Utilization Management

L.A. Care Health Plan

Please read carefully.

How to contact health plan staff if you have questions about Utilization Management issues

When L.A. Care makes a decision to approve or deny your care, this is called Utilization Management (UM). If you have questions about UM or our UM Process, you can call L.A. Care during business hours:

Monday through Friday, 8 a.m. to 5 p.m.
The number to call is 1-888-452-2273.
This call is free.

To learn more about how decisions about your care are made and services that need an OK, see your Member Handbook (also called "A Helpful Guide to Your Health Care Benefits").

L.A. Care Health Plan provides access to staff for members and practitioners seeking information regarding the Utilization Management process and the authorization of care.

UM staff is available during normal business hours Monday through Friday, 8:00 a.m. – 5:00 p.m. After hours staff is available for urgent requests and assistance to members and practitioners.

Referrals and Prior Authorizations
A referral is a request for health care services that are not usually provided by your PCP. All health care services must be approved by your PCP's PPG before you get them. This is called prior authorization. Prior authorization is required for all in-network and out-of-network providers.

There are different types of referral requests with different timeframes as follows:

Routine or regular referral – 5 business days
Urgent referral – 24 to 48 hours
Emergency referral – same day

Please call L.A. Care if you do not get a response within the above time frames.

The following services do not require a prior authorization:

Emergency services (go to *"Emergency Care Services"* section for more information)
Preventive health services (including immunizations)
Obstetrician and gynecological services in-network

All health care services are reviewed, approved, or denied according to medical necessity. Call L.A. Care's Member Services Department if you would like a copy of the policies and procedures used to decide if a service is medically necessary. The number is **1-855-270-2327**

Members and practitioners may use the toll-free number to communicate with UM staff. The toll free number is (877) 431-2273. Collect calls regarding UM issues are accepted.

Members who need language assistance to discuss UM issues may contact L.A. Care at (888) 839-9909 or TDD/TTY (866) 522-2731.

Additional instructions on how to obtain authorizations and communicate with UM staff are listed in your Member Handbook or L.A. Care Provider Manual.

Case Management and How to Self Refer

Care Management is a special program for helping members with chronic conditions or special health care needs such as diabetes, heart conditions, cancer or other medical or physical disabilities. Care Managers and Care Coordinators can help you:

- Make a plan for your care with your doctor
- Understand your health care benefits
- Organize your doctor and specialist appointments
- Locate community resources

For more information about care management, or to make a referral, call the L.A. Care UM Department at 1-877- 431-2273 and ask to speak with a Care Manager.

How to get specialty care when you need it, like services that require a referral, behavioral health services and hospital services

How to get care from a specialist

Your PCP doctor is the doctor who makes sure you get the care you need when you need it. Sometimes your PCP doctor will send you to a specialist. A "specialist" is a type of doctor who is an expert in some kind of health care. These specialists are within your PCP doctor and L.A. Care's network. If you need care from a specialist, your PCP doctor must approve these services before you receive them. Routine referrals to a specialist take up to five working days and rush referrals cannot take more than three calendar days (for example, when you need medical care right away or have an urgent condition). Female members who need Ob/Gyn care don't need their PCP doctor's okay to go to an Ob/Gyn or family planning doctor with L.A. Care.

Behavioral Health Care

Mental health services. Mental health services may include treatment for anxiety, behavior health problems, or depression. Your PCP doctor will provide you with some outpatient mental health services, within the scope of their training and practice. Specialized mental health services may be needed for services beyond your PCP doctor's training and practice. Specialized mental health services are provided through the Los Angeles County Department of Mental Health (LACDMH). You may receive services from LACDMH with or without a referral from your doctor. LACDMH may be reached toll free at 1-800-854-7771.

How to appeal a decision or ask for an independent review if you are denied services, coverage or benefits; or if you are disenrolled from your health plan

If you don't agree with the outcome of your grievance

If you do not hear from L.A. Care within 30 calendar days, or you do not agree with the decision about your grievance, you may request a State Fair Hearing and you may file a grievance with the Department of Managed Health Care (DMHC). For more information about State Fair Hearing, go to the "State Fair Hearing" section below. For information on how to file a grievance with DMHC, go to "Contacting the Department of Managed Health Care (DMHC)" section below.

How to file a grievance for health care services denied or delayed as not medically necessary

If you believe a health care service has been wrongly denied, changed, or delayed by L.A. Care because it was found not medically necessary, you may file a grievance. This is known as a disputed health care service.

Within five calendar days of receiving your grievance, you will get a letter from L.A. Care saying we have received your grievance and that we are working on it. The letter will also let you know the name of the person working on your grievance. Then, within 30 calendar days you will receive a letter explaining how the grievance was resolved.

Filing a grievance or requesting a State Fair Hearing does not affect your medical benefits. If you file a grievance or a request for a State Fair Hearing, you may be able to continue a medical service while the grievance is being resolved. To find out more about continuing a medical service, call L.A. Care.

If you don't agree with the outcome of your grievance for health care services denied or delayed as not medically necessary.

If you do not hear from L.A. Care within 30 calendar days, or you do not agree with the decision about your grievance, you may request a State Fair Hearing and you may file a grievance with DMHC. For more information about State Fair Hearing, go to the "State Fair Hearing" section below. For information on how to file a grievance with DMHC, go to "Contacting the Department of Managed Health Care (DMHC)" section below.

How to file a grievance for urgent cases

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of your health
- In urgent cases, you can request an "expedited review" of your grievance. You will receive a call and/or a letter about your grievance within 24 hours. A decision will be made by L.A. Care within three calendar days (or 72 hours) from the day your grievance was received.

You have the right to request an expedited "State Fair Hearing." You can request an expedited "State Fair Hearing" and file a grievance with or L.A. Care. For more information about State Fair Hearing, go to the "State Fair Hearing" section below.

You have the right to file an urgent grievance with DMHC without filing a grievance with L.A. Care. For information on how to file a grievance with DMHC, go to "Contacting the Department of Managed Health Care (DMHC)" section below.

If you don't agree with the outcome of your grievance for urgent cases

If you do not hear from L.A. Care within 30 calendar days, or you do not agree with the decision about your grievance, you may request a State Fair Hearing and you may file a grievance with the Department of Managed Health Care (DMHC). For more information about State Fair Hearing, go to the "State Fair Hearing" section below. For information on how to file a grievance with DMHC, go to "Contacting the Department of Managed Health Care (DMHC)" section below.

Independent Medical Review

You may request an Independent Medical Review (IMR) from DMHC. You have up to six months from the date of denial to file an IMR. You will receive information on how to file an IMR with your denial letter. You may reach DMHC toll-free at 1-888-HMO-2219 or 1-888-466-2219.

You may still request a State Fair Hearing if you request an IMR. However, you will not be able to use the IMR process if you have requested a State Fair Hearing. Go to the "State Fair Hearing" below to find out how to file a complaint.

There are no fees for an IMR. You have the right to provide information to support your request for an IMR. After the IMR application is submitted, a decision not to take part in the IMR process may cause you to lose certain legal rights to pursue legal action against the plan.

When to File an Independent Medical Review (IMR)

You may file an IMR if you meet the following requirements:

Your doctor says you need a health care service because it is medically necessary and it is denied; or
You received urgent or emergency services determined to be necessary and they were denied; or
You have seen a network doctor for the diagnosis or treatment of the medical condition, even if the health care services were not recommended.
The disputed health care service is denied, changed or delayed by L.A. Care based in whole or in part on a decision that the health care service is not medically necessary, and
You have filed a grievance with L.A. Care and the health care service is still denied, changed, delayed or the grievance remains unresolved after 30 days.
You must first go through the L.A. Care grievance process, before applying for an IMR. In special cases, the DMHC may not require you to follow the L.A. Care grievance process before filing an IMR. The dispute will be submitted to a DMHC medical specialist if it is eligible for an IMR. The specialist will make an independent decision on whether or not the care is medically necessary. You will receive a copy of the IMR decision from DMHC. If it is decided that the service is medically necessary, L.A. Care will provide the health care service.

Non-urgent cases

For non-urgent cases, the IMR decision must be made within 30 days. The 30-day period starts when your application and all documents are received by DMHC.

Urgent cases

If your grievance is urgent and requires fast review, you may bring it to DMHC's attention right away. You will not be required to participate in the health plan grievance process.

For urgent cases the IMR decision must be made within three calendar days from the time your information is received.

Examples of urgent cases include:

- Severe pain
- Potential loss of life, limb or major bodily function
- Immediate and serious deterioration of your health
- IMRs for Experimental and Investigational Therapies (IMR-EIT)

You can request an IMR-EIT through the DMHC when a medical service, drug or equipment is denied because it is experimental or investigational in nature. L.A. Care will notify you in writing that you may request an IMR-EIT within five days of the decision to deny coverage. You have up to six months from the date of denial to file an IMR-EIT. You may give information to the IMR-EIT panel. The IMR-EIT panel will give you a written decision within 30 days from when your request was received. If your doctor thinks that the proposed therapy will be less effective if delayed, the decision will be made within seven days of the request for an expedited review. In urgent cases the IMR-EIT panel will give you a decision within three business days from the time your information is received.

You may file an IMR-EIT if you meet the following requirements:

1. You have a very serious condition that is "lifethreatening" or "debilitating" (for example, terminal cancer).
2. Your doctor must certify that:

The standard treatments were not or will not be effective, or
The standard treatments were not medically appropriate, or
The proposed treatment will be the most effective.

3. Your doctor certifies in writing that:

A drug, device, procedure or other therapy is likely to work better than the standard treatment
Based on two medical and scientific documents, the recommended treatment is likely to work better than the standard treatment.

4. You have been denied a drug, equipment, procedure or other therapy recommended or requested by your doctor.
5. The treatment would normally be covered as a benefit, but L.A. Care has determined that it is experimental or investigational in nature.

To find out more, get help with the IMR or IMREIT process, or ask for an application form, please call L.A. Care.

You do not need to participate in L.A. Care's grievance process before asking for an IMR of a decision to deny coverage on the basis that the treatment is experimental or investigational in nature.

Contacting the California Department of Managed Health Care (DMHC)

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-888-839-9909 and use your health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible

for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The DMHC also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The DMHC's Internet website, http://www.hmohelp.ca.gov, has complaint forms, IMR application forms and instructions online.

State Fair Hearing

A State Fair Hearing is another way you can file a grievance. You can present your case directly to the State of California. All L.A. Care members have the right to ask for a State Fair Hearing at any time within 90 days of the incident. You may still request a State Fair Hearing if you request an IMR. However, you will not be able to use the IMR process if you have requested a State Fair Hearing. Go to the "IMR" section to find out more.

You may ask for a State Fair Hearing by calling toll-free 1-800-952-5253 (English and Spanish), or by writing to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

Expedited State Hearing

In cases of health services denials, you or your provider may ask for a faster decision through an Expedited State Hearing if your life, or health, or ability to attain, maintain or regain maximum function could be seriously risked by going through a standard State Fair Hearing. An emancipated minor, a parent on behalf of his/her minor child, and a duly-appointed guardian or conservator of a member may also request an Expedited State Hearing. Requests for Expedited State Hearings should be directed to:

Expedited Hearings Unit
California Department of Social Services
State Hearings Division
744 P Street, MS 19-65
Sacramento, CA 95814
Fax: 916-229-4267

You can also call the DPSS Los Angeles County office toll-free at 1-877-481-1044. If you do not speak English, please stay on the line and ask for the language you speak. DPSS has staff who speaks Armenian, Chinese, Russian, Spanish, Tagalog and Vietnamese. You may also write to:

Department of Public Social Services (DPSS)
State Fair Hearings Section
P.O. Box 10280
Glendale, CA 91209

Ombudsman Office

You may call the Ombudsman Office of the California Department of Health Services (CDHS) for help with grievances. The Ombudsman Office was created to help Medi-Cal beneficiaries to fully use their rights and responsibilities as a member of a managed care plan. To find out more, call toll-free 1-888-452-8609.

Arbitration: Solving problems without going to court

L.A. Care knows that some members wish to get health care services from a health plan that uses arbitration. When you choose arbitration, you give up the right to have your problem settled by a judge or jury. Many view arbitration as cheaper, quicker and better than the courts.

During arbitration, a neutral (unbiased) arbitrator will listen to everyone and make a decision. You and your doctor or health plan must follow that decision. That is why the process is often called "binding" arbitration.

The party that does not win will pay for the costs unless the arbitrator decides otherwise. That being said, the winning party will never be responsible for more than legal fees and costs or more than one-half of the costs.

L.A. Care may pay some or all of the fees and expenses of the arbitrator in cases of great financial hardship. Please contact L.A. Care for information and an application. Arbitration does not apply to claims or disputes about alleged medical malpractice.

Voluntary mediation

You may ask for mediation to resolve a grievance. An independent third person will resolve your grievance. This person is not related to L.A. Care. You and L.A. Care must agree to use the mediation process. You may ask for mediation, but L.A. Care may decline your request. You may still file a grievance with the DMHC even if you use mediation. You do not need to participate in L.A. Care's mediation process for any longer than 30 days prior to submitting a grievance to the DMHC. To request mediation, call L.A. Care.