# DEPARTMENT OF MANAGED HEALTH CARE
# OFFICE OF PLAN MONITORING
# DIVISION OF PLAN SURVEYS

# TECHNICAL ASSISTANCE GUIDE

# UTILIZATION MANAGEMENT

# ROUTINE BEHAVIORAL HEALTH SURVEY

# OF

# PLAN NAME

**DATE OF SURVEY:**

**PLAN COPY**

***Issuance of this August 19, 2015 Technical Assistance Guide renders all other versions obsolete.***

# BEHAVIORAL HEALTH TAG

## UTILIZATION MANGEMENT REQUIREMENTS

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***The following Utilization Management Requirements from the Full Service TAGs are not applicable to Behavioral Health Plan Surveys:**

- **Requirement UM-007: Terminal Illness Requirements and Compliance**
- **Requirement UM-008: UM Delegation Oversight**

***The following Utilization Management Requirements from the Full Service TAGs are not applicable to EAPs:**

- **Requirement UM-001 through UM-005**
- **Requirement UM- 009 through UM-011**

***The following Utilization Management Key Element is applicable to carve-out mental health plans only**

- **Requirement UM-009 Key Element 2**

***UM-011 is relevant ONLY to Carve-Out Mental Health Plans**

# BEHAVIORAL HEALTH TAG

## Requirement UM-001: UM Program Policies and Procedures

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- Medical Director and/or senior Physician responsible for utilization management
- Utilization Management Director

### DOCUMENTS TO BE REVIEWED

- UM policies and procedures, including org charts and committee descriptions (A UM Program description may be substituted or in addition to policies and procedures)
- Job Description of the Medical Director responsible for ensuring the UM Process complies with section 1367.01
- Copy of licenses of the medical directors
- UM Committee minutes
- Review licensing filing of the Plan's UM Program and confirm submission of appropriate policies and procedures.

### *UM-001 - Key Element 1:*

**1. The Plan has utilization management policies and procedures. CA Health and Safety Code section 1367.01(b).**

| Assessment Questions | |
|---|---|
| 1.1 | Do policies and procedures describe the process by which the Plan reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for Plan enrollees? |
| 1.2 | Do policies and procedures include utilization review processes such as prospective review, concurrent review and retrospective review? |

### *UM-001 - Key Element 2:*

**2. A designated Medical Director is responsible for the oversight of the UM process and holds an unrestricted license to practice medicine in California. CA Health and Safety Code section 1367.01(c).**

| Assessment Questions | |
|---|---|
| 2.1 | Is a Physician designated to provide clinical direction to the UM Program and ensure compliance with the requirements of 1367.01? |
| 2.2 | Does the designated individual hold a current unrestricted license to practice medicine in California? |

# BEHAVIORAL HEALTH TAG

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|---|---|
| 2.3 | Is there evidence that the individual is substantially involved in UM Program operations through significant time devoted to UM activities, clinical oversight and guidance to UM staff? |
| 2.4 | Is there evidence that the individual is substantially involved in UM Program operations through active involvement in UM Committee and subcommittees? |

***UM-001 - Key Element 3:***

**3. The Plan ensures telephone access for providers to request authorizations for health care services.**
**CA Health and Safety Code section 1367.01(i).**

| **Assessment Questions** | |
|---|---|
| 3.1 | Does the Plan have policies and procedures that describe and ensure telephone access for requesting authorizations for health care services? |
| 3.2 | Does the Plan maintain telephone access for providers to request authorizations for health care services? |

**End of Requirement UM-001: UM Program Policies and Procedures**

# BEHAVIORAL HEALTH TAG

## Requirement UM-002: UM Decision Making and Time Frames

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- UM Director/Managers
- Medical Director and/or senior Physician responsible for UM

### DOCUMENTS TO BE REVIEWED

- UM policies and procedures, including UM decision timeframe requirements
- Organization charts, committee descriptions and key staff job descriptions of staff involved in UM review
- Sample of UM denial files to be reviewed onsite

### *UM-002 - Key Element 1:*

**1. The Plan has written policies and procedures for review and approval, modification, delay or denial of services (medical necessity denials) and ensures they are consistently applied.**
**CA Health and Safety Code sections 1367.01(b), (e) and (g).**

| Assessment Questions | |
|---|---|
| 1.1 | Does the Plan have policies and procedures to ensure that only licensed Physicians or a licensed health care professional (competent to evaluate clinical issues related to requested health care services) make decisions to deny or modify requested services on the basis of medical necessity? |
| 1.2 | Do the Plan's denial files validate that only licensed Physicians or a licensed health care professional (competent to evaluate clinical issues related to requested health care services) make decisions to deny or modify requested services on the basis of medical necessity? |

### *UM-002 - Key Element 2:*

**2. The Plan has established and implemented written policies and procedures regarding the timeliness of UM Decisions and ensures they are consistently applied.**
**CA Health and Safety Code sections 1367.01(b), (h)(1) and (2).**

| Assessment Questions | |
|---|---|
| 2.1 | Does the Plan make decisions to approve, modify, or deny requests by providers in a timely fashion, not to exceed five business days after the Plan's receipt of the information reasonably necessary to make the determination? (This applies to requests prior to, or concurrent with the provision of health care services to enrollees.) |

# BEHAVIORAL HEALTH TAG

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|---|---|
| 2.2 | For urgent referrals and requests for other health care services, does the Plan make the decision to approve, modify, or deny requests by providers in a timely fashion, not to exceed 72 hours after the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination? (This applies to requests prior to, or concurrent with the provision of health care services to enrollees.) |
| 2.3 | Does the Plan communicate utilization review decisions to approve, deny, delay, or modify health care services to requesting providers initially by telephone, facsimile or electronic mail and then in writing within 24 hours of making the decision? |
| 2.4 | Does the Plan communicate UM decisions to approve, deny, delay, or modify health care services to enrollees in writing within 2 business days? |
| 2.5 | Does the Plan request information from the provider that is reasonably necessary to make a medical necessity decision in a timely fashion? (Appropriate for the nature of the enrollee's condition.) |
| 2.6 | Upon receipt of the requested information, does the Plan make decisions to approve, modify, or deny the request within the required timeframe? |
| 2.7 | For retrospective reviews, does the Plan make the decision to approve or deny the previous provision of health care services to enrollees, and communicate that decision within 30 days after the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination? |

***UM-002 - Key Element 3:***

**3. Care shall not be discontinued until a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. CA Health and Safety Code section 1367.01(h)(3).**

| **Assessment Questions** | |
|---|---|
| 3.1 | Does the Plan's policy and practice demonstrate that treating providers can readily access the Plan Physician that made the adverse decision? |
| 3.2 | Does the Plan document receipt of agreement by the treating provider? |
| 3.3 | What is the turnaround time for Plan provider to respond to treating provider? How does the Plan monitor it? |

**End of Requirement UM-002: UM Decision Making and Time Frames**

# BEHAVIORAL HEALTH TAG

## Requirement UM-003: UM Criteria Development

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- UM Director
- Medical Director or designee
- Senior mental health clinical officer

### DOCUMENTS TO BE REVIEWED

- UM policies and procedures and/or Program document outlining development and approval of UM criteria
- UM review criteria, including the criteria for parity diagnoses (for the diagnosis and treatment of serious mental illnesses, autistic disorders, other pervasive-developmental disorders and serious emotional disturbances of a child)
- Policies and procedures for verifying parity diagnosis including pervasive-developmental disorders and serious emotional disturbances of a child
- Policies and procedures related to individuals that are seriously mentally ill and are not adherent to Plan policies and procedures and/or treatment plans
- UM Committee minutes
- Signature page for UM Program/Plan/policies and procedures

***UM-003 - Key Element 1:***

**1. The Plan develops UM criteria consistent with acceptable standards and evaluates them annually.**
**CA Health and Safety Code section 1363.5(a) and (b); CA Health and Safety Code section 1367.01(b) and (f); CA Health and Safety Code section 1374.72(a) and (d).**

| Assessment Questions | |
|---|---|
| 1.1 | Does the Plan utilize criteria/guidelines when determining the medical necessity of requested health care services? |

# BEHAVIORAL HEALTH TAG

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|---|---|
| 1.2 | Does the Plan have written UM criteria that are consistent with accepted standards of practice for one or more of the following mental health parity conditions?<br>• Schizophrenia<br>• Schizoaffective disorder<br>• Bipolar disorder (manic depressive illness)<br>• Major Depressive disorders<br>• Panic disorder<br>• Obsessive-compulsive disorder<br>• Pervasive developmental disorder or autism<br>• Anorexia Nervosa<br>• Bulimia Nervosa<br>• Severe Emotional Disturbances of Children |
| 1.3 | Are criteria/guidelines developed with involvement from actively practicing mental health care providers? |
| 1.4 | Does the Plan have a mechanism to ensure that UM criteria/guidelines for making medical necessity decisions are updated annually? (Or more frequently if needed.) |
| 1.5 | Does the Plan have a mechanism to ensure that UM criteria/guidelines for making medical necessity decisions are disseminated to all UM decision-makers? |
| 1.6 | Does the Plan distribute clinical practice guidelines to primary care, specialty, and mental health providers as appropriate? |
| 1.7 | Is there supporting documentation to confirm the criteria/guidelines are consistent with accepted standards of practice? (For example, documented approval via minutes from Physician discussions; criteria/guidelines have been adopted by reputable Physician organizations; criteria/guidelines consistent with national standards from federal agencies.) |

**End of Requirement UM-003: Criteria Development**

# BEHAVIORAL HEALTH TAG

## Requirement UM-004: Communication Requirements for UM Decisions

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- UM Director
- Medical Director and/or senior Physician responsible for UM decisions

### DOCUMENTS TO BE REVIEWED

- UM policies and procedures, including UM decision communication requirements
- Sample of denial files to be reviewed on site
- Sample of extension letters (when the Plan cannot make a decision within the required timeframe)

***UM-004 not applicable to EAPs**

***UM-004 - Key Element 1:***

1. **The Plan has established and implemented guidelines for UM-related communications to providers and enrollees (including content, form and timeframes).**
   **CA Health and Safety Code section 1363.5(b)(4); CA Health and Safety Code section 1367.01(d), (h)(3) and (4); CA Health and Safety Code section 1374.30(i).**

| Assessment Questions | |
|---|---|
| 1.1 | For retrospective UM decisions, does the Plan communicate denials or modifications of health care services to providers in writing? |
| 1.2 | Do communications regarding decisions to approve requests by providers specify the specific health care service approved? |
| 1.3 | Do the Plan's denial letters provide a clear and concise explanation of the reasons for the Plan's decision to deny, delay, or modify health care services? |
| 1.4 | Do the Plan's denial letters specify a description of the criteria or guidelines used for the Plan's decision to deny, delay, or modify health care services? |
| 1.5 | Do the Plan's denial letters specify the clinical reasons for the Plan's decision to deny, delay, or modify health care services? |
| 1.6 | Do written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the name of the health care professional responsible for the denial, delay, or modification? |
| 1.7 | Do written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the direct telephone number or an extension of the healthcare professional responsible for the denial, |

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|---|---|
| | delay, or modification to allow the requesting Physician or health care provider to easily contact them? |
| 1.8 | Do written communications to an enrollee of a denial, delay, or modification of a request include information as to how he / she may file a grievance to the Plan? |
| 1.9 | Do written communications to an enrollee of a denial, delay, or modification of a request include information as to how he / she may request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers? |

***UM-004 - Key Element 2:***

**2. The Plan has established and implemented guidelines for communicating to the enrollee and Physician if a UM decision will not be made within 5 business days.**
**CA Health and Safety Code section 1367.01(b) and (h)(5).**

| **Assessment Questions** | |
|---|---|
| 2.1 | Does the Plan have guidelines for communicating with the enrollee and provider if UM decisions do not meet the required timeframes? |
| 2.2 | If the Plan is unable to make a UM decision within the required timeframe, does the Plan notify the provider and enrollee of the anticipated decision date? |

**End of Requirement UM-004: Communications Requirements for UM Decisions**

# BEHAVIORAL HEALTH TAG

## Requirement UM-005: Disclosure of UM Process to Authorize or Deny Services

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- UM Director
- Medical Director or designee
- Member Services staff
- Participating Physician

### DOCUMENTS TO BE REVIEWED

- Policies and procedures for disclosure of UM processes and criteria to providers, enrollees, and the public
- Policies and procedures for disclosure to the provider and enrollee of the specific UM criteria used in all decisions based on medical necessity to modify, delay, or deny care
- Template letter(s) with disclosure statement
- Review of disclosure documents including: Provider materials relating to disclosure; disclosures to provider groups and UM vendors; enrollee materials relating to disclosure; and public materials relating to disclosure
- Review licensing filing of the Plan's UM Program to confirm submission of policies and procedures, and the description of the UM process

***UM-005 not applicable to EAPs**

***UM-005 - Key Element 1:***

1. **The Plan shall disclose to network providers, contractors and enrollees the process the Plan uses to authorize, modify, or deny health care services under the benefits provided by the Plan.**
   **CA Health and Safety Code section 1363.5(b)(4)-(5) and (c).**

| Assessment Questions | |
|---|---|
| 1.1 | Do Plan policies and procedures provide for the disclosure of the process the Plan uses to authorize, modify, or deny health care services? |
| 1.2 | Does the Plan disclose the UM process information to network providers? |
| 1.3 | Does the Plan demonstrate that it discloses UM processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request? |
| 1.4 | Does the Plan demonstrate that it discloses to the enrollee and provider the UM criteria used as a basis to modify, deny or delay services in specified cases under review? |

# BEHAVIORAL HEALTH TAG

| | |
|---|---|
| 1.5 | Are UM Criteria available to the public upon request, which may include the availability through electronic communication means? |
| 1.6 | Is disclosure of UM criteria to the public accompanied by the following notice: “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.”? |

**End of Requirement UM-005: Disclosure of UM Process to Authorize or Deny Services**

# BEHAVIORAL HEALTH TAG

## Requirement UM-006: UM Processes as Part of the QA Program

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- UM Director
- QM Director
- Medical Director

### DOCUMENTS TO BE REVIEWED

- Policies and procedures for UM
- UM or QM Annual Work Plan
- UM or QM Committee minutes
- Trending reports
- Activity summaries
- Audit Reports
- Enrollee & Provider Satisfaction Surveys (UM-related questions and results)
- Corrective action plans
- Enrollee and Provider satisfaction survey questions related to UM
- Enrollee and Provider satisfaction survey results, last two years, if applicable
- Corrective action plans

***UM-006 - Key Element 1:***

1. **The Plan has established and implemented a QA process to assess and evaluate their compliance with UM requirements.**
   **CA Health and Safety Code sections 1367.01(j); 28 CCR 1300.70(a)(3), (b)(1)(A), (B), and (D).**

| Assessment Questions | |
|---|---|
| 1.1 | Does the Plan have a process in place to evaluate complaints and assess trends to identify potential quality issues in the UM process and regularly report this information to appropriate bodies? |
| 1.2 | Does the Plan have a process in place to monitor and assess compliance with timeliness of decision-making, timeliness of notification, and turnaround times for UM functions? |
| 1.3 | Has the Plan established and implemented policies and procedures to monitor and assess compliance with the use of appropriate licensed health care providers in making denial decisions and the appropriate use and application of criteria in making medical necessity decisions? |
| 1.4 | Has the Plan established and implemented policies and procedures to audit denial letters ensuring the required information is included, and communicated to the appropriate user, providers and/or enrollees? |

| | |
|---|---|
| 1.5 | Does the Plan systematically and routinely analyze its evaluation of the UM process to identify any potential quality issues in the UM process? |
| 1.6 | Does the Plan develop, communicate, and implement corrective action Plans when potential quality issues are identified in the UM process? |
| 1.7 | Does the Plan evaluate the effectiveness of any corrective action Plan (using performance measures, for example) and make further recommendations to improve the UM process? |
| 1.8 | Does the Plan systemically and routinely analyze UM data to monitor for potential over and under-utilization? |

***UM-006 - Key Element 2:***

***2.*** **The scope of quality assurance monitoring includes assessment and evaluation of provider referral and specialist care patterns of practice**. **28 CCR 1300.70(a)(1) and (b)(2)(G)(5).**

| **Assessment Questions** | |
|---|---|
| 2.1 | Does the Plan's quality assurance/utilization review mechanism encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services (e.g., laboratory, radiology, pharmacy, physical therapy services)and appropriate preventive health services based on reasonable standards established by the Plan and/or delegated providers? |
| 2.2 | Does the Plan have a process in place to routinely monitor and assess access to specialist care, ancillary support services (e.g., laboratory, radiology, pharmacy, physical therapy services) and appropriate preventive health services? |
| 2.3 | Does the Plan analyze its evaluation of access to specialist care, ancillary support services (e.g., laboratory, radiology, pharmacy, physical therapy services), and appropriate preventive health services? |
| 2.4 | Does the Plan have a process to routinely monitor and assess access to specialist care for any delegated providers? |
| 2.5 | Does the Plan identify, communicate, and implement corrective actions when potential access issues are identified in the UM process? |
| 2.6 | Does the Plan evaluate the effectiveness of any corrective actions (using performance measures, for example) and make further recommendations to improve potential access issues? |

**End of Requirement UM-006: UM Processes as Part of the QA Program**

# BEHAVIORAL HEALTH TAG

## Requirement UM-007: Terminal Illness Requirements and Compliance

***This requirement does not apply to Behavioral Health plans.**

**End of Requirement UM-007: Terminal Illness Requirements and Compliance**

## Requirement UM-008: UM Delegation Oversight

***This requirement does not apply to Behavioral Health plans.**

**End of Requirement UM-008: UM Delegation Oversight**

# BEHAVIORAL HEALTH TAG

## Requirement UM-009: Mental Health Parity Coverage & Claims Administration

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example**:

- Mental health claims director/manager
- Senior mental health clinician responsible for mental health

### DOCUMENTS TO BE REVIEWED

- Policies and procedures, protocols documents relating any application of limits on the number of services inconsistent with those for medical or surgical services
- Member materials regarding benefit limits (including limits for parity diagnoses)
- Customer Service staff materials used to quote member benefits
- Sample of claim denial files to be reviewed onsite

***UM-009 not applicable to EAPs**

***UM-009 - Key Element 1:***

1. **Limits on annual/lifetime maximum benefits, co-payments, individual and family deductibles for mental health services are consistent with, or no more stringent than, any limits placed on medical or surgical services. CA Health and Safety Code section 1374.72(a), (c), and (e).**

| Assessment Question | |
|---|---|
| 1.1 | Are coverage limits, co-payments and co-insurance for mental health services consistent with or no more stringent than limits for medical/surgical services? |
| 1.2 | When processing claims for mental health parity conditions, does the Plan or its delegate apply the following limits and co-payments consistent with medical diagnosis conditions to maximum lifetime benefits? |
| 1.3 | When processing claims for mental health parity conditions, does the Plan or its delegate apply the following limits and co-payments consistent with medical diagnosis conditions to individual and family deductibles? |
| 1.4 | When processing claims for mental health parity conditions, does the Plan or its delegate apply the following limits and co-payments consistent with medical diagnosis conditions to co-payments? |
| 1.5 | When processing claims for mental health parity conditions, does the Plan or its delegate apply the following limits and co-payments consistent with medical diagnosis conditions to co-insurance? |
| 1.6 | When processing claims for mental health parity conditions, does the Plan or its delegate apply the following limits and co-payments consistent with medical diagnosis conditions to benefit limits? |

# BEHAVIORAL HEALTH TAG

*** Key Element 2 is applicable to carve-out mental health plans only**

***UM-009 - Key Element 2:***

**2. The full service plan coordinates with the mental health plan to ensure that mental health parity benefits are being provided to its enrollees. CA Health and Safety Code section 1374.72(a) and (c); 28 CCR 1300.74.72(f) and (g).**

| Assessment Questions | |
|---|---|
| 2.1 | Does the agreement between the full service health care plan and the carve-out mental health plan delegate mental health parity responsibilities to the mental health plan? |
| 2.2 | Does the agreement include a description of how the mental health plan and full service health care plan coordinate the development of benefit design? (i.e., development of prescription formulary) |
| 2.3 | Does the agreement include a description of the collaboration between the mental health care plan and the full service health care plan for the timely exchange of information between medical and mental health providers? |
| 2.4 | Does the agreement include a description of the collaboration between the mental health care plan and the full service health care plan for improving access to treatment and follow-up for enrollees with co-existing medical and mental health disorders? |

**End of Requirement UM-009: Mental Health Parity & Claims Administration**

# BEHAVIORAL HEALTH TAG

## Requirement UM-010: Mental Health Triage and Referral

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example**:

- Senior mental health clinician responsible for triage and referral
- Mental Health Medical Director
- Triage Center Manager and personnel

### DOCUMENTS TO BE REVIEWED

- Triage Policies and Procedures
- Utilization Management Committee and/or work group meeting minutes
- Job descriptions of call center clinical and non-clinical personnel
- Record of periodic review and Plan assessment to ensure timely access and ready referral in accordance with 1300.74.72(f)
- Review of cases from the Triage Center's telephone log, including cases in which the enrollee required emergent care or urgent care

***UM-0010 not applicable to EAPs**

***UM-010 - Key Element 1:***

1. **The Plan maintains a telephone intake system for enrollees, which is staffed by trained personnel who are either individually licensed mental health professionals, or supervised by a licensed mental health professional, and which provides for appropriate crisis intervention and initial referrals to mental health providers.**
   **CA Health and Safety Code section 1367(d); CA Health and Safety Code section 1367.01(i); 28 CCR 1300.67(a)(1).**

| Assessment Questions | |
|---|---|
| 1.1 | Does the Plan have an enrollee telephone intake system that is staffed by trained personnel who are individually licensed or are supervised by a licensed mental health professional? |
| 1.2 | Does the Plan have policies and procedures and/or training that define protocols for initial referrals to mental health providers? |

***UM-010 - Key Element 2:***

2. **If the Plan requires that an enrollee access the mental health delivery system through a centralized triage and referral system, the Plan's protocols for mental health triage and referral address the level of urgency and appropriate level of care relative to the enrollee's mental status and level of functioning.**
   **CA Health and Safety Code section 1367(d); 28 CCR 1300.67(a)(1).**

# BEHAVIORAL HEALTH TAG

| Assessment Questions | |
|---|---|
| 2.1 | Does the Plan require that enrollee's access the mental health delivery system through a centralized triage and referral system? |
| 2.2 | Do the Plan's protocols for mental health triage and referral address the level of urgency relative to the enrollee's mental status and level of functioning? |
| 2.3 | Do the Plan's protocols for mental health triage and referral address the appropriate level of care relative to the enrollee's mental status and level of functioning? |

***UM-010 - Key Element 3:***

**3. The Plan has established standards and goals for the timeliness of response to its triage and referral telephone lines and measures performance against those standards.**
**CA Health and Safety Code section 1367(d); CA Health and Safety Code section 1367.01((j); 28 CCR 1300.67(a)(1).**

| Assessment Questions | |
|---|---|
| 3.1 | Does the Plan have established standards and goals for timeliness of response to triage and referral telephone lines? |
| 3.2 | Does the Plan measure performance against standards at least quarterly? |
| 3.3 | If the Plan does not meet its goals, does it take corrective action? |
| 3.4 | Does the Plan re-measure results after corrective action has been implemented? |

***UM-010 - Key Element 4:***

**4. The Plan reviews and updates triage protocols on mental health conditions, when appropriate, on a regular basis.**
**CA Health and Safety Code section 1363.5(b).**

| Assessment Question | |
|---|---|
| 4.1 | Does the Plan review and update triage protocols on parity conditions on a regular basis? |

***UM-010 - Key Element 5:***

**5. Licensed clinical staff members make decisions about the type and level of care to which enrollees are referred.**
**CA Health and Safety Code section 1367.01(e).**

| Assessment Question | |
|---|---|
| 5.1 | Do licensed clinical staff make decisions about the type and level of care to which enrollees are referred? |

**End of Requirement UM-010: Mental Health Triage and Referral**

# BEHAVIORAL HEALTH TAG

## Requirement UM-011: Standing Referrals

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- Medical Director
- Director of Provider Relations
- UM Director

### DOCUMENTS TO BE REVIEWED

- Policies and procedures for standing referrals of enrollees
- Plan reports on monitoring of standing referrals
- Plan reports on monitoring of standing referrals at UM delegated entities
- Policies and Procedures regarding identifying appropriate specialists and specialty care centers for standing referrals
- Sample of standing referral files to be reviewed onsite
- Corrective Action Plans
- FS Plan to BH carve-out Plan contract

**CA Health and Safety code section 1374.16(c) is NOT applicable to specialized health care service plans.**

***UM-011 is relevant ONLY to Carve-Out Mental Health Plans**

***UM-011 is not applicable to EAPs**

***UM-011 - Key Element 1:***

1. **The Plan has established policies and procedures for standing referrals of: (a) enrollees who need continuing care from a specialist, and (b) enrollees who require specialized care over a prolonged period of time for the purpose of having the specialist coordinate the enrollee's health care, including HIV/AIDS. CA Health and Safety Code section 1374.16(a) through (f).**

| Assessment Questions | |
|---|---|
| 1.1 | Does the Plan have established policies and procedures for standing referrals? |
| 1.2 | Does the Plan disseminate those policies to primary care providers? (e.g., via provider manual) |

# BEHAVIORAL HEALTH TAG

***UM-011 - Key Element 2:***

**2. The Plan makes determinations within three (3) business days of the date a request for standing referral is made and all appropriate information necessary to make the determination is provided. When approved, the Plan makes the referral within four (4) business days of the date the proposed treatment plan, if any, is submitted to the Plan Medical Director or his/her designee.**
**CA Health and Safety Code section 1374.16(c).**

| Assessment Questions | |
|---|---|
| 2.1 | Does the Plan make a determination regarding requests for standing referrals within three (3) business days? |
| 2.2 | Once approved, does the Plan make the referral in 4 (four) business days of the proposed treatment plan? |
| 2.3 | Do communications to approve standard referrals specify the specific services approved? |
| 2.4 | Do denial letters provide a clear and concise explanation of the reasons for the denial? |
| 2.5 | Do the Plan's denial letters specify the clinical reasons for the Plan's decision to deny, delay, or modify health care services? |
| 2.6 | Do written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the following information: The name of the health care professional responsible for the denial, delay, or modification? |
| 2.7 | Do written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the following information: The direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them? |
| 2.8 | Do written communications to an enrollee of a denial, delay or modification of a request include information as to how he / she may file a grievance with the Plan? |
| 2.9 | Do written communications to an enrollee of a denial, delay, or modification of a request include information as to how he / she may request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers? |

***UM-011 - Key Element 3:***

**3. The Plan appropriately approves the treatment plan or a current standing referral to a specialist or specialty care center when an enrollee requires specialized medically necessary care over a long period of time.**
**CA Health and Safety Code section 1374.16(a), (b) and (e).**

# BEHAVIORAL HEALTH TAG

| Assessment Question | |
|---|---|
| 3.1 | Does the Plan approve a treatment plan or a current standing referral to a specialist or specialty care center when an enrollee requires specialized medically necessary care over a long period of time? |

***UM-011 - Key Element 4:***

**4. When a specialist or specialty care center has been approved to coordinate the enrollee's health care, the Plan approves the specialist to provide health care services within the specialist's area of expertise and training in the same manner as it approves the enrollee's primary care Physician's services, subject to the terms of the treatment plan.**
**CA Health and Safety Code section 1374.16(b); 28 CCR 1300.74.16(e) and (f).**

| Assessment Question | |
|---|---|
| 4.1 | Does the Plan demonstrate that it complies with section 1374.16 (b) and approves the specialist to provide health care services within the specialist's area of expertise and training in the same manner as it approves the enrollee's primary care Physician's services, subject to the terms of the treatment plan? |

**End of Requirement UM-011: Standing Referrals**

# BEHAVIORAL HEALTH TAG

## Requirement UM-012: Post-Stabilization

### INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

**Staff responsible for the activities described above, for example:**

- UM Director / Managers
- Medical Director and/or senior Physician responsible for UM

### DOCUMENTS TO BE REVIEWED

- UM policies and procedures, including UM decision timeframe requirements
- Organization charts, committee descriptions and key staff job descriptions of staff involved in UM review
- Sample UM denial template letters.
- Sample of UM denial files to be reviewed on site.

***UM-012 not applicable to EAPs**

***UM-012 - Key Element 1:***

1. **The Plan properly arranges for the transfer of enrollees after the enrollee has been stabilized subsequent to an emergency psychiatric or medical condition but the provider believes further medically necessary health care treatment is required and the enrollee cannot be safely discharged.**
   **CA Health and Safety Code section 1262.8; CA Health and Safety Code section 1317.1; CA Health and Safety Code section 1317.4a.; 28 CCR 1300.71.4.**

| Assessment Questions | |
|---|---|
| 1.1 | Does the Plan fully document all requests for authorizations and responses to such requests for post-stabilization medically necessary care? |
| 1.2 | Does the Plan's documentation include the date and time of the provider's request? |
| 1.3 | Does the Plan's documentation include the name of the health care provider making the request? |
| 1.4 | Does the Plan's documentation include the name of the Plan representative responding to the request? |
| 1.5 | Does the Plan require prior authorization for post-stabilization care? If not, Assessment Questions 1.6-1.8 are not applicable. |
| 1.6 | Does the Plan provide 24-hour access for patients and providers, including non-contracting hospitals, to obtain timely authorization for medically necessary post-stabilization care? |
| 1.7 | If post-stabilization request was denied, was the decision made within one half hour of the request? |
| 1.8 | If the Plan does not respond to a post stabilization request within 30 minutes, does it pay any claims submitted by the provider for the post stabilization care rendered? |

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| 1.9 | Does the Plan provide all non-contracting hospitals with a contact number at which the hospital can obtain authorization from the Plan? |
| 1.10 | Does the Plan respond to a transferring hospital after the first call such that the transferring hospital does not have to make more than one call before it gets an initial response from the Plan? |
| 1.11 | Does the Plan ensure that a patient is not transferred to a contracting facility unless the provider determines no material deterioration of the patient is likely to occur upon transfer? |
| 1.12 | Does the Plan ensure that prior authorization is not required for the provision of emergency services and care to a patient with a psychiatric emergency? |

**End of Requirement UM-012: Post-Stabilization**

# Statutory/Regulatory Citations

### CA Health and Safety Code section 1262.8

(a) A noncontracting hospital shall not bill a patient who is an enrollee of a health care service plan for poststabilization care, except for applicable copayments, coinsurance, and deductibles, unless one of the following conditions are met:
(1) The patient or the patient's spouse or legal guardian refuses to consent, pursuant to subdivision (f), for the patient to be transferred to the contracting hospital as requested and arranged for by the patient's health care service plan.
(2) The hospital is unable to obtain the name and contact information of the patient's health care service plan as provided in subdivision (c).
(b) If a patient with an emergency medical condition, as defined by Section 1317.1, is covered by a health care service plan that requires prior authorization for poststabilization care, a noncontracting hospital, except as provided in subdivision (n), shall, prior to providing poststabilization care, do all of the following once the emergency medical condition has been stabilized, as defined by Section 1317.1:
(1) Seek to obtain the name and contact information of the patient's health care service plan. The hospital shall document its attempt to ascertain this information in the patient's medical record, which shall include requesting the patient's health care service plan member card or asking the patient, or a family member or other person accompanying the patient, if he or she can identify the patient's health care service plan, or any other means known to the hospital for accurately identifying the patient's health care service plan.
(2) Contact the patient's health care service plan, or the health plan's contracting medical provider, for authorization to provide poststabilization care, if identification of the plan was obtained pursuant to paragraph (1).
(A) The hospital shall make the contact described in this subparagraph by either following the instructions on the patient's health care service plan member card or using the contact information provided by the patient's health care service plan pursuant to subdivision (j) or (k).
(B) A representative of the hospital shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the hospital upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the hospital who makes the telephone call may be, but is not required to be, a physician and surgeon.
(3) Upon request of the patient's health care service plan, or the health plan's contracting medical provider, provide to the plan, or its contracting medical provider, the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary for the health care service plan or the plan's contracting medical provider to make a decision to authorize poststabilization care or to assume management of the patient's care by prompt transfer.
(c) A noncontracting hospital that is not able to obtain the name and contact information of the patient's health care service plan pursuant to subdivision (b) is not subject to the requirements of this section.

(d)(1) A health care service plan, or its contracting medical provider, that is contacted by a noncontracting hospital pursuant to paragraph (2) of subdivision (b), shall, within 30 minutes from the time the noncontracting hospital makes the initial contact, do either of the following:
(A) Authorize poststabilization care.
(B) Inform the noncontracting hospital that it will arrange for the prompt transfer of the enrollee to another hospital.
(2) If the health care service plan, or its contracting medical provider, does not notify the noncontracting hospital of its decision pursuant to paragraph (1) within 30 minutes, the poststabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges for the care, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) and any regulation adopted thereunder.
(3) If the health care service plan, or its contracting medical provider, notified the noncontracting hospital that it would assume management of the patient's care by prompt transfer, but either the health care service plan or its contracting medical provider fails to transfer the patient within a reasonable time, the poststabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and any regulation adopted thereunder, for the care until the enrollee is transferred.
(4) If the health care service plan, or its contracting medical provider, provides authorization to the noncontracting hospital for specified poststabilization care and services, the health care service plan, or its contracting medical provider, shall be responsible to pay for that authorized care.
(e) If a health care service plan, or its contracting medical provider, decides to assume management of the patient's care by prompt transfer, the health care service plan, or its contracting medical provider, shall do all of the following:
(1) Arrange and pay the reasonable charges associated with the transfer of the patient.
(2) Pay for all of the immediately required medically necessary care rendered to the patient prior to the transfer in order to maintain the patient's clinical stability.
(3) Be responsible for making all arrangements for the patient's transfer, including, but not limited to, finding a contracted facility available for the transfer of the patient.
(f)(1) If the patient, or the patient's spouse or legal guardian refuses to consent to the patient's transfer under subdivision (e), the noncontracting hospital shall promptly provide a written notice to the patient or the patient's spouse or legal guardian indicating that the patient will be financially responsible for any further poststabilization care provided by the hospital.
(2) For patients whose primary language is one of the Medi-Cal threshold languages, the notice shall be delivered to them in their primary language.
(3) The Department of Managed Health Care shall translate the notice required by this subdivision in all Medi-Cal threshold languages and make the translations available to the hospitals subject to this section.
(4) The written notice provided pursuant to this subdivision shall include the following statement:

THIS NOTICE MUST BE PROVIDED TO YOU UNDER CALIFORNIA LAW
"You have received emergency care at a hospital that is not a part of your health plan's provider network. Under state law, emergency care must be paid by your health plan no matter where you get that care. The doctor who is caring for you has decided that you may be safely moved to another hospital for the additional care you need. Because you no longer need emergency care, your health plan has not authorized further care at this hospital. Your health plan has arranged for you to be moved to a hospital that is in your health plan's provider network.
If you agree to be moved, your health plan will pay for your care at that hospital. You will only have to pay for your deductible, copayments, or coinsurance for care. You will not have to pay for your deductible, copayments, or coinsurance for transportation costs to another hospital that is covered by your health plan.
IF YOU CHOOSE TO STAY AT THIS HOSPITAL FOR YOUR ADDITIONAL CARE, YOU WILL HAVE TO PAY THE FULL COST OF CARE NOW THAT YOU NO LONGER NEED EMERGENCY CARE. This cost may include the cost of the doctor or doctors, the hospital, and any laboratory, radiology, or other services that you receive. If you do not think you can be safely moved, talk to the doctor about your concerns. If you would like additional help, you may contact:
Your health plan member services department. Look on your health plan member card for that phone number. You can file a grievance with your plan.
The HMO Helpline at 888-HMO-2219. The HMO Helpline is available 24 hours a day, 7 days a week. The HMO Helpline can work with your health plan to address your concerns, but you may still have to pay the full cost of care at this hospital if you stay."
(5) The hospital shall give one copy of the written notice required by this subdivision to the patient, or the patient's spouse or legal guardian, for signature and may retain a copy in the patient's medical record.
(6) The hospital shall ensure prompt delivery of the notice to the patient or his or her spouse or legal guardian. The hospital shall obtain signed acceptance of the written notice required by this subdivision, and signed acceptance of any other documents the hospital requires for any further poststabilization care, from the patient or the patient's spouse or legal guardian, and shall provide the health care service plan, or its contracting medical provider, with confirmation of the patient's, or his or her spouse or legal guardian's, receipt of the written notice.
(7) If the noncontracting hospital fails to meet the requirements of this subdivision, the hospital shall not bill the patient or the patient's health care service plan, or its contracting medical provider, for poststabilization care provided to the patient.
(8) If the patient, or the patient's spouse or legal guardian, refuses to sign the notice, the noncontracting hospital shall document in the patient's medical record that the notice was provided and signature was refused. Upon the patient's refusal to sign, the patient shall assume financial responsibility for any further poststabilization care provided by the hospital.
(9) The Department of Managed Health Care may, by regulation, modify the wording of the notice required under this subdivision for clarity, readability, and accuracy of the information provided.
(10) The Department of Managed Health Care may, in conjunction with consumer groups, health care service plans, and hospitals, modify the wording of the notice to include language regarding Medicare beneficiaries, if appropriate under Medicare

rules. The initial modification shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340, et. seq.) of Part 1 of Division 3 of Title 2 of the Government Code).
(g) If poststabilization care has been authorized by the health care service plan, the noncontracting hospital shall request the patient's medical record from the patient's health care service plan or its contracting medical provider.
(h) The health care service plan, or its contracting medical provider, shall, upon conferring with the noncontracting hospital, transmit any appropriate portion of the patient's medical record, if the records are in the plan's possession, via facsimile transmission or electronic mail, whichever method is requested by the noncontracting hospital's representative or the noncontracting physician and surgeon. The health care service plan, or its contracting medical provider, shall transmit the patient's medical record in a manner that complies with all legal requirements to protect the patient's privacy.
(i) A health care service plan, or its contracting medical provider, that requires prior authorization for poststabilization care shall provide 24-hour access for patients and providers, including noncontracting hospitals, to obtain timely authorization for medically necessary poststabilization care.
(j) A health care service plan shall provide all noncontracting hospitals in the state with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.
(k) In addition to meeting the requirements of subdivision (j), a health care service plan shall provide the contact information described in subdivision (j) to the Department of Managed Health Care. The contact information provided pursuant to this subdivision shall be updated as necessary, but no less than once a year. The receiving department shall post this contact information on its Internet Web site no later than January 1 of each calendar year.
(*l*) This section shall only apply to a noncontracting hospital.
(m) For purposes of this section, the following definitions shall apply:
(1) “Health care service plan” means a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 that covers hospital, medical, or surgical expenses.
(2) “Noncontracting hospital” means a general acute care hospital, as defined in subdivision (a) of Section 1250 or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that does not have a written contract with the patient's health care service plan to provide health care services to the patient.
(3) “Poststabilization care” means medically necessary care provided after an emergency medical condition has been stabilized, as defined by subdivision (j) of Section 1317.1.
(4) “Contracting medical provider” means a medical group, independent practice association, or any other similar organization that, pursuant to a signed written contract, has agreed to accept responsibility for provision or reimbursement of a noncontracting hospital for emergency and poststabilization services provided to a health plan's enrollees.
(n) Subdivisions (b) to (h), inclusive, shall not apply to minor treatment procedures, if all of the following apply:

(1) The procedure is provided in the treatment area of the emergency department.
(2) The procedure concludes the treatment of the presenting emergency medical condition of a patient and is related to that condition, even though the treatment may not resolve the underlying medical condition.
(3) The procedure is performed according to accepted standards of practice.
(4) The procedure would result in the direct discharge or release of the patient from the emergency department following this care.
(*o*) Nothing in this section is intended to prevent a health care service plan or its contracting medical provider from assuming management of the patient's care at any time after the initial provision of poststabilization care by the noncontracting hospital before the patient has been discharged. Upon the request of the health care service plan or its contracting medical provider, the noncontracting hospital shall provide the health care service plan or its contracting medical provider with any information specified in paragraph (3) of subdivision (b).
(p) Nothing in this section shall authorize a provider of health care services to bill a Medi-Cal beneficiary enrolled in a Medi-Cal managed care plan or otherwise alter the provisions of subdivision (a) of Section 14019.3 of the Welfare and Institutions Code.

**CA Health and Safety Code section 1317.1.**
Unless the context otherwise requires, the following definitions shall control the construction of this article and Section 1371.4:
(a)(2)(A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.
(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
(1) Placing the patient's health in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.
(c) “Active labor” means a labor at a time at which either of the following would occur:
(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.
(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.
(d) “Hospital” means all hospitals with an emergency department licensed by the state department.
(e) “State department” means the State Department of Public Health.
(f) “Medical hazard” means a material deterioration in medical condition in, or jeopardy to, a patient's medical condition or expected chances for recovery.
(g) “Board” means the Medical Board of California.
(h) “Within the capability of the facility” means those capabilities that the hospital is required to have as a condition of its emergency medical services permit and services

specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.
(i) “Consultation” means the rendering of an opinion or advice, prescribing treatment, or the rendering of a decision regarding hospitalization or transfer by telephone or other means of communication. When determined to be medically necessary, jointly by the treating physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure, under the supervision of a physician and surgeon, and the consulting physician and surgeon, “consultation” includes review of the patient's medical record, examination, and treatment of the patient in person by a consulting physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a consulting physician and surgeon, who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient. A request for consultation shall be made by the treating physician and surgeon, or by other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, provided the request is made with the contemporaneous approval of the treating physician and surgeon. The treating physician and surgeon may request to communicate directly with the consulting physician and surgeon, and when determined to be medically necessary, jointly by the treating physician and surgeon and the consulting physician and surgeon, the consulting physician and surgeon shall examine and treat the patient in person. The consulting physician and surgeon is ultimately responsible for providing the necessary consultation to the patient, regardless of who makes the in-person appearance.
(j) A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.
(k)(1) "Psychiatric emergency medical condition" means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:
(A) An immediate danger to himself or herself or to others.
(B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.
(2) This subdivision does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or medical personnel.

**CA Health and Safety Code section 1317.4a.**
(a) Notwithstanding subdivision (j) of Section 1317.1, a patient may be transferred for admission to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, for care and treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1, provided that, in the opinion of the treating provider, the patient's psychiatric emergency medical condition is such that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency medical condition is likely to result from, or occur during, a transfer of the patient. A

provider shall notify the patient's health care service plan, or the health plan's contracting medical provider of the need for the transfer if identification of the plan is obtained pursuant to paragraph (1) of subdivision (b).
(c)(1) A hospital shall [notify the health plan of a transfer to a psychiatric unit within a general acute care hospital] by either following the instructions on the patient's health care service plan member card or by using the contact information provided by the patient's health care service plan. A health care service plan shall provide all noncontracting hospitals in the state to which one of its members would be transferred pursuant to paragraph (1) of subdivision (b) with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.
(2) A hospital making the transfer pursuant to subdivision (a) shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the provider upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the hospital who makes the telephone call may be, but is not required to be, a physician and surgeon.
(d) If a transfer made pursuant to subdivision (a) is made to a facility that does not have a contract with the patient's health care service plan, the plan may subsequently require and make provision for the transfer of the patient receiving services pursuant to this section and subdivision (a) of Section 1317.1 from the noncontracting facility to a general acute care hospital, as defined in subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that has a contract with the plan or its delegated payer, provided that in the opinion of the treating provider the patient's psychiatric emergency medical condition is such that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency medical condition is likely to result from, or occur during, the transfer of the patient.
(e) Upon admission, the hospital to which the patient was transferred shall notify the health care service plan of the transfer, provided that the facility has the name and contact information of the patient's health care service plan. The facility shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the facility upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the facility who makes the telephone call may be, but is not required to be, a physician and surgeon.

**CA Health and Safety Code sections 1363.5**
(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for sub-acute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the

policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.
(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify or deny health care services shall:
(1) Be developed with involvement from actively practicing health care providers
(2) Be consistent with sound clinical principles and processes
(3) Be evaluated, and updated if necessary, at least annually
(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.
(5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.
(c) The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: "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."

**CA Health and Safety Code section 1367**
(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

**CA Health and Safety Code section 1367.01**
**…**
(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.
(c) A health care service plan subject to Section 1367.01, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued to pursuant Section 2050 of the Business and Professions Code or pursuant to Osteopathic Act, or if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care

provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.
(d) If health Plan personnel, or individuals under contract to the Plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).
(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).
(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.
(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service Plan subject to this section shall meet the following requirements:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.
(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health

Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.
(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee'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.
4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1and 51014.2 of Title 22 of the California Code of Regulations
5) If the health care service Plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the Plan is not in receipt of all of the information reasonably necessary and requested, or because the Plan requires consultation by an expert reviewer, or because the Plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the Plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the Plan cannot make a decision to approve, modify, or deny the request

for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the Plan, the Plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.
(6) If the director determines that a health care service Plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the State Managed Care Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.
(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.
(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

**CA Health and Safety Code section 1374.16**
(a) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.
(b) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the

purpose of having the specialist coordinate the enrollee's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the plan medical director or his or her designee determines that this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist or specialty care center, and enrollee, if a treatment plan is deemed necessary to describe the course of care. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the plan or its contracting provider, medical group, or independent practice association. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.
(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the determination is made by the enrollee or the enrollee's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.
(d) Subdivisions (a) and (b) do not require a health care service plan to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no specialist within the plan network that is appropriate to provide treatment to the enrollee, as determined by the primary care physician in consultation with the plan medical director as documented in the treatment plan developed pursuant to subdivision (a) or (b).
(e) For the purposes of this section, "specialty care center" means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
(f) As used in this section, a "standing referral" means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.
(g) This section shall become operative on (1) January 1, 2004, or (2) the date of adoption of an accreditation or designation by an agency of the state or federal government or by a voluntary national health organization of an HIV or AIDS specialist, whichever date is earlier.

**CA Health and Safety Code section 1374.30(i)**
(i) No later than January 1, 2001, every health care service Plan shall prominently display in every Plan member handbook or relevant informational brochure, in every Plan contract, on enrollee evidence of coverage forms, on copies of Plan procedures for resolving grievances, on letters of denials issued by either the Plan or its contracting organization, on the grievance forms required under Section 1368, and on

all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers.

**CA Health and Safety Code section 1374.72**

(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).
(b) These benefits shall include the following:
(1) Outpatient services.
(2) Inpatient hospital services.
(3) Partial hospital services.
(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.
(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:
(1) Maximum lifetime benefits.
(2) Co-payments.
(3) Individual and family deductibles.
(d) For the purposes of this section, "severe mental illnesses" shall include:
(1) Schizophrenia.
(2) Schizoaffective disorder.
(3) Bipolar disorder (manic-depressive illness).
(4) Major depressive disorders.
(5) Panic disorder.
(6) Obsessive-compulsive disorder.
(7) Pervasive developmental disorder or autism.
(8) Anorexia nervosa.
(9) Bulimia nervosa.
(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.
(f) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Division 9 of Part 3 of the Welfare and Institutions Code, between the State Department of Health Services and a health care service plan for enrolled Medi-Cal beneficiaries.
(g)(1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate

specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.
(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.
(3) Notwithstanding any other provision of law, in the provision of benefits required by this section, a health care service plan may utilize case management, network providers, utilization review techniques, prior authorization, co-payments, or other cost sharing.

**28 CCR 1300.67**
The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve:
(a) Physician services, which shall be provided by physicians licensed to practice medicine or osteopathy in accordance with applicable California law. There shall also be provided consultation with and referral by physicians to other physicians.
(1) The plan may also include, when provided by the plan, consultation and referral (physician or, if permitted by law, patient initiated) to other health professionals who are defined as dentists, nurses, podiatrists, optometrists, physician's assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other professionals engaged in the delivery of health services who are licensed to practice, are certified, or practice under authority of the plan, a medical group, or individual practice association or other authority authorized by applicable California law.

**28 CCR 1300.70(a)(1) and (3), (b)(1)(A)-(B) and (D), (b)(2)(G)(5)**
(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.
**…**
(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.
**…**
(b) Quality Assurance Program Structure and Requirements.
(1) Program Structure.
To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

(A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
(B) quality of care problems are identified and corrected for all provider entities;
**…**
(D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others.
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements. In order to meet these obligations each plan's QA program shall meet all of the following requirements:
**…**
(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
**…**
(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the Plan and/or delegated providers.

**28 CCR 1300.71.4**
The following rules set forth emergency medical condition and post-stabilization responsibilities for medically necessary health care services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred. These rules do not apply to a specialized health care service plan contract that does not provide for medically necessary health care services following stabilization of an emergency condition.
(a) Prior to stabilization of an enrollee's emergency medical condition, or during periods of destabilization (after stabilization of an enrollee's emergency medical condition) when an enrollee requires immediate medically necessary health care services, a health care service plan shall pay for all medically necessary health care services rendered to an enrollee.
(b) In the case when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and may not be discharged safely, the following applies:
(1) A health care service plan shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request.
(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the health care service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of

such care; provided, that the health care service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.
(3) Notwithstanding the provisions of Subsection (b) of this rule, a health care service plan shall pay for all medically necessary health care services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.
(c) In the case where a plan denies the request for authorization of post-stabilization medical care and elects to transfer an enrollee to another health care provider, the following applies:
(1) When a health care service plan responds to a health care provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another health care provider, the plan shall effectuate the transfer of the enrollee as soon as possible,
(2) A health care service plan shall pay for all medically necessary health care services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer.
(d) All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary health care services shall be fully documented. All provision of medically necessary health care services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the health care provider making the request, and the name of the plan representative responding to the request.

**28 CCR 1300.74.16(e) and (f)**

**…**
(e) For the purposes of this section an "HIV/AIDS specialist" means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:
(1) Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or
(2) Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or
(3) Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
(A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
(B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection,

combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or
(4) Meets the following qualifications:
(A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
(B) Has completed any of the following:
1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or
2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
(f) When authorizing a standing referral to a specialist pursuant to Section 1374.16(a) of the Act for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, a health care service plan must refer the enrollee to an HIV/AIDS specialist. When authorizing a standing referral to a specialist for purposes of having that specialist coordinate the enrollee's health care pursuant to Section 1374.16(b) of the Act for an enrollee who is infected with HIV, a health care service plan must refer the enrollee to an HIV/AIDS specialist. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:
(1) The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
(2) The nurse practitioner or physician assistant meets the qualifications specified in subsection (e)(4); and
(3) The nurse practitioner or physician assistant and that provider's supervising HIV/AIDS specialist have the capacity to see an additional patient.

**28 CCR 1300.74.72 (f) and (g)**

**…**

(f) A plan’s referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.
(g) If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:
(1) the specialized health care service plan shall maintain a telephone number that an enrollee may call during normal business hours to obtain information about benefits, providers, coverage and any other relevant information concerning an enrollee's mental health services;

(2) if the plan issues identification cards to enrollees, the identification cards shall include the telephone number required to be maintained above and a brief statement indicating that enrollees may call the telephone number for assistance about mental health services and coverage;
(3) the plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network;
(4) the plan shall monitor, as often as necessary, but not less frequently than once every year, the collaboration between medical and mental health providers including, but not limited to, the following:
(A) exchange of information,
(B) appropriate diagnosis, treatment and referral, and
(C) access to treatment and follow-up for enrollees with co-existing medical and mental health disorders;
(5) the plan shall retain full responsibility for assuring continuity and coordination of care, in accordance with the requirements of this subsection, notwithstanding that, by contract, it has obligated a specialized health care service plan to perform some or all of these activities.