ALAMEDA Alliance FOR HEALTH

Health care you can count on.
Service you can trust.

POLICY AND PROCEDURE

Policy Number	UM-050
Policy Name	Tracking and Monitoring of Services Prior Authorized
Department Name	Health Care Services
Department Officer	Chief Medical Officer
Department Owner	Director Utilization Management
Lines of Business	All
Effective Date	3/24/2016
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

POLICY STATEMENT

A. The Alliance maintains a specialty referral system to track and monitor referrals requiring prior authorization. The system includes authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system includes non-contracting providers.

B. Services and specialist referrals that may require prior authorization include:

- Out of network (OON) specialist referrals

Some in network specialists

C. Services which require PA is subject to change annually following approval from the Quality Improvement HealthEquity Committee (QIHEC)

D. The Alliance ensures that all contracting health care practitioners are aware of the referral processes and tracking procedures

E. The member's Primary Care Provider (PCP) or treating provider arranges and coordinates any specialty referrals or services which may require a prior authorization.

F. A monitoring process is in place to ensure those authorized services are completed in a timely manner.

PROCEDURE

A. The Alliance Utilization Management Program has an established tracking system for prior authorizations (PA) authorized, denied, deferred or modified for members

assigned to a Directly Contracted Provider (DCP).

B. The Alliance captures all inpatient and outpatient authorization requests for members assigned to a DCP in the Alliance Clinical Information Management system. Refer to Policy and Procedure UM-057 Authorization Service Requests process. The following information, at a minimum, is tracked:
    1. Services requested
    2. Date of request
    3. Date(s) of service(s) requested
    4. Diagnosis
    5. Requesting provider
    6. Rendering provider
    7. Date(s) of service(s) authorized

C. HealthCare Analytics runs a report monthly using data from the Clinical Information System to track, at a minimum, the following:
    1. Authorization turn-around times
    2. Authorization decision approved, partial approved, denied, and deferred
    3. Prior authorizations never utilized
    4. Authorizations for specialist referrals, including out-of-network

D. A monitoring report is in place to ensure those services authorized are utilized within the authorized time duration. The monitoring report identifies all authorizations without a corresponding claim by the mid-cycle of the authorization duration and 90 days following the end of the authorization period.

E. On a monthly basis, the monitoring report for unused authorizations is reviewed by the assigned UM Specialist.

F. For unused authorizations within 60 calendar days of the initial authorization, a reminder letter will be sent to all the members with an authorized service without a corresponding claim. The letter is to remind the member to obtain the authorized services before authorization expiration.
    1. A monthly report with applicable information is sent securely to our mail vendor to send out all letters. A confirmation report for each member is sent from the vendor to AAH for tracking
    2. A copy of reports and confirmation is maintained by the UM Manager.

G. For unused authorization that remain unused greater than 90 calendar days from the end of the authorization period with no corresponding claim, a reminder letter will be sent to the Member and/or Member's Representative and Requesting Provider informing them the authorization has expired and, if needed, how to obtain a new authorization.

Monitoring and Access

Every quarter, the monitoring report will be reviewed and presented to the UM-Subcommittee to evaluate whether there are access constraints for certain providers and

specialties. In addition, if there are certain members that have 100% open and unused authorizations, this may warrant case management to help coordinate the member's care.

Delegation Oversight

The Alliance adheres to applicable contractual and regulatory requirements and accreditation standards**.** All delegated entities with delegated utilization management responsibilities will also need to comply with the same standards. Refer to CMP-019 for monitoring of delegation oversight.

DEFINITIONS/Acronyms:

1) **Directly Contracted Provider (DCP):** provider directly contracted with the Alliance; the Alliance manages the care for members with a PCP directly contracted with the Alliance.
2) **Quality Imporvement Health Equity Committee (QIHEC**): committee comprising of medical services.
3) **Utilization Management Subcommittee:** monthly committee comprising of management from UM, pharmacy, and appeals department to discuss utilization metrics; reports up to QIHEC.
4) **Delegated entity**: entity the Alliance contracts with to perform utilization management functions.
5) **Out of Network (OON):** provider not contracted with the Alliance.

AFFECTED DEPARTMENTS/PARTIES

HealthCare Analytics
Utilization Management

RELATED POLICIES AND PROCEDURES

CMP-019 Delegation Oversight
UM-057 Authorization Service Request Process

RELATED WORKFLOW DOCUMENTS OR OTHE ATTACHMENTS

REVISION HISTORY

3/24/2016, 12/15/2016, 04/16/2019, 3/19/2020, 5/21/2020, 5/15/21, 5/20/2021, 6/28/2022, 9/18/2023, 04/25/2024

REFERENCES

MONITORING

The Compliance and Utilization Department will review this policy annually for compliance with regulatory and contractual requirements. All policies will be brought to the Quality Improvement Health Equity Committee annually.