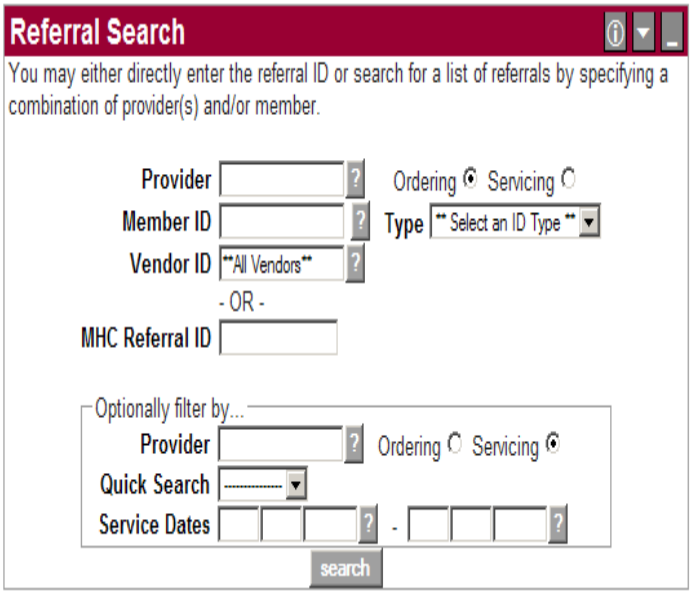
On weekends, after hours or holidays, the primary physician or the CCHCA attending physician has the authority to authorize treatment for services that the physician considers urgent/emergent. The attending physician should then submit a timely SAF to the Utilization Management Department the next business day.

Instructions for Checking the Status of Authorizations Online

Requests for Prior Authorization must be submitted by FAX to the Utilization Management Department using a CCHCA Service Authorization Form (SAF). We are not currently able to accept requests for authorization via the Web site.
You can view the status of authorization requests that have been received by the UM Department on the Web site. Please note that the term "Referral" as used on the Web site means "Authorizations." To check the status of authorizations:

1. Go to http://www.cchphmo.com/eligibility_inquiry.html
2. Select "Web Based Inquiry".
3. Enter your username and password and click on "login".
4. From the "Referral Search" screen, enter the member's ID # (Example: 000111222*01) on you slight right of the screen choose the **type** of ID: **"MHC"** from the pull down menu, you may also select the option for **servicing** or **ordering** provider accordingly. You may also search by name and last name by clicking on the question mark symbol and enter the last name and first name.
5. On the "Referral Search" screen towards the lower area of the referral search you have optional filters **(Optionally Filter by)** to narrow the information being searched. Select a **"Quick Search"** option and from the drop down menu choose your option.

   See **"Referral search"** screenshot below

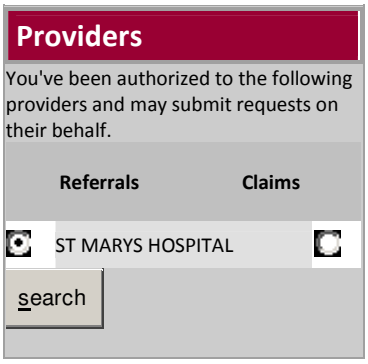


6. Click on the "Search" button and the "Search Results" Screen will list applicable Authorizations (SAF) requests received. Double click on the left side of the screen

authorization tracking number in red and a detail explanation of the authorization will be display.

You can also search for authorizations From the My CCHP – Provider Snapshot Page, on the right side of the screen. Select "Providers" and then place the cursor on the "Referrals" option. Place the cursor in the small circle, select the option by place a dot to view all referrals (Authorization Request) submitted for your provider and "Enter".

See **"Providers"** shortcut screen snapshot below.



For more detail, select a specific "Authorization (Referral) Number" and you will see an Authorization Referral summary.