NETWORK MEDICAL MANAGEMENT
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Utilization Management information for our NMM Providers. 10/2021

To our contracted providers.

We would like to notify you of some updates to the UM Department.

The health plans require that we follow a hierarchy of criteria to make our clinical decisions. Here is the current updated Hierarchy of criteria used to make clinical decision by Line of Business.

❖ Order of Criteria: Medicare

- Plan Eligibility and Coverage (benefit plan package or EOC)
- CMS Criteria
- CMS National and Local Coverage Determination (NCD/LCD)
- Other CMS guidelines issued by CMS as required by CMS section
- 90.5 of Chapter 4 of the Medicare Managed Care Manual
- Medicare Claims Processing Manual (SCAN health plan requirement)
- CMS Drug Compendia (SCAN Health plan requirement
- Health Plan Medical Policies or Medication Policies
- Nationally Evidenced Based Criteria (MCG, InterQual, Up-To-Date, Hayes)
- Proprietary guidelines
- Administrative Policies

❖ Order of Criteria: Commercial

- Eligibility and benefits
- Federal and State Law Mandates (Code of Federal Regulations, Department of
- Managed HealthCare)
- Health Plan Medical Policy and/or Clinical Guidelines,
- National Evidence Based Guidelines (MCG, InterQual, Up-To-Date, Hayes)
- Society Guidelines (e.g. American Medical Association, American Congress of
- Obstetricians and Gynecologists, National Guidelines Clearinghouse,
- National Comprehensive Cancer Network etc.);
- Diagnostic and Statistical Manual of Mental Disorders (DSM), current edition.
- Administrative Policies

❖ Order of Criteria: Medi-Cal

- Eligibility and benefits
- Medi-Cal/Medicare Guidelines
- National Guideline Clearing House
- National Comprehensive Cancer Network
- National Evidence Based Guideline (MCG, InterQual, Up-To-Date, Hayes, Nelson textbook of Pediatrics based on health plan contracts)
- Health Plan Criteria
- Health Plan Evidence of Coverage
- Administrative Policies

❖ Order of Criteria: Cal-Medi Connect

- CMS National Coverage Determination (NCD),
- CMC Local Coverage Determination (LCD),
- CMS Benefit Interpretation Manual,
- Medi-Cal Guidelines,
- MCG- Current edition, Up to date, InterQual,
- Nelson Textbook of Pediatrics,
- National Guideline Clearinghouse, Hayes, NCCN,
- Health Plan Evidence of Coverage (EOC)
- Administrative Policies

Based on our recent audits we were required to update many of our UM Policy and Procedures. The list policies and procedures that were updated is located at the end of this document.
If your office would like a copy of the updated UM program and or of a policy and procedure, please email:
ProviderRelationsDept@networkmedicalmanagement.com

Turn Around Times.
To ensure that we meet our TAT's as set by the health plans, submit complete information with your referral request.

- **Urgent Requests:** 72 hrs from date and time received to date and time member notified.
  - A referral is considered urgent for the following: • Life or health is serious Jeopardized • Jeopardize the ability to regain maximum function
- **Routine requests**: 5 business days from date received to decision with notification to the Provider within 2 days of decision.
- **Retro requests**: 30 days from date received.

J Code requests:
Please use the pharmacy form available on the Portal and or website for your medication requests. If the J code is part of the radiological procedure you do not need to use the pharmacy form.

Provide the NCD with your request.

- Urgent J codes: 24 hrs from date and time received to date and time member notified.

Use only If member requires the medication within the next 5 days, otherwise please use routine.

- Routine J codes: 72 hrs from date and time received to date and time member notified.

If you have Provider Portal Access, you will be able to view the determination of the referral within 5 minutes of our decision.

Reminders for our Primary Care Providers

- **Initial Health Assessments and yearly visits:**

o Your office will receive a list of all new members. Ensure that your members are scheduled timely to complete the required "initial health assessments" and or yearly assessments. All attempts to contact your members should be documented in the chart.

o Please see your provider manual for more information as to requirements or your Provider Portal.

- **Specialists Referrals:** *Closing the loop*

o Those with Provider Portal Access, will have an open authorization report to view.

o This list consists of referrals that are expired and have no claim attached to the referral. The referrals will be on the list up to 90 days past the expiration date.

o At the end of those 90 days the referrals will be expired and a letter will be faxed and or posted notifying you to follow up with your member.

o For your members that have seen a specialist, ensure that notes from the specialists are in your member's chart. This is required for health plan audits.

- **Documentation required** in your member's medical records at each visit if your member is participating in one of the following programs:

o Regional Center
o California Children's Services (CCS)
o Genetic Handicapped Person Program (GHPP)
o Women's Infant and Children's program (WIC)
o Hospice and or Palliative Care
o Behavioral Health

The Provider Portal and or the NMM website have information for your office and for your members.

Information for our Specialists:

- **Sterilization Requests for our Medi-cal members:** **Effective 9/1/2021**

o Referrals will require a completed PM 330 and proof that member has received the DHCS Booklet

o If we do not receive the complete information, we will cancel the request and request you resubmit with the complete information.

- **Your initial consult and treatment plan** is to be sent to the primary care provider timely.

Yearly trainings required by the Health Plans, Local and Federal agencies.

Information regarding these trainings is available on our website or contact your provider relations representative for information.
Please email: ProviderRelationsDept@networkmedicalmanagement.com

- **REQUIRED: PROVIDER OFFICE ANNUAL TRAINING**
  - **Provider Manual**
  - **Cultural Competency**
  - **HIPPA Compliance / Confidentiality**
  - **How to handle Critical Incidents**
  - **Special Needs Plan / Model of Care Training (SNP MOC)**
  - **Fraud, Waste, and Abuse (FWA)**
  - **Timely Access to Care:**
- **Appointment Availability**
- **After – Hours Provider Access**
  - **Initial Health Assessment (IHA)**
  - **Standard of Conduct**
  - **California Children's Services Process (CCS)**
  - **Child Health and Disability Prevention Program (CHDPP)**
  - **Comprehensive Perinatal Service Program (CPSP)**
  - **Early Start, Early Intervention, Developmentally Disabled (ES/EI/DD)**
  - **Specialty Referral Tracking**
  - **Standing Referrals**
  - **PM330 / DHCS Education booklet requirements- STERILIZATION**
  - **Advance Directive**
  - **Language Assistance Program (LAP)**
  - **Screening, Brief Intervention and Referral to Treatment (SBIRT)**
  - **Hospice / Palliative Care**
  - **Behavioral Health Therapy (BHT)**

Here is the list of our **updated UM Program and Policy and Procedures** that were approved by our Utilization Management Committed 8-2021

If your office would like a copy of the updates UM program and or of a policy and procedure, please email:
ProviderRelationsDept@networkmedicalmanagement.com

UM Program 2021

UM 001 Referral auth process

UM006 Emergency Services Review
UM 008 OB GYN
UM 14 IRR -Physicians Review
UM 16 Concurrent Review- Acute/sub acute
UM 18 - Authorization Denial- appeals process
UM 21 - Over and Under Utilization
UM 25 - Transgender
UM 30 - Language Assistance Program
UM 40 - Initial Health Assessment
UM 41 - California childrens services
UM 44 - Sensitive Services
UM 45 - Services that are automatically approved.
UM 47 - Continuity of Care AB 1286
UM 060- Confidentiality HIPAA
UM 064 - Authorization Denial Determination Process -BH
UM 069- LEP Process
UM 037- Cancellation Process
UM 076 - NOMNC and CORF services.
UM 080- Communication Services
UM 083 Alcohol Misuse Screening and Counseling.
UM 108 - Hospice
UM 109 - Behavioral Health Treatment under 21
UM 117 - Continuity of Care New and Current Members
UM 120- Continuity of Care for Medi-cal
UM 121- Early Start
UM 126 - Referral tracking
UM 127- Alternative Birthing Centers
UM 128 Training Health services dept.

UM References:
#2 Asthma Nebulizer
#4 Economic profiling
#8 covered california eligibility
#10 Acupuncture Services

Physician References:

#1 CHDP
#2 EPSDT
#3 Informed consent
#4 PKU
#5 Medi-cal Carve our services
#6 Immunizations
#7 Maternity Benefits
#8 Children and Youth with special health care needs
9 Physician reference Diabetes Self Management
#10 SB1210 Cervical CA screening
#11 AB 1424 Confidentiality of Psychiatric admit
#12 Physician Practice Guidelines.
#13 Women, infant and children
#14 Vision Care
#15 Dental Services
#16 Spectrum Disorder
#17 Ready Access -Anthem Blue Cross
#18 Contraception guidelines
#19 Physician Office Referral Tracking system
#20 Calif. Children's Services
#21 CCS Inpatient
#22 COC transition
#23 COC transition after MER
#24 COC DPL 16002
#25 Nursing Facility APL 15-004
#26 - Wheelchair Coverage
#27 Calviva Transgender services
#28 Covered California transgender services
#29 Supervised exercise therapy
30 Comprehensive Tobacco Prevention.
#32 Transgender

CM P&Ps
CM 007 EPSDT
CM 014 CM process

UM Misc Subcontractor APL 17