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Owner	Ashley Miffitt: DIRECTOR MEDICAL MGMT : HOAG CLINIC UTILIZATION MG
Area (Category)	MSO
Applicability	Hoag Clinic

UM Determination (Authorizations) UM 5A

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PURPOSE:

To provide a detailed description of the process for requesting Utilization Management (UM) authorizations from Hoag Clinic, if delegated to perform these functions. Policy includes all Medical, Behavioral Health, and Pharmacy (including Part B) authorizations if delegated to the organization.

SCOPE:

Hoag Clinic MSO

AUTHORIZED PERSONNEL:

MSO Utilization Management Staff Members

1. Definition of Terms:

A. **Authorization/Referral Management:** Is the method by which requested health services are reviewed for medical necessity, appropriateness to standards of care, cost effectiveness, experimental and investigational, plan coverage or exclusions. Appropriately licensed health care professionals supervise all reviewer decisions and processes, and qualified health professionals assess relevant clinical information used to support utilization management decisions on all services including behavioral health.

B. **Concurrent Review Determinations**: A Concurrent Review Determination is any review for an ongoing course of treatment. Concurrent reviews are typically associated with inpatient care.

C. **Non-Urgent Services**: Non-urgent Services is any request for medical care or treatment which is routine and would not jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment.

D. **Post-service Determinations**: A post-service determination is any request for care or services that have already been rendered or received. A request for coverage of care that was provided by an out of network practitioner and for which the required prior authorization was not obtained will fall under the post-service determination category.

E. **Pre-service Determinations**: A pre-service determination is any case or service that Hoag Clinic must approve, in whole or in part, prior to the member obtaining medical care or services. Prior authorization, pre-authorization and precertification are pre-service determinations.

F. **Urgent Services**: Urgent care is any request for medical care or treatment with respect to which the application of time periods for making non-urgent care determinations could result in the following circumstances:

    I. Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or

    II. In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

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2. Authorization/Referral Generation:

A. Hoag Clinic conducts preservice, concurrent, and/or retrospective reviews when delegated. Hoag Clinic will accept request for initial organization determinations received from the member, member's representative (with valid Appointment of Representative or AOR) or from the Health Plan (requesting in behalf of the member) per each of the health plan's delegation agreement. Turn-around time for member initiated standard and expedited organization determinations will start from the time when the member contacts Hoag Clinic or the Health Plan whichever is applicable. Hoag Clinic will follow the standard and expedited timeframes listed on this policy for any member-initiated organization determination.

B. Hoag Clinic will process and start the request submitted by a member's representative, only if a valid AOR and/or power attorney is faxed and validated by the UM Clinical Support Team. Once the valid AOR is verified, the UM Clinical Support team will setup up the auth and use the received date and time when the valid AOR was sent.
If the member representative passes the phone to the member to verbally provide consent, the UM Clinical Support team will authenticate the caller by asking for 2 of the following: 1. Member's Full Name, 2. Member's Date of Birth, 3. Member's Social Security Number, and 4. Member's address including zip code. The UM clinical support team will accept the verbal authorization once the call has been authenticated and will start the request in the medical management system. The UM Clinical Support will document the validation process in the system and inform the member representative that the verbal consent will need to be followed by a written valid AOR form.

C. Request can be made by calling the UM department at 949-791-3490 (Direct) or 800-348-6575

(Toll Free), through fax at 949-791-3489 for Inpatient Admission Notification, 949-791-3491 for Routine/Standard requests, or at 949-791-3492 for Urgent/Expedited requests or online through the automated referral management system.

D. Hoag Clinic will allow providers to submit prior authorization requests 6 months in advance. Requests that will be submitted more than 6 months in advance of the service will be evaluated on a case to case basis. Individual consideration based on clinical presentation, provider treatment plan and other factors will be assessed during the evaluation process.

    I. Hoag Medical Group (HMG) Referrals Operations (For Hoag Medical Group Referrals only):

        a. Prior to Hoag Clinic MSO review, HMG referrals are reviewed and completed by the Hoag Medical Group Referrals team. HMG referral requests are reviewed by the HMG Referral team to ensure completeness and accuracy, including but not limited to inclusion of appropriate CPT codes. Complete and accurate referral requests are then sent to Hoag Clinic UM for review and determination.

E. When a request is approved by the UM Team, the authorization will expire one year from the decision date. The system will automatically generate the authorization validity on the member and/or provider notices.

F. Hoag Clinic will allow the requester of the authorization to rescind/withdraw the request in writing or verbally at any time before the decision is issued. A written notification may be sent out per the requester request. The UM Team will document in the referral management system the interaction with the requester for the request to withdraw the service.

G. Eligibility and Request Information Verification:

    I. Once the request is received, the UM Staff will conduct eligibility verification by looking at the internal eligibility information received from the plan and looking at the health plan's website to confirm if the member has a valid coverage. Steps on eligibility verification will be documented in the automated referral management for tracking. They will also need to determine third party liability/other insurance or potential subrogation information and will coordinate accordingly with the Hoag Clinic Eligibility Team.

    II. If not eligible, the requesting provider is notified verbally and/or in writing on the status of member's eligibility. Member and provider will be notified verbally and/or in writing, with the reason for ineligibility.

    III. Once eligibility is confirmed with the internal eligibility system and/or the health plan's website, the UM support staff will verify if all information submitted for review is sufficient to make a sound determination. Hoag will verify the following information:

        a. Member Name

        b. Member's Health Plan

        c. Other Insurance (if applicable)

        d. Member ID #

        e. Requesting Provider

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f. Name of the provider/vendor being requested and if the provider is part of the Hoag or the plan's network. If provider has terminated the support staff will validate if patient was authorized for continuity of care

g. Services, which are requested as a result of an accident (are specified as such and the location of the accident is noted: work, home, auto, other). Case is labeled as such.

h. Diagnoses (ICD-10 Code), if available

i. Clinical History/Findings, which justify the request

j. Prior treatment, other consults

k. Medications as applicable

l. Requested care, procedure/test accurate CPT codes (if available)

m. Location or facility where services are to be performed

n. Description of service (inpatient, outpatient, office)

o. Estimated length of stay (for inpatient requests)

IV. If information is incomplete, the staff will request the necessary information or data from the requesting provider/vendor via on-line, fax, or by phone. Hoag Clinic will accept clinical information from any reasonably reliable source that will assist in the authorization process including but not limited to: 1. Referring Provider/Specialist, 2. Facilities, 3. Ancillary Providers, 4. Member or member's representative highly involved on the patient's care. Hoag Clinic will not routinely require hospitals, physicians, and other providers to numerically code diagnoses or procedures to be considered for certification but may request such codes if available.

V. The UM support staff verifies the requesting and rendering providers to ensure it is a network provider.

a. If the request is from and to an in-network provider, no further action is needed, and the request may be reviewed.

b. If not, the UM Support staff will contact the requesting provider for clarification regarding reasons for choosing a non-network provider.

c. If the request should be processed through a carve out vendor, Hoag Clinic will follow the health plan specific instructions on handling carve out vendors.

i. For any request that is not covered by original Medicare but covered as a supplemental benefit (e.g., under a SCAN benefit plan, eye exams and hearing test services) or not covered by Medicare but may be covered by Medi-Cal (e.g., incontinence supplies, safety DME, home health services supplies, hearing aids, etc.) the Informational (Carve-Out) Letter is issued and used to guide the member to the Health Plan. A copy of the request and records are forwarded to the Health Plan.

ii. If the member calls on a request for a carve out vendor, Hoag Clinic will call the member service line (found at the back of their insurance card) and warm transfer the member to a

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representative of the Health Plan. Hoag Clinic will explain what is requested and transfer the member's call to the representative. If the request comes from a provider, the provider will be redirected to the Health Plan provider service line.

VI. If the information is complete, the UM support staff will assign this to the UM nurse for review. If requested services falls into the admin approval process (automatic authorizations) the UM support can approve the request per the admin approval process rules. All out of network (OON) requests are subject to Medical Director Review and Approval. The UM support staff cannot deny any requests especially those that would require clinical interpretations and clinical verifications.

VII. Hoag clinic will also evaluate the circumstance of the request. Requests cannot be denied for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the claimant. Special consideration will be given on these types of requests per plan procedure.

3. Clinical Information Verification:

A. Once the request is received the nurse will review the submitted documentation for relevant and appropriate clinical information:

I. If the request is incomplete, the nurse will notify the provider or the member. The outreach will be documented in the Automated Referral Management System.

II. If additional information is needed, the nurse will notify the member and/or provider that the information is insufficient and to request additional clinical information. This outreach is documented in the authorization request in the Automated Referral Management System.

III. If the request is complete, the nurse will proceed with authorization request and review all clinical information

IV. If the request meets medical necessity criteria, the nurse will document the criteria and rationale used to approve the authorization request and notify the provider and/or the member verbally or in writing, or via patient portal.

V. If request does not meet medical necessity criteria and nurse is unable to authorize, the request will be forwarded to the Medical Director/Physician Reviewer for determination.

B. Hoag Clinic may share clinical information with other departments that have a need to know to avoid duplicate requests while maintaining the patient and provider confidentiality in accordance with HIPAA and state regulations.

4. Lack of Clinical Information (LOI) Process:

A. When additional information is required, the UM Clinical support staff will attempt to reach out to the provider and/or member using the following process:

I. Hoag Clinic only requests information reasonably necessary to make a

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determination.

II. Initial Outreach
    a. Initial request must be a telephone call to the requesting provider.
    b. Notify provider what information is missing; be specific about what is needed to approve coverage
    c. Document how outreach was conducted and what was requested
    d. Document the date and time of all outreach attempts and whether outreach was successful (all missing information requested is obtained).
    e. Second or third request may be by phone, fax, or via the automated Referral Management System.
    f. If unsuccessful in outreach attempts, UM Clinical Support Staff will contact UM Leadership.
    g. For Medicare Advantage plans:
        i. In the event of an expedited organizational determination or reconsideration, requests for necessary information from both contracted and non-contracted providers will be made within 24 hours of receipt of request.

III. Hoag Clinic will make at Least Two Additional Attempts:
    a. Will use methods of outreach different from the initial outreach
    b. When feasible, make outreach attempts only during business hours. If not within business hours, follow the after hours instructions, if any, on the providers voice mail or answering service.
    c. Hoag Clinic will leave at least a few hours between attempts for the provider to respond.
    d. Hoag Clinic will be specific on request for information. Hoag Clinic will notify provider what information, if any, is missing.
    e. UM staff will clearly document all outreach attempts; note method, date and time in the automated Referral Management System.
    f. UM staff will leave some time after their final attempt prior to issuing a decision.
    g. If no additional clinical received, the request will be sent to Medical Director/Physician Reviewer for determination.

IV. Hoag Clinic will ensure the following standards are met based on DMHC rules for Commercial Members on Standard Requests:
    a. Hoag Clinic will provide written notification to the practitioner and member within 5 working days from receipt of requests of the need for specific information necessary to make the decision.
    b. Hoag clinic will allow up to 45 calendar days for submission of requested information if the member request for an extension.
    c. When the additional information is received (complete or incomplete),

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Hoag clinic will make a decision within 5 business days of receipt of information.

d. If the additional information requested is not received within the 45 calendar days, Hoag Clinic will make a decision with the information available within an additional 5 business days.

e. When expert reviewer is required the following decision TAT must be adhered to:

i. Within 5 business days of obtaining expert review not to exceed 15 calendar days from the date of the delay notice sent to the practitioner and member

V. Hoag Clinic will ensure the following standards are met based on DMHC rules for Commercial Members on Expedited/Urgent Requests:

a. Hoag Clinic will provide written notification to the practitioner and member within 24 hours from receipt of requests of the need for specific information necessary to make the decision.

b. Hoag clinic will allow up to 48 hours for submission of requested information if the member request for an extension.

c. When the additional information is received (complete or incomplete), Hoag Clinic will make a decision within 48 hours from the receipt of information.

d. If the additional information requested is not received within the 48 hours, Hoag Clinic will make a decision with the information available within an additional 48 hours.

VI. Hoag Clinic will ensure the following standards are met based on DMHC rules for Commercial Members on Post-Service/Retroactive Requests:

a. Hoag Clinic will provide written notification to the practitioner and member within 30 calendar days from receipt of requests of the need for specific information necessary to make the decision.

b. Hoag clinic will allow up to 45 calendar days for submission of requested information if the member request for an extension.

c. When the additional information is received (complete or incomplete), Hoag Clinic will make a decision within 15 calendar days of receipt of information.

d. If the additional information requested is not received within the 45 calendar days, Hoag Clinic will make a decision with the information available within an additional 15 calendar days.

5. UM Review and Guideline Interpretation:

A. The UM nurse will review the submitted documentation for relevant and appropriate clinical information and consult with any treating practitioners as appropriate. The nurse will utilize nationally accepted clinical criteria sets to determine order of guidelines and criteria when reviewing. This will include all Behavioral Health requests for referrals as applicable and

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delegated, by contract to the organization.

B. When applying criteria/guidelines the reviewer should also evaluate the medical necessity of the request based on the following, as applicable:
    I. age
    II. illness and/or co-morbidity
    III. complications
    IV. home environment, as applicable
    V. progress to treatment or failure of prior treatment (Therapies, Medication, Surgeries, etc)
    VI. psycho-social situation
    VII. UM decisions consider the following characteristics of the local delivery system:
    VIII. Availability of services within the service area including SNF, sub-acute or home care.
    IX. Coverage of benefits such as SNF, sub-acute or home care
    X. Ability of local hospitals to provide recommended services within the length of stay.

C. Hoag Clinic conducts reviews according to the severity or complexity of the member's medical condition and discharge planning needs. Hoag Clinic does not reverse a determination unless it receives new information that is relevant to the authorization and that was not available at the time of the original authorization or it is a clerical error, for example the information provided was incorrect, falsified, or fraudulent.

D. If the referral request meets the appropriate criteria, an approval determination is made. If the referral is complex, could result in a denial, or predetermined that specific cases will require physician review; the referral is submitted to the Medical Director or physician designee for second level review and determination.

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6. The Medical Director/Physician Reviewer Reviews the Request and Makes a Determination:

A. If additional information is required, the Medical Director/Physician Reviewer will contact the provider to obtain additional information.

B. If denied, the request is forwarded to the UM Clinical support staff to generate a denial letter. The Physician Reviewer/Medical Director will provide specific denial language to be used for the Member and Provider letters indicating the specific denial reason. In addition, the Clinical Reviewers (RN/Physician Reviewer) will include rationale and criteria utilized for the determination. The provider and member are notified of the denial in writing.

C. The nurse and/or the medical director will document all activities of the review process in the referral management system this include but not limited to contact attempts to obtain additional information, verification of the request, peer to peer conversations (for MD), criteria used for the review and the determination and rationale for the determination, criteria used in making a determination and all other pertinent information.

D. Refer to policy "Second Opinion Requests" for information on Second Opinion requests.

E. Hoag Clinic will always observe and promote Medical and Behavioral Health Parity. Each staff member should ensure that the level of coordination between Medical and Behavioral Health

are in sync with Federal, State, Health Plan and Accreditation Standards. Services may include but not limited to Autism Services, Speech Therapy Services, Mental Health and Substance Abuse services, Gender Identity Services, Developmental delays rules etc. UM will coordinate with the appropriate BH providers on mental health issues and work with the Care Management team's social workers for any potential mental health cases.

I. All staff is required to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex (TGI).

II. The evidence-based cultural competency training implemented will include:

a. nformation about the effects, including, but not limited to, ongoing personal effects, of historical and contemporary exclusion and oppression of TGI communities.

b. Information about communicating more effectively across gender identities, including TGI-inclusive terminology, using people's correct names and pronouns, even when they are not reflected in records or legal documents; avoiding language, whether verbal or nonverbal, that demeans, ridicules, or condemns TGI individuals; and avoiding making assumptions about gender identity by using gender-neutral language and avoiding language that presumes all individuals are heterosexual, cisgender or gender conforming, or nonintersex.

c. Discussion on health inequities within the TGI community, including family and community acceptance.

d. Perspectives of diverse, local constituency groups and TGI-serving organizations, including, but not limited to, the California Transgender Advisory Council.

e. Recognition of the difference between personal values and professional responsibilities with regard to serving TGI people

f. Facilitation by TGI-serving organizations.

i. Use of any training curricula shall be subject to approval by the department, following stakeholder engagement with local constituency groups and TGI-serving organizations, including, but not limited to, the California Transgender Advisory Council.

g. After first-time completion of the evidence-based cultural competency training, in the form of initial basic training, staff shall complete a refresher course if a complaint has been filed with the health care service plan or the department pursuant to Section 1368, and a decision has been made in favor of the complainant, against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary by the health care service plan or the department for purposes of providing trans-inclusive health care.

F. Transplant, Experimental/Investigational, Clinical Trial Reviews

I. The UM Team will be handling transplant request per plan procedure. Hoag Clinic will notify the Health Plan within 1 business day of all transplant cases and/or

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potentially transplant cases and all related investigational/experimental and/or clinical services per plan direction. If the plan wishes for Hoag Clinic to notify that the provider should reach back to Medicare for approved clinical trial services, Hoag Clinic will follow as instructed.

II. Hoag Clinic will conduct due diligence to determine if the requested treatment is an FDA Approved Transplant Service and this is not a trial by looking at the www.fda.gov and www.clinicaltrials.gov websites.

III. The Hoag Clinic staff will also assess if the Transplant Network is in place based on each health plan's contract or determine if there is a need to do a special pricing agreement.

IV. The Hoag Clinic staff will determine if the facility is a Medicare Certified Facility/ Center of Excellence for this transplant based on the health plan or CMS's COE list.

7. Medicare Advantage Prior Authorizations

A. Hoag Clinic will not deny items or services for lack of medical necessity if they were previously approved through prior authorization or a pre-service determination. Hoag Clinic will not reopen the case for any reason except for good cause or if there is reliable evidence of fraud or similar theft.

B. Hoag Clinic will approve a course of treatment as long as medically necessary to avoid disruptions in care.

C. Hoag Clinic will only use prior authorizations to

I. Confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service,

II. For basis benefits, to ensure an item or service is medically necessary

III. For supplemental benefits, to ensure that the furnishing of a service or benefit is clinically appropriate.

D. Approval of a prior authorization request for a course of treatment must be valid as long as medically necessary to avoid disruptions in care in accordance with:

I. Applicable coverage criteria

II. Member's medical history

III. Treating provider's recommendation

8. Concurrent Review

A. In the case of concurrent review, care shall not be discontinued until the member’s treating provider has been notified of the plan’s decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

B. Continued stay review determinations regarding care that is underway must be communicated to the attending physician within twenty four (24) hours of the determination.

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9. UM Review Decision and Notification timeframes:

A. See Timeliness of UM Review Determinations - UM 5.

10. Timeliness of Reopening Requests:

A. For re-openings requested by a party that the plan agrees to reopen, the reopening action will be completed within 60 days from the date of receipt of the party's reopening request.

11. Member and Provider Notification Letter Formatting:

A. Hoag Clinic UM Member and Provider notifications will contain the following:

1. Correct written notice Logo's: Displays delegates logo, when applicable (The delegate's legal name or Doing Business As (DBA) under which it is incorporated in the state)
2. Health Plan Name, if applicable to written notice template
3. Delegate uses correct health plan-driven letter templates or their own Commercial Letter templates incorporating required elements.
    a. Delegates are not required to use UHC Commercial letter templates but need to ensure required elements are contained in their Commercial Letters.
4. Letter content in understandable plain language.
5. Initial requested service(s) addressed in Letter content- Example: Approval Notice states approved Service that was requested. The Initial Service Request should match the Approval Written Notice. (Note: If not a match, then would not be considered an Approval)
6. State requirements for written notices (e.g., 12-point font, bolded wording, meet regulatory grade-level or reading-ease requirements.) Letter Examples:Approval, denial, extensions, downgrade State-mandated letter format and requirements.

12. Member and Provider Notification:

A. Once a determination is made the UM Nurse and/or the UM Support staff will notify the member, provider or member's representative in writing (via portal or mail) and/or orally. Speaking with the Member or Representative directly is considered valid oral notification.

B. For routine (standard) Medicare and Commercial Requests:

I. For urgent/expedited requests, if written notification will not adhere to turn round timeliness, the Hoag Clinic may attempt an oral (verbal) notification at least once. If successful, Hoag Clinic will provide written notification within three (3) calendar days of oral notification.

C. If not successful Hoag Clinic will send written notice within an applicable time frame in accordance with turn around time standards.

D. On expedited adverse determinations, Hoag Clinic's UM Staff will attempt to contact the

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member to provide an oral notification of the decision. If the Hoag Clinic's UM Staff was able to provide the determination notification to the member, a letter will be sent within 3 calendar days from the oral notification date. If the Hoag Clinic's UM staff was unable to provide the oral notification to the member, a letter will be generated and sent to the member within 72 hours from the request received date.

E. Provider notifications are automatically sent to the provider portal upon UM determination. These notifications are verified within the EMR system from timestamps showing the date and time the notification was sent and the method utilized. If notifications fail to send upon initial notification method, a physical letter will be automatically generated to send via mail according to the mailroom policy. The provider portal is monitored and maintained by Hoag IT.

F. Hoag Clinic includes appropriate Non-Discrimination Notice and Language Assistance Program verbiage in provider and member communications in accordance with ACA section 1557 and health plan requirements.

13. Out of Network Requests:

A. Consultation and/or treatment requests for out of network (OON) providers may be initiated by the primary care physician, specialists, or member(s). This request may be initiated for the following reasons (as applicable):

I. The service cannot be provided in-network

II. Member's request

III. In network consulting specialists recommend different treatment plans

IV. The opinion of the PCP differs substantially from the recommended treatment plan of the specialist consulting on the case.

V. The request of the Hoag Clinic

VI. Cultural consideration for members

VII. Provider Gender Preferences

VIII. Continuity of Care (See Continuity or Middle of Care Due to Termination of Provider or New Enrollee P&P)

IX. Urgent/Emergent Services

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14. Hoag Clinic will obtain documentation indicating why the service cannot be provided in network:

A. If the service can be provided in network, a referral will be provided. If the physician was not aware that the service can be provided in network, the physician has the option to redirect to an in-network provider. If the requesting physician agrees that services can be provided by an in-network provider, then the clinician will document this in the referral and modify the original request. However, if the physician determines that an out of network provider is in-fact needed then the request will be sent to the medical director for a determination. If the member requested an out of network provider and is denied, the letter to the member will notify the member of in network referral to an appropriate specialist and their right to contact the health plan for a referral for an out of network provider.

B. Hoag Clinic screens out of network providers against appropriate resources prior to approving all out of network services. Once approved, Hoag Clinic will arrange for an individual Letter of

Agreement (LOA) with the specialist. The cost to the member is no greater than it would be if the service was provided in-network

C. If an out of network specialist requests a procedure to be performed, Hoag Clinic will determine whether the procedure could be performed in network. If it cannot be done in network, the procedure will be authorized if deemed medically indicated.

D. Hoag Clinic will follow the DMHC's geo access consideration in reviewing for OON requests. Hoag Clinic will evaluate if the hospital and PCP is within 15 miles or 30 minutes from the patient's work/home and if the specialists is within 30 miles or 60 minutes of work/home. If the services are outside of the geo access standards of DMCH, Hoag Clinic will approve the request as a gap exception request for Commercial Plans and process the OON request as if the provider is an INN provider.

15. Hoag Clinic UM will screen out of network providers utilizing the following:

A. Commercial:
    I. Exclusion Lists (OIG and SAM)

B. Medicare
    I. Exclusion Lists (OIG and SAM)
    II. Preclusion List
    III. Medicare Opt-Out

C. Pended Review Notifications:
    I. Notifications are sent to members for all of the following reasons for extending decision timeliness:
        a. Information was requested but not received
        b. Consultation by an expert reviewer is required
        c. Additional examinations or tests are required.
        d. Time frame for submitting the information
        e. Expected date of decision
        f. Type of expert reviewer required, if applicable
    II. Benefit or contractual clarifications are not reasons to pend a request.
    III. If Hoag cannot make a determination for non-urgent prospective or continued stay reviews within the required time frames due to not receiving all of the requested necessary information, Hoag must immediately notify the health care provider and the covered person in writing.
        a. Hoag must send such notification upon the expiration of the required five (5) business day time frame or as soon as delegate become aware that they will not be able to meet the required five (5) business day time frame, whichever occurs first.
        b. The notification must specify the information requested, but not received, and the anticipated date on which a prospective or continued stay review

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determination may be rendered. Upon receipt of all necessary information, Hoag must render a prospective or continued stay review determination within the required five (5) business day time frames.

16. Dismissal Process

A. Reasons for dismissal of a request may include:
    I. The individual or entity making the request is not permitted to request an initial determination under the applicable regulation.
    II. Hoag Clinic determines that the individual or entity making the request failed to make a valid request for an initial determination that substantially complies with 42 CFR §§ 422.568(a) or 423.568(a).
    III. The enrollee dies while the request is pending and the enrollees spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the initial determination. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.
    IV. The individual or entity who requested the review submits a timely verbal or written request for withdrawal of their request for an initial determination with the organization.

B. Hoag Clinic may vacate its own dismissal if good cause is established within 6 months of the date of the notice of the dismissal. If a party submits a request to vacate a dismissal of an initial determination request and the request contains sufficient evidence or other documentation that supports a finding of good cause for vacating, Hoag Clinic makes a favorable good cause determination. Once Hoag Clinic makes a favorable good cause determination, it vacates its prior dismissal action and performs an initial determination consistent with the timeframes at § 40.10. Where a finding for good cause is made, Hoag Clinic documents the reason for that finding in the case file.

C. If Hoag Clinic does not find good cause to vacate the dismissal, the dismissal remains in effect. Hoag Clinic issues a letter (not a dismissal notice) explaining that good cause has not been established and the dismissal cannot be vacated. Hoag Clinic will explain in clear language why the information submitted with the request to vacate the dismissal does not establish good cause to vacate the dismissal action.

17. Authorization Data Integrity:

A. Hoag Clinic will always ensure data integrity of each authorizations. Once the authorization is finalized and member and/or provider notification were sent. Hoag Clinic will not allow any request for re-opening on all request type unless for the following reasons: 1. Mathematical or computational Mistakes, 2. Inaccurate Data Entry/Clerical Errors or 3. Denial of Organization Determination/Claims as duplicates.

B. For legal and on a special circumstance, only the UM Manager or Director of Medical Management can edit the authorization after a decision is rendered. Each roles will document in the medical management system the rationale why the request is edited and/or explain the legal basis of such action.

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C. Pursuant to CA Health and Safety Code section 1371.8, Hoag Clinic will not rescind or modify any authorizations after the provider renders the health care service in good faith and pursuant to the authorization for any reason for Commercial Members only. However, Hoag Clinic or the plan may reserve the right to rescind or modify the request due to eligibility prior to the provider rendering any services.

18. Emergency Services:

A. The Hoag Clinic will not require prior referral of emergency services necessary to screen and stabilize a member. This applies to cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. The group will approve emergency services if an authorized representative acting for the Hoag Clinic has authorized the provision of emergency services or medical necessity has been determined. Requests cannot be denied for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the claimant (e.g., the member is unconscious and in need of immediate care at the time medical treatment is required).

B. A post claim review might be conducted on Emergency Services that do not meet Emergency Care provisions set by the Federal, State, Health Plan or Accreditation standards. Um Nurse will review the diagnosis and determine any alternative care settings for non-emergency visits per plan policy and recommendations.

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19. Request Receipt preceding a holiday:

A. If Hoag Clinic receives a request on a day preceding a holiday, Hoag Clinic will process the request and notify the member and the provider on the following business day. If the following business leads to the request exceeding the processing time frame, Hoag Clinic will process and notify the member and the provider on the business day preceding the holiday. Overnight mail will be sent out on the same day if oral notification was not given to the member and provider.

20. UM Determination Mailing Procedure:

A. Written notifications of determinations will be mailed to members in accordance with the same time-frames described in Timeliness of UM Review Determinations - UM 5. Notification letters are sent via secure methods of file transfer (SFTP) by 4:30PM PST Monday through Thursday, and by 5:00PM PST Friday to the contracted Mailing House Vendor.

B. Monday-Thursday

   I. Letters that are sent by 11:00AM PST Monday through Thursday will be printed and mailed that same day at 7:00PM PST. Letters that are sent after 11:00AM PST Monday through Thursday will be printed and mailed the next business day at 7:00PM PST.

C. Friday

   I. Letters that are sent by 5:00PM PST Friday are mailed that same day at 7:00PM PST. Letters that are sent Friday after 5:00PM PST will be printed and mailed the following business day at 7:00PM PST.

D. Weekends and Holidays

I. Printed written notifications are not sent to members on weekends, and the holidays below:

a.

Holiday	Occurrence
New Year's Day	January 1st
Martin Luther King, Jr. Birthday	Third Monday in January
Presidents' Day	Third Monday in February
Memorial Day	Last Monday in May
Juneteenth National Independence Day	June 19th
Independence Day	July 4th
Labor Day	First Monday in September
Columbus Day	Second Monday in October
Veterans Day	November 11th
Thanksgiving Day	Fourth Thursday in November
Christmas Day	December 25th

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II. Any letters that are sent to the contracted Mailing House Vendor during weekends, and the above holidays will be printed and mailed the following business day at 7:00PM PST.

E. For reporting purposes and monitoring of timeliness the notification date is defined as the date the notifications are mailed in accordance with the appropriate time-frames.

I. In no case should written communication be sent to the alternate address, as shipping to the alternate address may constitute a privacy violation.

F. Notifications are sent via envelopes with the "Important Plan Information" designation printed on them. Letters will be printed using Arial font and size twelve (12).

G. Random and quarterly audits take place to ensure the accuracy of the notification letters as well as adherence to timeliness requirements.

H. If written notification is expected to be sent after turn around time, verbal notification process is followed.

I. Written notification may be generated and printed by Hoag Utilization Management and delivered manually to USPS as necessary.

I. When overnight mail is required, Utilize Priority Mail Express through United States Postal Service (USPS). USPS Priority Mail allows for overnight delivery to residential addresses or PO boxes.

21. Returned Mail:

A. The automated Referral Management System is checked to determine if the address in the system matches the address on the returned notification letter. When letters are returned from members or providers the following steps are taken:
    I. If the address matches the data in the system, a request is sent to the Eligibility team for research.
    II. If the address does not match and has a yellow USPS change of address sticker, a task is sent to the Eligibility team with the new information to be changed in the system and the letter is sent to the new address.
    III. If no new address appears in the health plan's portal, the member's primary care practice is tasked to reach out to the member to request the correct information. Practice staff will notify the member and assist them with contacting their respective health plan's member services department in order to update their address

B. Electronic Notification
    I. Electronic notifications may be sent to members in accordance with the appropriate time-frames following a determination. Electronic notifications are sent via Hoag Connect MyChart and require the member opt in to create an account and receive electronic notifications.
        a. Members receive notification that a new document is available in the portal when posted via email and/or application notices.
        b. If a member does not choose to create a Hoag Connect MyChart account, they will receive physical mail notifications in accordance with the appropriate time-frames.
        c. If for any reason Hoag is unable to send electronic notifications via Hoag Connect MyChart, Hoag will default to physical mail notifications in accordance with the appropriate time-frames.

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22. D-SNP

A. If Hoag Clinic were to be delegated for DSNP, the following would be used to meet compliance for the CMS 1/1/2020 Final Rule Requirements for DNSP Reasonable Assistance:
    1. Hoag Clinic will be prepared to transfer DSNP members to Health Plan Customer Service in order to provide:
        a. Reasonable assistance with filing grievances and requesting appeals
        b. Reasonable assistance with resolving coverage and authorization issues
        c. Assistance and information on Medicaid-covered service(s) when aware of a member’s need
        d. Coordinated delivery of Medicaid benefits for individuals who are eligible for such servicesIntegrates Medicare and Medicaid in one of three ways:
            i. Fully Integrated Dual Eligible Special Needs Plan (FIDE)

ii. Highly Integrated Dual Eligible Special Needs Plan (HIDE)
iii. DSNP that meets notification requirements for high risk members

2. Actions taken will be documented within the members electronic medical record (EMR)

Reference:

NCQA UM 5, 6 and 7, ICE UM Turn Around Time – Standards, CMS Managed Care Manual, ACA Standards

Review and/or input for this policy and procedure was given by the following:

UM/QM Committee Approval: February 02, 2026

Elevance Health-Medicare UM Committee Approval 08/07/2025

Title and version of IFU: n/a

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Attachments

ICE_UM_TAT_Commercial_Standards_070116.doc

Approval Signatures

Step Description	Approver	Date
VP Approval	Jim Boyle: VP HOAG CLINIC MSO : HOAG CLINIC ADMINISTRATION -	2/9/2026
Policy Management Approval	Anna Do: CORPORATE COMPLIANCE ASSOCIATE : CORPORATE COMPLIA	2/9/2026
Owner Approval	Ashley Miffitt: DIRECTOR MEDICAL MGMT : HOAG CLINIC UTILIZATION MG	2/6/2026

Applicability

Hoag Clinic