SECTION 9 Referrals and Authorizations

General Information

The PAMF Utilization Management (UM) Program is carried out by the Managed Care department. The UM Program is designed to ensure that all Members receive impartial, consistent, timely, and appropriate medical care. The Managed Care department collects utilization data that is tracked and evaluated on an ongoing basis. This data is used to identify areas for improvement in the quality of patient care.

Prior Authorization is performed by the Managed Care department. Prior Authorization is the process of obtaining approval for services that will be provided to PAMF HMO Members before services are provided. The Authorization process includes but is not limited to: verifying eligibility, reviewing relevant clinical information, determining medical necessity and ensuring appropriate providers are delivering the services.

All medical care except emergency services must be authorized by PAMF before the service takes place. If Professional Provider wishes to provide additional services or refer the Member to other non-PAMF Providers that are not covered by the existing Authorization, the Professional Provider must notify PAMF and obtain another, separate prior Authorization. Requests for Authorization of additional services must be directed to PAMF (physicians or departments) unless PAMF determines a need exists for the referral/service to be provided outside of PAMF.

UM decision making is based only on appropriateness of care and service and existence of coverage. Compensation for Managed Care personnel does not contain incentives, direct or indirect, based on the decisions made.

Key Contacts For Referrals and Authorizations

Although it is important to keep the Primary Care or Referring Physician informed of patient care, Professional Provider must submit authorization requests directly to Managed Care. The Managed Care department is structured to review and process authorization requests in a centralized environment.

Managed Care: Hours of operation 8am – 5pm
Phone: 650-812-3700
Fax: 650-394-8658
Types of Authorizations and Definitions

**Pre-Service**: review of services for Authorization before services are provided

- **Commercial pre-service review types**
  - **urgent pre-service**: services are needed within 72 hours or it could seriously jeopardize the Member’s life, health or ability to regain maximum function.
  - **urgent concurrent**: (in-hospital/SNF/rehab): length of stay or ongoing ambulatory services extension needed within 24 hours to prevent lapse in care
  - **routine pre-service**: routine Authorization request before services are provided

- **Medicare Advantage pre-service review types**
  - **expedited initial organization determination (EIOD)**: services are needed within 72 hours or it could seriously jeopardize the Member’s life, health or ability to regain maximum function
  - **standard initial organization determination**: routine Authorization request prior to services being provided

**Emergency**: per NCQA, “A medical or psychiatric emergency is the sudden and unexpected onset of a condition with symptoms so severe (including severe pain), that a person possessing average knowledge of health and medicine would expect that without prompt medical attention their health would be in serious jeopardy or impaired.”

**Post Service**: If an Authorization was never obtained before the service then it is submitted as a post service Authorization.

Procedures For Authorizations

**General Information**

Referral requests may be submitted electronically via Sutter Link or via fax. Once any Authorization request is received by Managed Care, the first step is to verify Member eligibility and benefit coverage. If the Member is not eligible with PAMF or if eligibility will terminate before the service request date, the Managed Care Coordinator notifies the requesting Provider’s office and an eligibility denial is issued.

Requests for services that require health plan review for prior Authorization may include requests such as transplant-related services, clinical trials or investigational/experimental services, or bariatric surgery. These requests are faxed to the health plans for their determination.
Managed Care staff review referrals against pre-established clinical guidelines and health plan guidelines. Referrals that meet the criteria are approved. Other factors taken into consideration when reviewing referral requests include: age, co-morbidity, complications, home environment, progress of treatment, psychosocial needs, benefits and availability of services in local area (such as SNF beds and ability of contracted hospitals to provide needed services).

Authorization requests not meeting medical criteria or guidelines are further reviewed by a Managed Care Medical Director. The Managed Care Medical Director is the only person who may render a denial for the lack of medical necessity. Authorization requests are completed within the timeframes set forth by the Industry Collaboration Effort (ICE) Commercial and Centers for Medicare and Medicaid Services (CMS) UM Timeliness Standards for turnaround times and referral processing.

Upon written request, the Member or requesting Provider is sent a copy of the criteria used in making a decision to approve, modify, or deny health care services. Professional Providers and PAMF Members have phone access to Managed Care staff during normal business hours and messages may be left.

PAMF does not restrict its contracted Professional Providers from advocating on behalf of Members or advising Members about medical care, including, but not limited to, treatment options (without regard to plan coverage), risks, benefits, consequences of treatment or non-treatment, or the Member’s right to refuse medical treatment or self-determine treatment plans.

Authorized referrals are not rescinded or modified after the Professional Provider has rendered services in accordance with the Authorization.

**Pre-Service Authorization Procedures**

**Commercial Urgent Pre-Service/Expedited Authorization Procedure**

1. Urgent Pre-Service Authorizations may be submitted to a Managed Care Coordinator electronically via Sutter Link, or by fax or in person (see key contacts for referrals and authorizations).
2. Urgent/expedited Authorization requests received by 3:00 pm are processed by close of the same business day and no later than within 72 hours of receipt of the request. The requesting Provider and Member are contacted with the review determination within 24 hours of the day the determination is rendered and not later than 72 hours of receipt of the request.

3. When additional clinical information is required to render a determination, the Managed Care staff will contact the requesting Provider and the Member within 24 hours of receipt of request and try to obtain the necessary information. The additional information must be received within 48 hours of request. Once the information is either received or 48 hours have elapsed with no additional information, a decision will be made within 48 hours. The Provider and Member are then notified of the determination within 24 hours of the day the determination is rendered and not later than 72 hours of receipt of the request.

4. Managed Care determines if the request is urgent per the definition of “urgent” (see types of authorizations and definitions above). If submitted as “urgent” and determined not to be medically “urgent”, the referral will processed under standard turn-around times.

   **Note:** a non-urgent appointment for which referral authorization has not yet been submitted does not qualify as medically “urgent” under the DMCH definition.

**Commercial Urgent Concurrent Authorization Procedure**

For services needed urgently/emergently, the Provider shall make best efforts to obtain authorization, as per the Urgent Pre-Service section, above.

**Commercial Routine Pre-Service Authorization Procedure**

1. Routine Pre-Service referrals may be submitted to Managed Care electronically via Sutter Link, or by fax or in person).

2. Services are reviewed under protocol by a Managed Care Coordinator, Nurse or Medical Director. Adequate clinical records are required to assess medical necessity for type of service and place of service. Incomplete information results in delays in referral processing. Referrals requiring additional clinical information will have a “Pending Review” status.
3. A determination will be made within 5 business days. Providers using Sutter Link can access referral status and referral decision in real time. Once a determination is made the referring Provider is notified within 24 hours and the Member is notified within 2 days.

4. Notification may use the Professional Provider’s fax number or office address. The member receives written notification via mail.

5. Requests that require additional medical information and cannot be determined within 5 business days are placed in “pending” status and the Professional Provider and Member are notified within 5 calendar days of receipt of request. At least 45 business days are provided for receipt of the requested information. Once the information is received it will follow the normal timeline. PAMF makes every effort to get all needed information to make an initial determination within the initial 5 business days.

Medicare Advantage Pre-Service Expedited Initial Organization Determination EIOD Procedure

1. Providers are requested to follow the definition of “urgent” above in requesting services for Medicare Advantage members, as PAMF follows a policy of not “downgrading” these requests to routine. Consequently, urgent requests are processed as above for Commercial Urgent Pre-Service requests.

2. Notification of Professional Providers will follow process for Commercial, Urgent, above, with immediate faxing. If no fax number is available, the Provider office will be notified by phone. MA Members are notified of urgent referral decisions by phone.

3. When providers use “urgent” requests inappropriate, this pattern will be reviewed by the Managed Care Medical Director or UM Leadership. Provider Contracting will be involved in engaging the Professional Provider office in appropriate use of priority status requests.

4. To expedite processing for urgent MA members, Provider is strongly encouraged to supply all necessary information in the initial referral submission.

Medicare Advantage Pre-Service Initial Organization Determination Procedure (Routine)

See the procedure for commercial routine authorizations above. However, the turn-around time for processing of routine requests for senior HMO members is 14 calendar days. Other processes are the same as for commercial members.
**Emergency Procedure**

1. Emergency services do not require prior Authorization.

2. Professional Providers requesting prior Authorization for emergency services are notified to proceed with the services.

3. All notification of emergency services to Managed Care should occur within 48 hours from provision of service in order to place referrals and to coordinate with PAMF for continued care.

4. Claims may be submitted following the normal procedures (see section 10 claims submission and payment). Make sure to submit evidence that emergency care was needed along with the claim.

**Post-Service Authorization Procedure**

1. Post-Service Authorizations may be submitted to the Managed Care Department as above. Please note that post-service requests may be denied, at which point the contracted Professional Provider may not balance bill the Member for services rendered without express financial waiver signed by the member.

2. For commercial members, a post-service review is completed within 30 calendar days of receipt of a request. Provider and Member are notified of the determination within the 30 days.

3. For senior HMO members, CMS does not allow requests for post service authorization without submission of a claim.
Authorization Request Form

Managed Care Prior Authorization Request Form

Priority: □ Routine □ Urgent* □ Retro

Fax this form to: (650) 934-8658 or (831) 458-5815
For questions call: (650) 812-3700

Patient Last Name: ___________________ First Name: ___________________ MI: ______

DOB: ___________________ PAMF Medical Record Number (if known): ________ Other MRN: ________

Patient Insurance Information: Member ID# ___________________

□ Aetna □ Anthem Blue Cross □ Blue Shield □ Cigna □ HealthNet □ HealthNet Seniority Plus
□ Humana □ UHC □ UHC West Medicare □ Other

Provider Requesting Authorization:
Physician/Provider Name: ___________________

Business/Office Name: ___________________ Dept/Specialty: ___________________

Office Contact: ___________________ Phone: ___________________ Fax: ___________________

Vendor/Provider Requested: ___________________ TIN/NPI: ___________________

Place of Service/Facility: ___________________ TIN/NPI: ___________________

Service(s) Requested: □ Consultation □ Follow-up Visits □ Tests or Procedures (include description and CPT /HCPCS Code)

□ Injectable Medication: Given at □ Office □ Home □ Other ___________________

Medication Name: ___________________ Dose: ___________________ Frequency: ___________________ Duration/Cycle: ___________________

Date of Service: ___________________ Type of Stay: □ Inpatient □ Outpatient □ 23 Hr stay

Diagnosis(es): ___________________ ICD-9/ICD-10(s): ___________________

CPT/HCPCS# _______ #Units _______ Procedure/Service Description
CPT/HCPCS# _______ #Units _______ Procedure/Service Description
CPT/HCPCS# _______ #Units _______ Procedure/Service Description
CPT/HCPCS# _______ #Units _______ Procedure/Service Description

Comments: ___________________

*Urgent definition: service(s) needed within 72 hours or it could seriously jeopardize the member’s life or health or ability to regain maximum function, includes severe pain.

Updated August 2014
Sample Commercial Authorization Approval Letter

P.O. Box 50549
Palo Alto, CA 94303

Carmine Division (408) 521-1200
Palo Alto/Alamo Division (650) 321-1211
Santa Cruz Division (831) 458-4139

Referral Authorization
August 27, 2014

Referral To Provider: Flyer Kelly
Flyer Kelly MD
17979 LOS GATOS BLVD STE 179
LOS GATOS CA 95032-9988

Referral P: 1535
Referral Date: 08/07/2014 HMO ANTHEM
BLUE CROSS ID: 589461785678
DOB 02/10/1980

Patient
To Ref. Plant Be One Ztest
4560 JOHN CT
SAN JOSE CA 95110

Work Not on File
Home: 550-858-5852 Mobile
650-458-5862

PCP: Kristin Razzaeza
Referring Phy: Kristin Razzaeza

Diagnoses:
374.20 (ICD-9-CM) Phoes of both eyes


Procedure:
Code Procedure Name Modifiers Approved
95244 PR CONSULT CUT PT LEVA
3282 PRE-EXIST FIELD EXAM INTERMED

Additional Instructions:
No notes of specific diagnosis found.

Notice: This form is not in and of itself a guaranty of payment. Charges for non-covered services or services rendered to patients whose coverage is no longer in effect are the patient’s responsibility. Provider should verify eligibility with the patient’s HMO on the Date of Service. Future consultations or treatments are not approved by Pre-authorization.

Note: All Anesthesia, Lab, Radiology and Pathology services must be done at the Medical Group contracted facility/provider. Call the Primary Care Physician’s office to verify the contracted providers for each group.

Note: In all cases, communicate your assessment and recommendation back to the Primary Care Physician. If services beyond those authorized are needed, call the Primary Care Physician.

Ref questions to: Managed Care (650) 612-3760

Providers, to expedite the timely and accurate payment of your claim, you must include the following information on your CMS 1500, UB-02 or UB-04: Patient’s Name, Patient’s Date of Birth, Name of Health Plan, Identification Numbers, Date(s) of Service, CPT/HCPCS Revenue code(s) and Description of Service, Diagnosis code(s), DBC Information, Billed Amount. Please include the Referral Number in box 23 on the CMS 1500 form and in box 63 on the UB-02/UB-04 form.
Sample Commercial Authorization Denial Letter

August 27, 2014

UCSF Department of Dermatology
1701 DIVISADERO ST THIRD FLOOR
SAN FRANCISCO, CA 94115

Member Name: Tp Rec Pamf Be One Zztest
DOB: 05/10/1980
Member ID#: 586144785678

Health Plan Name: Anthem Blue Cross
Requested Provider: UCSF DERMATOLOGY
Requested Service: 99243 (CPT®) - PR CONSULT OUT-PT LEV 3
Requesting Provider/Physician: UCSF Department of Dermatology
Authorization Request Reference#: 15354

Dear Ms. Zztest:

The requesting provider/physician has asked for the above referenced service. The service requested is being denied by Palo Alto Medical Foundation because there is a lack of medical necessity. This decision was based on your medical information.

No notes of specified type found

You may obtain a free of charge copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request, by calling Palo Alto Medical Foundation (650) 812-3700. You may contact your provider for detailed information about your diagnosis or treatment. This could include the detailed codes and their meanings.

The requesting provider/physician has been advised of this denial and given the opportunity to discuss this determination with a Palo Alto Medical Foundation physician reviewer.

How to Dispute This Determination*

If you believe that this determination is not correct, you have the right to appeal the decision by filing a grievance with your health plan. Your health plan requests that you submit your grievance within 180 days from the postmark date of this notice. You or someone you designate (your authorized representative) may submit your grievance verbally or in writing. You may call your health plan to learn how to name your authorized representative.

There are two types of grievancees: standard and expedited.

Standard Grievance Process
A standard grievance will be resolved within 30 days. Your health plan will notify you in writing of the decision within 30 calendar days of receiving your grievance.
Expedited/72 hour Grievance Process
Your health plan makes every effort to resolve your grievance as quickly as possible. In some cases, you have the right to an expedited grievance when a delay in the decision making might pose an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb, major bodily function, or if the normal timeframe for the decision making process would be detrimental to your life, health or could jeopardize your ability to regain maximum function. If you request an expedited grievance, your health plan will evaluate your grievance and health condition to determine if your grievance qualifies as expedited. If so, your grievance will be resolved within 72 hours. If not, your grievance will be resolved within the standard 30 days.

Submitting Your Grievance
Please submit a copy of your denial notice and a brief explanation of your situation, or other relevant information to your health plan. Your health plan will document and process your standard or expedited grievance and provide you with written notification of the decision. You may write, call or fax your grievance to your health plan. Health plan address, telephone and FAX number is listed at the end of this letter.

Department of Managed Health Care Complaint Process
The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-365-0609 or TTY/TTD at 1-866-333-4823 and use your health plan’s grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are 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. The department also 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 department’s Internet Web site http://www.crmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

You may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if you are enrolled with your health plan through an employer who is subject to ERISA. First, be sure that all required reviews of your claim appeal have been completed and your claim has not been approved. Then consult with your employer's benefit plan administrator to determine if your employer's benefit plan is governed by ERISA. Additionally, you may have other voluntary alternative dispute resolution options, such as mediation.

Other resources to help you: Do you have questions about your appeal rights or this notice? Need help with an appeal? You can get help from the Consumer Assistance Program (CAP) in California.
California Department of Managed Health Care Help Center
Toll Free: 1-888-466-2219 TDD/TTY 1-877-688-9891
http://www.healthhelp.ca.gov

*Federal Employee Health Benefit Program (FEHBP) members: The preceding appeals information does not apply to participants of the FEHBP. If you are covered by the FEHBP, please refer to Section 8, *The Disputed Claims Process*, of your Federal Brochure, which explains the FEHBP appeals process.

If the treating physician would like to discuss this case with the physician or health care professional reviewer or obtain a copy of the criteria used to make this decision, please call 650-812-3700.

Sincerely,

Deborah Bronstein, MD
Managed Care Medical Director
Palo Alto Medical Foundation

C: Member File
   UCSF Department of Dermatology
   Kristin Razzace
   Anthem Blue Cross

<table>
<thead>
<tr>
<th>Standard Grievance</th>
<th>Expedited Grievance</th>
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<tr>
<td><strong>Anthem Blue Cross</strong></td>
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<tr>
<td>Attn: Grievance &amp; Appeals Department</td>
<td>Attn: Grievance &amp; Appeals Department</td>
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<tr>
<td>P.O. Box 4310</td>
<td>P.O. Box 4310</td>
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<tr>
<td>Woodland Hills, CA 91365-4310</td>
<td>Woodland Hills, CA 91365-4310</td>
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<tr>
<td>Telephone: 1-800-365-0609</td>
<td>Telephone: 1-800-365-0609</td>
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<tr>
<td>TTY/TDD: 1866-333-4823</td>
<td>TTY/TDD: 1866-333-4823</td>
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<tr>
<td>Fax: 1-818-234-1089</td>
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<td>Internet: <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
<td>Internet: <a href="http://www.anthem.com/ca">www.anthem.com/ca</a></td>
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Sample Medicare Advantage Authorization Approval Letter
Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

Notice of Denial of Medical Coverage

Date: August 27, 2014  Member number: 454531551

Name: Tp Rec Pamf Sp Two Zztest  Provider Name: Stanford Cardiology Department
56 Long Street  Date of Service:
Palo Alto CA 94303

Your request was denied
We’ve denied the medical services/items listed below requested by you or your provider: 99214 (CPT®) - PR OV EST PT LEV 4

Why did we deny your request?
We denied the medical services/items listed above because: No notes of specified type found

You have the right to appeal our decision
You have the right to ask Health Net to review our decision by asking us for an appeal.

Appeal: Ask Health Net for an appeal within 60 days of the date of this notice. We can give you more time if you have a good reason for missing the deadline.

If the treating physician would like to discuss this case with the physician or health care professional reviewer or obtain a copy of the criteria used to make this decision, please call Deborah Bronstein, MD at 650-812-3700.

If you want someone else to act for you
You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-800-275-4737, 8:00 AM to 8:00 PM PST, 7 days a week to learn how to name your representative. TTY users call 1-800-929-9955, 8:00 AM to 8:00 PM PST, 7 days a week. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us.

Important Information About Your Appeal Rights

There are 2 kinds of appeals

Form CMS 10003-NDMCP (Iss. 06/2013)  OMB Approval 0938-0829
Standard Appeal – We’ll give you a written decision on a standard appeal within 30 days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a service you’ve already received, we’ll give you a written decision within 60 days.

Fast Appeal – We’ll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We’ll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 days.

How to ask for an appeal with Health Net

Step 1: You, your representative, or your provider must ask us for an appeal. Your request must include:
- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: Mail, fax, or deliver your appeal.
For a Standard Appeal:
Address: Mail: Health Net of California, Inc. Medicare Appeals and Grievances P.O. Box 10344 Van Nuys, CA 91410-0344

Deliver: Health Net of California, Inc. Medicare Appeals and Grievances 21281 Burbank Blvd. Woodland Hills, CA 91367

Fax: 1-877-713-6189

For a Fast Appeal: Phone: 1-800-275-4737 TTY: 1-800-929-9955 Fax: 1-877-713-6189

What happens next?
If you ask for an appeal and we continue to deny your request for a service, we’ll send you a written decision and automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.
Denied Referrals

Referral requests not meeting medical necessity criteria are further reviewed by a Managed Care Medical Director. Denials due to lack of medical necessity may be rendered only by a California board-certified, licensed Managed Care Medical Director. The Medical Director reviews the referral against pre-established medical criteria or guidelines. If necessary, the Medical Director will speak with the requesting physician and/or a specialist in the area, prior to making a decision. Behavioral health care denials will be reviewed by a physician, behavioral health practitioner, or pharmacist, based on medical necessity.

Managed Care Coordinators or Case Managers may deny referral requests related to “lack of health plan benefits” where no medical necessity determination is required and the health plan benefits do not cover the requested service under any circumstance.

ICE Denial Guidelines for timeliness and notification are strictly followed. Providers and Members are notified in writing of appeal rights and rights to obtain criteria or guidelines. The name and phone number for the Managed Care Medical Director denying a case is provided on the denial letter to the Provider. Denial letters for Members and Professional Providers include: service requested, service denied, criteria source, specific criteria, and the reason the Member did not meet the established criteria.

Characteristics of the local delivery system are considered in making denial decisions. Some examples are availability of SNF, sub-acute or home health care in the service area, benefit coverage, and ability of local contracted hospitals to provide services within the length of stay. Other characteristics considered include but are not limited to age, co-morbidity, complications, and psychosocial needs.

Upon written request from a Member or Provider, PAMF discloses the process used to authorize, modify, or deny health care services and provides criteria or guidelines as requested. PAMF also provides criteria or guidelines
for specific services to Members or the public in response to written requests.

UM decision making is based only on appropriateness of care and service and existence of coverage. Compensation plans for individuals who provide utilization review services do not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions. PAMF does not specifically reward practitioners or others for issuing denials of coverage or service care.

If a service is denied as not a covered service and the patient still wants the service PAMF requires that the patient is notified that it will be their financial responsibility.
Denied Referral Appeals Process

If an service request is denied, the Member and Provider are notified in writing and they are given detailed instructions on how to appeal the decision.

Prior to Appealing: If Professional Provider feels that there is new or additional medical information that was not included in the original Authorization request, the Provider may contact the Managed Care Department with all the new supporting information. This may be in writing that includes additional records, or it may include phone communication with a Managed Care Medical Director. This request for reconsideration based on new information should be submitted by Professional Provider before filing an appeal.

If there is no new or additional medical information, the first step is to contact the Managed Care Medical Director that made the determination. The name and contact information of the Managed Care Medical Director is located on the denial letter. If this doesn’t resolve the dispute, the Member may submit a Standard Appeal or an Expedited Appeal directly to the health plan for reconsideration. Professional Providers may submit appeals on behalf of the patient; however, Health Plans encourage Members to submit appeals directly to the Health Plans.

- A standard Appeal will be resolved within 30 days. The Member’s health plan will notify the Member in writing of the decision within 30 calendar days of receiving the appeal.
- An expedited Appeal may be submitted when a delay in the decision making might pose an imminent and serious threat to the Member’s health. This includes but is not limited to severe pain, potential loss of life or limb, and disruption of major bodily function. If an expedited Appeal is submitted, the Member’s health plan will evaluate the appeal and Member’s health condition to determine if the appeal qualifies as expedited. If so, the appeal will be resolved within 72 hours. If not, the appeal will be resolved within the standard 30 days.

If the health plan upholds PAMF’s initial denial decision, the case, if it qualifies, may be forwarded by the health plan, to a third party for Independent Medical Review (IMR). If the Member remains dissatisfied with the outcome, the Member may submit an appeal to the Department of Managed Health Care (DMHC) or request a hearing with an Administrative Law Judge.
Economic Profiling

General Information

“Economic profiling” per California Code of Regulations, Title 8, Section 9767 1 Medical Professional Provider Network is defined as: “any evaluation of a particular physician, Professional Provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, Professional Provider, medical group, or individual practice association.”

Economic profiling may be used for utilization review, peer review, quality, incentive and penalty programs, and in Professional Provider retention and termination decisions. The primary goal is to assess and improve the quality and the value of health care services. The provision of services and medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management as required by California Health and Safety Code Section 1367 (g). Information on economic costs or utilization of services may be used to renew employment, independent contracts, or agreements.

Economic Profiling Procedure

1. Proper methods such as credible observations and statistically significant data are used to profile practice patterns, efficiency, utilization of services, and cost. The methodologies used are documented at the time of review. This data is compared to benchmarks of national or regional standard if possible.

2. Utilization data is collected and analyzed. The areas of analysis include but are not limited to:
   - ambulatory services,
   - inpatient services, and
   - pharmacy services.

3. The following areas will be taken into account during analysis:
   - race mix
   - type and severity of illness
   - Member age
   - other enrollee characteristics that may account for higher or lower than expected costs or utilization of services

4. Economic profiling activities may include, but are not limited to:
   - Utilization management
   - Quality management
   - Clinical outcomes by physician
• Physician and Member satisfaction scores
• Access to health care services
• Efficiency and appropriateness of care and services
• Cost-of-care analysis

5. Health care entities and physicians may review and comment on the findings and data sources used to construct their profiles.

6. Upon written request, information is available to the profiled Professional Provider for up to 60 days after the termination date of a contract between the Payer and the individual Professional Provider.

7. The confidentiality and/or proprietary business interest of the data source is protected by removing or obscuring personal identifiers.

8. Activities that profiling may be used for include, but are not limited to:
   • Physician education regarding practice patterns such as over or under utilization
   • Identifying physician UM practices to focus utilization review activities
   • Adjusting reimbursement or payment
   • Recredentialing
   • Granting or restricting privileges

9. Economic profiling results for external Professional Providers are reviewed by the Managed Care Medical Director who informs relevant PAMF physicians of the findings prior to any changes in contract status.