No. UM-008	Referral Policy	
Effective Date: 1/1/2022	POLICY AND PROCEDURE	
Committee Approval: 01/11/23 Previous Versions: See revision history on last page		
DMHC TAG: Utilization Management NCQA UM Standard 2-7		

Scope of this Referral Policy

This referral policy applies to utilization management responsibilities which are delegated to Canopy Health and not retained by Canopy Health's upstream health plans, per the Division of Financial Responsibility (DOFR) document for each plan. All such decisions delegated to Canopy Health are sub-delegated to each of Canopy Health's medical groups/IPAs and conducted by each group's Utilization Management department.

Examples of services requiring prior authorization by upstream health plans are listed below and are detailed in each DOFR. This list is not all inclusive; enrollees should refer to their benefit plan for more detail (See UM-009 for details).

- Experimental/investigational services and new technologies
- Some Tier III prescription drugs obtained through retail pharmacies
- Out of area emergency care
- Out of network second opinions

Behavioral health services requiring prior authorization are managed by the behavioral health provider network contracted with the employer or Health Plan; these are not delegated to Canopy Health. These services include but are not limited to: non-emergent behavioral health inpatient admissions, intensive outpatient programs, partial day hospitalizations, substance use and alcohol rehabilitation programs, and ongoing office-based psychotherapy or psychiatry care (see UM-003).

UM DECISION MAKING

Canopy Health and its delegated medical groups/IPAs, and hospitals recognize the importance of a timely, transparent referral process to provide appropriate, high quality specialty services that meet the healthcare needs of its enrollees. Canopy Health also recognizes the importance

of having licensed healthcare professionals render decisions about clinical referral services, since such professionals are best positioned to understand the enrollee's clinical needs, local environment, the specialty physicians and other services available in the community.

Canopy Health and the delegated medical groups/IPAs use written criteria based on sound clinical evidence to make utilization decisions and specify procedures to appropriately apply the criteria. Utilization Management (UM) policies and procedures comply with California Department of Managed Health Care (DMHC) and federal requirements, National Committee for Quality Assurance (NCQA) standards and each enrollee's benefit plan structure. Canopy Health provides all of its policies and procedures online and makes them available to delegated medical groups/IPAs. This Referral Policy covers the following topics:

- Designated PCP and Primary Medical Group
- Criteria for UM Decision Making
- Availability of Criteria
- Interrater Reliability
- Appropriate Professionals and Use of Board-Certified Consultants
- Licensed Healthcare Professionals' Role in Supervising Non-Licensed UM Staff
- Written Documentation Requirements
- Communication Services
- Oversight of UM Decision Making
- Timeliness of Medical Decision Making
- Timeliness of Pharmacy UM Decision Making
- The Role of Clinical Information in Decision Making
- Denial Notices
- Reconstructive/Cosmetic Surgery

Designated PCP and Primary Medical Group

Enrollees choose a Primary Care Physician ("PCP") when they enroll in a Canopy Health health plan and select a medical group/IPA. If an enrollee does not choose a PCP, the upstream health plan assigns a PCP for the enrollee. The health plan assigned PCP may only be changed when the enrollee contacts his/her health plan. Health plan policy dictates the effective date for the PCP reassignment.

Enrollee choice of a PCP is not limited by geography or Medical Group/IPA. Canopy Health enrollees may change their primary care physician to any other Canopy Health PCP. The timing of designated PCP change is subject to policies of the enrollee's health plan: for example, all changes are effective on the first of the month.

If specialist consultation or treatment is required, the treating provider may refer the enrollee to any Canopy Health specialist for medically necessary care. The choice of a specialist is a collaborative decision between each enrollee and his/her PCP or other treating physician. Care is generally offered within the Canopy Health home dyad made up of the local medical group, IPA and hospital. Enrollees may be referred to any specialist physician, hospital or facility outside of their home dyad in the Canopy Health network.

For Medicare Advantage enrollees, authorization requests are accepted directly from enrollees, their Appointed Representative or from Canopy Health or the upstream MA Health Plan on behalf of the enrollee. These requests may be oral or in writing. For referrals from the Health Plan, the turn-around timeframes start at the time the enrollee initially contacts the Health Plan and not at the time the delegate receives the call from the Health Plan.

A complete directory of affiliated medical groups/IPAs, providers, hospitals and contracted facilities is available at www.canopyhealth.com.

Criteria for UM Decision Making

Canopy Health and delegated medical groups/IPAs' UM Departments do the following for UM decision making:

- maintain written UM decision-making criteria that are objective and based on medical evidence.
- maintain written policies/procedures for application of the UM criteria that are based on individual needs that include age, comorbidities, complications, progress of

treatment, psychosocial situation and home environment, when applicable.

- For MA enrollees a request for out-of-network services should consider cultural considerations in addition to medical necessity and benefits. Such considerations include but are not limited to: enrollees with diverse cultural and ethnic backgrounds, religious beliefs, limited English proficiency or hearing incapacity. They also include consideration of gender as it relates to the above examples.
- maintain written policies/procedures for applying the criteria based on an assessment of the local delivery system.
- document that appropriate practitioners were involved in the development, adoption and review of the criteria.
- annually review and update both the criteria and the procedures for their application, maintain documentation of such activity.

Availability of Criteria

Canopy Health requires that delegated medical groups/IPAs will provide the criteria on which UM decisions are made to their practitioners when requested by any means available within the local UM program.

The requesting provider's copy of the notice of denial includes the availability of the reviewer who issued the denial to discuss that decision, the reasons for the denial and how to reach the medical reviewer to facilitate discussion with the enrollee about other options, such as different approaches to care, alternate providers or medications, or appeal of the denial. UM policies are available to providers, enrollees and the public via the delegated medical group/IPA's UM Department. Distribution of the criteria should include the following notice as required by HSC 1363.5(c): *"The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."*

Consistency in Applying the Criteria

At least annually, the delegated medical groups/IPAs conduct interrater (IRR) assessments, using hypothetical UM cases or a sample of UM determination files, of those making UM decisions to evaluate the consistency with which the criteria are applied. Corrective action plans are developed to address inconsistencies when necessary.

Appropriate Professionals

Qualified licensed health professionals assess the clinical information used to support UM

decisions. All practitioners making UM decisions have a current and unrestricted license to practice or an administrative license to review UM cases in California with knowledge of Medicare coverage criteria. The following personnel are required for UM decision making:

- Denials: Physicians, all types – medical, behavioral healthcare, dental, chiropractic and vision
- Pharmaceutical Denials: Pharmacists

Each delegated medical group/IPA has a written job description with qualifications for the practitioners who review denials of care based on medical necessity.

Use of Board Certified Consultants

Each delegated medical group/IPA uses board-certified consultants to help determine the medical necessity of requested services.

Licensed Healthcare Professionals' Role in Supervising Non-Licensed UM Staff

Referral requests, including those entered into the referral system by medical group staff, are supervised daily by California licensed nurses and physicians for compliance with local and national accepted care guidelines and criteria within each participating medical group/IPA.

Supervisory responsibilities include staff training, auditing for adequate documentation and daily availability to support and advise. All delegated medical groups use licensed health care professionals to make UM decisions that require clinical judgement. Unlicensed UM staff may review certain referral requests using explicit UM criteria under the supervision of appropriately licensed health professionals when no clinical judgement is required. Only physicians may make adverse medical necessity decisions to modify or deny requests for services.

Decisions about requested referrals are based on the best available clinical evidence and accepted practice norms. Referrals are clinically appropriate in terms of type, frequency, location and duration based on individual care needs. Referrals for the convenience of the provider or individual are considered not medically necessary. There are no financial incentives to approve or deny referrals for any staff in the Utilization Management team, IPA and/or medical group physicians, or the Canopy Health Medical Director.

Written Documentation Requirements

All initial referrals to a specialist outside the enrollee's home medical group/IPA must be generated by a provider within the enrollee's medical group/IPA. If a specialist from outside

the enrollee's home medical group/IPA who was authorized to see that enrollee wants to offer services that require prior authorization or wants to send the enrollee to another specialist outside the enrollee's home medical group/IPA, that specialist must seek authorization through that enrollee's medical group/IPA Utilization Management department through usual processes. Referrals may be initiated by telephone, secure electronic means or fax.

The referral decision letter must include the following information:

- referring provider's identification
- requested provider's identification
- reason for referral
- scope of services requested e.g. new patient consultations, follow-up visits, specified diagnostic testing and treatments
- name and credentials of the reviewer
- date that the referral decision was rendered
- authorization expiration date

Other information that must be documented in the referral file but not necessarily in the referral decision letter include:

- date the referral was submitted
- date and time that electronic or written notification of the decision was provided to the requesting/treating practitioner, if applicable

Referral requests, decisions, notifications and all pertinent related actions are documented in the applicable Utilization Management and/or electronic record file. All Commercial UM decision-making applies DMHC timeliness standards. See Canopy Health "Consistency and Timelines for Utilization Management Decisions Policy" (UM-005). All Medicare Advantage UM decision-making applies Centers for Medicare and Medicaid Services (CMS) Medicare timeliness standards. See Canopy Health Policy "Medicare Consistency and Timeliness for UM Decisions" (UM-012).

Pursuant to Senate Bill 282 and Assembly Bill 374, the DMHC and the Department of Insurance developed a mandatory prescription drug prior authorization or step therapy exception request form. This form must be used or elements from this form may be submitted electronically by providers when requesting a prescription drug prior authorization or step therapy exception.

The Utilization Management departments of Canopy Health's medical groups/IPAs communicate their decisions to approve requests by practitioners and enrollees within

timeframes specified in Canopy Health policy UM-005 (Commercial) and UM-012 (Medicare). Approved referral notifications specify the health care services approved: their types, quantity, location, provider, and timeframe.

Communication Services

Canopy Health requires that delegated medical groups/IPAs document their communication services and the materials used to inform enrollees and practitioners about referral decisions. Communication services include all the following:

- The ability to receive inbound or toll-free calls regarding UM issues 8 hours/day during normal business hours
- The ability to receive inbound communication regarding UM issues after normal business hours
- Staff initiating or returning calls regarding UM identify themselves by name, title and organization name
- TDD/TTY services
- Language assistance for enrollees to discuss UM issues, free of charge
- The ability for a physician to request an authorization for care and service on an enrollee's behalf via telephone

Oversight of UM Decision Making by Delegates

Canopy Health Delegation Oversight Committee reviews and provides oversight of the delegated medical group's/IPA's decision making and referral management by reviewing monthly UM logs, annual and semi-annual ICE ©reports and by auditing of records. Deviance from the timeliness standards are tracked for trend and corrective actions required when indicated. See UM-005 and UM-012 for complete details.

Canopy Health captures service requests for its enrollees in a data warehouse, where authorizations, denials and referral patterns are monitored and tracked electronically. Examples of reports that may be used for Canopy Health's network oversight are the number and type of referrals between dyads, costs per specialty, high volume and high impact physician utilization.

Timeliness Standards

Canopy Health requires that the delegated medical groups/IPAs maintain DMHC Utilization Management turn-around times for enrollees for all decision making and enrollee and provider notifications. Commercial timeliness requirements and prescription drug approvals are detailed in UM-005. Medicare timeliness requirements are detailed in UM-012.

The Role of Clinical Information

UM records shall demonstrate that relevant clinical information and consultation with the treating practitioner were obtained prior to rendering authorization decisions based on medical necessity.

Denial Notices

Only a Medical Director or a pharmacist may render a decision to deny a service or medication based on medical necessity. If the reviewer determines that the same or similar professional service or medication are medically necessary but are not available within the Canopy Health provider network, the reviewer may approve a referral to a non-Canopy Health provider.

If the requested provider is not approved, the Utilization Management physician reviewer must issue a denial. The physician reviewer may not modify the referral request to change the requested provider and then approve the request without agreement by the referring provider: if the requesting provider agrees to change the requested provider to one who may be approved, and this happens before the Utilization Management physician reviewer issues the denial, this is acceptable practice. In that circumstance, the enrollee must receive a notice of modification letter that specifies the changes to the initial request, references the Canopy Health policy or Health Plan explanation of benefits that supports the modification, and includes information about the enrollee's appeal rights for the services that were modified.

Denial notifications to the enrollee and requesting provider will include clinical information that was documented in the authorization request form and pertinent notes from the medical record, along with reasons for the denial and alternate options to the services or medication that were denied, if applicable. Denials based on benefit limitations or exclusions must document the resources referenced that supported the denial decision, such as Health Plan policies.

Denial Letter Content

At least annually, Canopy Health audits their partner medical groups/IPAs to ensure that all denial notifications include:

- specific reasons for the denial, in easily understandable language
- reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based
- statement that enrollees can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request
- Language Assistance Program required information
- description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal
- explanation of the appeal process, including enrollees' rights to representation and appeal timeframes
- description of the expedited appeal process for urgent preservice or urgent concurrent denials and
- language specifying that expedited external review can occur concurrently with the internal appeals process for urgent care.

Denials are tracked for quality and UM program analysis.

Reconstructive and Cosmetic Surgery

Canopy Health through its delegated Medical Group/IPA Utilization Management departments implement policies for review, modification, delay or denial of reconstructive/cosmetic surgery services as follows: *reconstructive* surgery is covered to correct, or repair abnormal body structures caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, to improve function or to create normal appearance to the extent possible. In contrast, *cosmetic* surgery is not covered and is focused on enhancing appearance through surgical and medical techniques and does not alter or improve the body's function.

Revision History:

Version Date	Edited By	Reason for Change
1/29/16	M. Stevens	Creation date
9/29/16	M. Durbin	Clarifies language contained in Exhibit I-6, specifies Canopy Health's contracted medical groups/IPAs and hospitals, adds detail regarding how and when authorizations may be modified and patient notification, reformats the timeliness of decision requirements and appointment availability standards in tabular form for ease of reference and adds supplemental details regarding authorization for services (e.g., services that require "automatic authorization" per California regulation and as agreed upon by Canopy Health and its medical groups/IPAs, services that require prior authorization)
7/25/17	M. Durbin	Updated in response to the Health Net UM audit to add in latest ICE standards and add section relating to reconstructive/cosmetic survey and consent of minors under age 18 for medical care
12/22/17	A. Kmetz	Updated to reflect additional Canopy Health parent plans
1/12/18	A. Kmetz	Updated to address population health, CCM evaluation items IRR and clinical content per WHA pre-delegation requirements
1/13/18	M. Durbin	Updated High Volume and High Impact Specialists Monitoring section and reviewed Andrea's edits per WHA pre-delegation requirements
1/17/18	A. Kmetz	Updated to include new PBM vendor add a row
02/062018	A. Kmetz	Revised to meet NCQA standards 2-7, removed appointment access stands and moved that content to UM-009. Removed the content of UM-009 because the content of this policy (UM-008) was duplicated in UM-009. Removed high volume and high impact physician monitoring and placed that topic in network adequacy.
2/15/18	M. Durbin	Corrected some wording, edited the list of services that all our parent HPs authorize.
3/28/2018	M Durbin	Added wording to specify 1) specialty care outside a member's home IPA requires auth 2) specialists outside a member's home IPA must seek auth from the home IPA Utilization Management dept for services requiring auth 3) Utilization Management depts may not redirect members back into the home IPA or deny medically necessary services in Canopy Health network outside a member's home IPA. Removed reference to parent health plan and potentially broader networks.

7/30/18	A Kmetz	Added DMHC to timeliness paragraph per WHA CAP. Added physicians may request care and service via telephone call per WHA CAP. Also included DMHC required wording for disclosure of UM decision-making criteria.
8/14/2018	M Durbin	Added section specifying scope of this policy: services delegated by parent health plans for authorization.
8/30/2018	M. Durbin	Clarifying ability to send prior auth or step therapy exception request via form or electronically, and indicated “physician reviewers” as conducting utilization review, (not necessarily always the UM medical director)
1/1/2020	R. Scott	Inclusion of Medicare Advantage requirements.
6/30/2020	M. Durbin	Added language to clarify cosmetic surgery and to specify which prior authorization requirements apply to which types of products.
1/1/2022	R. Scott	Deleted references to delegated PBM since the contract was terminated as of 1/1/21 and updated the DMHC link to form 61-211. Changed references from members to enrollees to better reflect upstream health plan responsibility for member administration.
01/01/23	L. Sasaki	Updated to reflect current oversight processes. Included references to Medicare Advantage timeliness requirements and associated policies. Reordered the list of topics (page 2) to match the order discussed in the policy.