

PCSD
Psychiatric Centers
At San Diego

PSYCHIATRIC CENTERS AT SAN DIEGO

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Reviewed and approved by the PCSD Board of Directors:

_____	_____
<i>(Name and title of Member of Board of Directors)</i>	<i>(Date)</i>
_____	_____
<i>(Name and title of Member of Board of Directors)</i>	<i>(Date)</i>
_____	_____
<i>(Name and title of Member of Board of Directors)</i>	<i>(Date)</i>
_____	_____
<i>(Name and title of Member of Board of Directors)</i>	<i>(Date)</i>
_____	_____
<i>(Name and title of Member of Board of Directors)</i>	<i>(Date)</i>

PCSD
Psychiatric Centers
At San Diego

TABLE OF CONTENTS

<i>Utilization Management Policy and Procedure</i>	3
Purpose and Intent/ UM Management and Philosophy	3
1. Definitions	3-4-5
2. Oversight of Utilization Management Program	5-6
3. Scope and Content of Utilization Management Program	6-7
4. Utilization Management Program	7-8
5. Access and Certification Procedures	9
6. Second Opinions	9-10
7. Continuity of Care/Terminated Providers	10
8. Denial Procedures	10-11
9. Appeal Procedures	11-12
10. Clinical Guideline Use	12
11. Interrater Reliability Testing	12
12. Confidentiality Requirements	13-14
13. Provider Satisfaction	14
14. Patient Satisfaction	14-15
15. Over/Under Utilization	15
16. New Technologies	15-16

Utilization Management Policy and Procedure

Purpose and Intent

To establish reasonable criteria for the structure and operation of PCSD's Utilization Management processes designed to facilitate assessment and ongoing management of health care services.

PCSD is committed to assuring that each patient member is afforded the opportunity to receive medically indicated treatment and care at the appropriate level. In an effort to assure consistent accomplishment of this goal, the Utilization Management (UM) Program is reviewed and modified annually. The program is updated when/if changes in processes occur as a result of changes, updates, and/or modifications of PCSD or legislative/regulatory agencies. The program assures that medically indicated patient care will be delivered in a timely and cost efficient manner and will comply with contracted health plan guidelines and regulatory agencies. Consistent monitoring of the delivery system will assure quality patient outcomes and patient satisfaction.

On an annual basis and as updates occur, this plan (which outlines the UM process) is distributed to contracted Health Plans, with the understanding that the process would be disclosed to Health Plan members upon request by the Health Plan. PCSD will also disclose to those patients who request a description of the Utilization Management Review process. (SB59)

1. Definitions

“Appeals Procedure” means a formal process whereby an attending physician, ordering provider or patient can appeal a Denial rendered by PCSD. Hospitals, other health care providers or a representative of the patient may assist in an appeal. *(Appeals relate primarily to treatment issues and are most typically brought forth by providers. See also Complaint Policy and Procedure.)*

“Behavioral Health Care Services” means services for the evaluation and treatment of psychiatric (including substance abuse) disorders.

“Certification” means a determination by PCSD that an admission or continued stay, or other Covered Behavioral Health Care Service has been reviewed and, based on the information provided, satisfies PCSD's clinical requirements for Medical Necessity, appropriateness, and level of care or effectiveness.

“Clinical Guideline” means systematically developed statements to help determine appropriate behavioral health care services for specific clinical circumstances. They have a sound scientific basis in the behavioral health clinical literature and reflect expert consensus. They are based on “best practices” for helping persons with behavioral health disorders to achieve stability, quality of life and recovery.

PCSD
Psychiatric Centers
At San Diego

“Clinical Peer” means a physician or other health care professional who holds a non-restricted license in the United States and practices in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

“Clinical Review Criteria” means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by PCSD to determine Medical Necessity and appropriateness of health care services.

“Concurrent Review” means Utilization Review conducted during a patient’s hospital stay or course of treatment.

“Covered Behavioral Health Care Service(s)” means services as defined by the appropriate group benefit plan.

“Denial” means a determination that an admission, continued stay or other Covered Behavioral Health Care Service has been reviewed and, based upon the information provided, does not meet PCSD’s clinical requirements for Medical Necessity and/or appropriateness, and level of care or effectiveness.

“Discharge Planning” means the formal process for determining, coordinating and managing the care a patient receives following discharge from a Facility.

“Emergency” A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. Seriously jeopardy to the health of the individual or, in the case of a pregnant women, the health of the women and/or her unborn child.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.
4. A risk to self or others.

The determination as to whether the Emergency existed will be made based upon the above definition.

“Facility” means an institution or health care setting rendering the prescribed health care service(s) under review. Facilities include, but are not limited to, hospitals and other licensed inpatient facilities, chemical dependency treatment centers, residential treatment centers, or other therapeutic health care settings.

“Medically Necessary” (also **“Medical Necessity”**) means services or supplies which are determined to be:

1. appropriate and necessary for the diagnosis or treatment of the behavioral health condition; and

PCSD
Psychiatric Centers
At San Diego

2. provided for the diagnosis or direct care and treatment of the behavioral health condition; and
3. within the standards of good medical/clinical practice within the organized medical/clinical community; and
4. the most appropriate supply or level of service can safely be provided; and
5. of measurable benefit to the patient receiving treatment.

“Patient” means a person eligible to receive benefits under a group benefit plan.

“PHI” means protected health information which is individually identifiable health information that is transmitted by electronic media or transmitted or maintained in any other form or medium (Federal Register, vol.65, no. 250, section 164.501).

“Provider/Clinician” means an individual health care professional independently licensed or certified in California to provide Behavioral Health Care Services as a physician/psychiatrist, psychologist, clinical social worker, marriage-family therapist, nurse practitioner, Registered Nurse or substance abuse counselor.

“Retrospective Review” means Utilization Review conducted after services have been provided to a patient, but does not include retrospective review of a claim, which is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

“Second Opinion” means an opportunity or requirement to obtain a clinical evaluation by a Provider other than the one originally making a recommendation for a proposed healthcare service to assess the Medical Necessity and appropriateness of the originally proposed health service.

“Utilization Review” means a set of formal techniques designed to monitor and evaluate the Medical Necessity and appropriateness of health care services, procedures and facilities. Techniques may include: Prospective Review, Second Opinion, Certification, Concurrent Review, Discharge Planning and Retrospective Review.

2. Oversight of Utilization Management Program

The PCSD Quality Management and Improvement Committee, as appointed and approved by the PCSD Board of Directors, will be responsible for overseeing PCSD’s Utilization Management activities.

The Quality Management and Improvement Committee appoints members of the PCSD Utilization Management Subcommittee, which is chaired by a senior licensed board-certified psychiatrist, with a current California license. The Committee composition also includes multidisciplinary clinicians and administrative staff. The Utilization Management Subcommittee, reporting to the Quality Management and Improvement Committee, will periodically review and revise the Utilization Management Program documents to assure ongoing appropriateness and will present the written Utilization Management Program to the Quality Management and Improvement Committee for

PCSD
Psychiatric Centers
At San Diego

approval no less than annually. The Program will include a description of all Utilization Management activities performed, as required by Section 3.

Periodically, but no less than semi-annually, the Quality Management and Improvement Committee or its designee(s) will review reports of Utilization Management activities, including appeals, and report such data to the PCSD Board of Directors.

3. Scope and Content of Utilization Management Program

Utilization data is continuously collected, trended and evaluated (from prospective, concurrent and retrospective reviews) in an effort to identify provider practice patterns (under and over utilization), quality and safety of care and service, access, member satisfaction and compliance with HMO, state and federal government standards. PCSD's UM Program incorporates the following:

1. Procedures to evaluate access, triage and referral, medical necessity, appropriateness and efficiency of health care services, level of care and effectiveness, and processes to detect under as well as over-utilization of services;
2. Job descriptions for the behavioral healthcare practitioners who review denials of care based on medical necessity. Each with education and experience in clinical practice with a current license to practice without restriction.
3. Data sources and Medical Necessity/Utilization Review criteria used in decision-making;
4. Review, revision, and adoption of Clinical Practice Guidelines annually with input from PCSD's practitioners;
5. Distribution of the Clinical Practice Guidelines to PCSD's providers;
6. Conduct appeals of adverse Utilization Review determinations;
7. Access for staff, patients, and practitioners seeking information about the UM process and the authorization of care.
8. Mechanisms to ensure consistent application of review criteria and compatible decisions;
9. Provisions for assuring confidentiality of clinical information;
10. Processes to periodically assess Utilization Review activities;
11. Review of all requests for new Clinical Technologies and new application of existing Technologies.

PCSD
Psychiatric Centers
At San Diego

12. Coordinate efforts with contracted health plans and other regulatory agencies to facilitate provider compliance with all quality of care, utilization management and reporting issues.
13. A staff position who is functionally responsible for day-to-day program management.

4. Utilization Management Program

PCSD's Utilization Management Program annually adopts Clinical Guidelines for inpatient and outpatient care as its Medical Necessity/Utilization Review criteria. These Medical Necessity/Utilization Review criteria will be reviewed annually, revised as necessary, and approved by the PCSD Board of Directors. The review criteria is available in each PCSD office and each Clinician signs a statement annually stating: "I understand PCSD has adopted these guidelines and they are available at any PCSD Office location as well as the Administrative Office."

- a) The Medical Necessity/Utilization Review criteria used in conjunction with a Denial will be made available, upon request, to affected Providers.
- b) The Medical Necessity/Utilization Review criteria will be made available, upon request, to authorized government agencies.

The Utilization Management Director, a licensed board-certified psychiatrist, who is a senior behavioral health practitioner will chair the Utilization Management Subcommittee. The UM Committee will meet bi-monthly and add additional meetings as necessary. Qualified health care professionals will administer the Utilization Review Program and oversee review decisions (job descriptions on file). Board-certified physicians will be utilized when appropriate. A licensed, board-certified psychiatrist will evaluate the clinical appropriateness of adverse Utilization Review decisions. The composition of the Utilization Management Subcommittee includes the following:

- i) Medical Director, Managed Care/Utilization Management
- ii) Ph.D., Clinical Practice Representative
- iii) Ph.D., Clinical Quality Assurance Representative
- iv) Floating Administrator
- v) Manager, Clinical Services

A quorum of one more than half of the filled positions on the Committee must be present either in person or via telephone for voting purposes. When Committee has three or less voting members, then all must be present either in person or via the telephone for voting purposes. Only Clinicians have a right to vote on clinical issues.

Contracted health plan representatives are allowed to attend meetings.

Utilization review decisions will be issued in a timely manner pursuant to the requirements of Sections 5 and 8.

PCSD
Psychiatric Centers
At San Diego

- c) PCSD will obtain all information required to make a Utilization Review decision, including pertinent clinical information and consultation with the treating Provider. UM approvals are based on the information available to the requesting provider at the time they provided care. The UM Committee ensures the frequency of reviews for the extension of initial determinations and is based on the severity or complexity of the patient's condition or on necessary treatment and discharge planning. PCSD will take into consideration the needs of the patient and the healthcare benefit package of the patient (as determined by the respective health plan and the patient's eligibility status with that health plan). The following factors will be considered when applying criteria to a given individual; age, co-morbidities, complications, progress of treatment, psychosocial situation and, home environment, when applicable. Characteristics of the local delivery system will also be considered including:
- Availability of alternative levels of care, such as intensive outpatient programs, outpatient detoxification programs or residential treatment centers in the organization's service area to support the patient after hospital discharge.
 - Coverage of benefits for alternative levels of care, such as intensive outpatient programs, outpatient detoxification programs or residential treatment centers where needed.
 - Ability of local providers to provide all recommended services within the estimated length of stay.

Treating Providers are required to submit requested information in a timely manner to facilitate the decision.

- d) PCSD will ensure that Medical Necessity/Utilization Review criteria are consistently applied.
- e) Determination of denial for services will be based on relevant clinical information and physician consultation, which reflect effective and efficient utilization practices. Denials will satisfy the requirements of Section 8.

PCSD will routinely assess the effectiveness and efficiency of the Utilization Management Program through its annual evaluation and revisions of Utilization Management Program and its policies and procedures, all supervised by the Quality Management and Improvement Program and work plan.

Data systems will be sufficient to support Utilization Management Program activities and to generate management reports to enable PCSD to effectively monitor and manage behavioral health care services. UM data/statistics are reported at least quarterly for review and recommendations.

PCSD
Psychiatric Centers
At San Diego

Utilization Management Program activities will be coordinated with other medical management activities including, but not limited to, quality assurance, credentialing, provider contracting, data reporting, member satisfaction assessment processes, provider satisfaction assessment processes and risk management.

When conducting Utilization Review, PCSD will collect only the information necessary to certify the admission, procedure or treatment, length of stay, frequency or duration of services to satisfy requirement of Section 5. *(See forms PCSD uses to review utilization of services, which demonstrate what information is gathered in order to make review decisions.)*

5. Access and Certification Procedures

Clerical staff answers PCSD's phones. The urgency of the call and level of care requested as determined by the caller (e.g. physician, nurse, clinician, patient, etc.) determines the need for clinical triage and referral (see Accessibility of Service/Appointment Availability policy). If the caller requests emergent or urgent services or a level of care other than outpatient, the on-call physician at the PCSD site triages the call and dispositions the care to the appropriate referral source. The Medical Director of Managed Care oversees PCSD's clerical staff to ensure they meet their responsibilities for access and triage.

Certification decisions regarding a proposed admission, continued stay or other Covered Behavioral Health Care Service will be made in compliance with the time lines specified. It is the responsibility of all parties involved in the Certification to facilitate this process. (For purposes of this section, "necessary information" includes the results of any Second Opinion that may be required or receipt of other factual or clinical information.)

Certification notices will be provided based on the policy and procedure for Timeliness Standards for Utilization Management Decision Making and Notification.

Concurrent review certifications of continued stay in a Facility or additional health care services will be communicated to the Provider via telephone or in writing within one business day of receipt of all information necessary to complete the review process.

Appropriate physicians conduct retrospective reviews of those cases that were not certified prospectively. Services offered to help screen and stabilize members where a prudent layperson, acting reasonably and who believed an emergency medical condition existed, will be taken into consideration in the decision making process for retrospective review. Written notification to the member and provider is made within five (5) working days of making the decision.

PCSD provides access to staff for enrollees, patients, and practitioners seeking information about the UM process and the authorization of care. To this end PCSD will have staff available eight hours during normal business days for inbound calls regarding UM issues. Inbound communication after hours is directed to voice-mail and fax machine. Staff identifies themselves for inbound and outbound calls using, name, title

PCSD
Psychiatric Centers
At San Diego

and organization name when call is regarding UM issues during normal business hours, unless otherwise agreed upon. Collect calls will be accepted when calls are regarding UM issues.

6. Second Opinions

It is the policy of PCSD to provide a consistent method for review and adjudication of requests for authorization for second opinions by an appropriately qualified health care professional if requested by a patient or a PCSD clinician that is treating that patient. PCSD will ensure appropriate and timely access to second opinions within the group.

Reasons for a second medical opinion may be provided:

- If the member questions the reason or necessity of recommended treatment.
- If the member questions a diagnosis or plan of care for a condition that threatens loss of life or substantial impairment, including, but not limited to a serious chronic condition.
- If clinical indications are not clear or are complex, a diagnosis is in doubt, or the treating practitioner is unable to diagnose the condition, and the member requests an additional diagnosis.
- If the treatment plan in progress is not improving the psychiatric condition within an appropriate period of time given the diagnosis and plan of care, and the member requests a second opinion regarding the diagnosis or continuance of the treatment.
- If the member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
- At the request of a PCSD Mental Health provider.

The UM Department at PCSD will assist the patient in finding an appropriate qualified healthcare professional, of the members choice, within the network, or will provide an out of network referral if there is not a network provider appropriately qualified to meet the patients needs.

PCSD ensures procedures are in place for expedient determination for second opinion. The timeframes for service delivery can be found in the Second Opinion Policy and Procedure.

A second opinion consists of one visit for a consultation or evaluation only, with all follow-up care and treatment to be directed back to the patient's primary PCSD Clinician.

7. Continuity of Care/Terminated Providers

It is the policy of PCSD to provide continuation of covered services rendered to a patient when treatment is interrupted due to termination of a provider. Best efforts will be made to provide the following:

PCSD
Psychiatric Centers
At San Diego

- Upon notification of the unscheduled termination of a provider contract, the Billing Supervisor will run a report that identifies all active patients currently in treatment, and send a letter indicating the change of provider.
- The provider with a terminated contract will meet with a clinician from the UM Committee to discuss transfer of care issues.
- The provider with a terminated contract will explain transfer of care to minimize anxiety.
- The provider with a terminated contract will review patient care issues with the newly assigned provider.
- The treatment provider will identify the new provider to the patient. Ideally, a face-to-face introduction with the new provider would be the best practice to minimize anxiety.

8. Denial Procedures

Denials of admissions, continued stays, and precertifications of non-urgent care or other Covered Behavioral Health Care Services will be clearly documented including:

- The specific reasons for the denial in easily understandable language.
- A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial was based.
- Notification that the enrollee upon request can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.

All denial timeframes can be found in UM policy Timeliness Standards for Utilization Management Decision Making and Notification. The Clinician is notified upon denial there is a UM reviewer available to discuss any UM denial decision and how to contact the reviewer.

Retrospective review denials will be issued after obtaining all necessary information on the Denial, and will include the reason(s) for the determination.

Written notice of a Denial will include a description of the appeal procedures, and instructions for initiating an appeal.

Since PCSD's contracted Providers are required to provide treatment as the Provider deems appropriate, care to the patient will not be withheld or denied, but rather reimbursement to the Provider will be withheld or denied if services are no longer deemed Medically Necessary as determined through the Utilization Review processes.

When reimbursement for care is denied to PCSD's Providers, written notification will be sent to the patient (or patient's guardian or representative) within one business day of the Denial. This notice will include a description of the Appeal Procedures, and instructions for initiating an appeal. (*See Patient Complaint Process under Member's Rights and Responsibilities.*)

At this time PCSD does not issue denials for BHA/MHN cases.

PCSD
Psychiatric Centers
At San Diego

9. Appeal Procedures

PCSD's written procedures for standard and expedited appeals of decisions not to certify an admission, continued stay, or other Covered Behavioral Health Care Service reflect PCSD's standards for timely response to the Providers. An appeal of a Denial, which contains time frames and other procedural information, must be filed with PCSD within 180 days of PCSD's written notification of the Denial.

Appeals will be evaluated by a member of the clinical team of the Utilization Management Subcommittee or an appropriate Clinical Peer professional in the same or similar specialty as would typically manage the case being reviewed. The Clinical Peer will not have been involved in the initial Denial.

For standard appeals, PCSD will notify in writing affected provider(s) and the patient of the decision on the appeal. Notice will be timely, but in no event more than twenty (20) working days following the request for appeal. In the event a second level appeal is requested the IPA or Health Plan will be notified within two (2) days of receipt of the information.

An expedited appeal is available only when the standard appeal process would cause a delay in care that could be detrimental to the health of the patient or the patient believes the delay would jeopardize his health. For expedited appeals, PCSD will make every reasonable effort to process the request within one business day. These efforts may include requests for additional information which PCSD will accept over the telephone with written documentation to follow via facsimile as may be requested by PCSD. PCSD will issue a decision no later than one business day following receipt of all necessary information. It is the responsibility of all parties involved in the appeal to facilitate this process.

In the event a Health Plan did not delegate appeals to PCSD, all requests for appeals will be forwarded to the appropriate health plan.

At this time PCSD is not delegated for any appeals by any entity.

10. Clinical Guideline Use

The Utilization Management Committee reviews available Clinical Guidelines for adoption. The guidelines must be based on reasonable scientific evidence and knowledge of the best practices for treating behavioral health disorders. The Committee selects, approves and recommends adoption to the Quality Improvement Committee and the Board of Directors. This is a provider-driven process, therefore the guidelines are adopted with input from clinicians.

Once approved, the Utilization Management Committee provides copies to each PCSD office, and requests a signed statement from each provider that they have read the guidelines. The guidelines are made available to patients, contracting medical groups, and government agencies, upon request.

PCSD
Psychiatric Centers
At San Diego

The Utilization Management Committee may reference the guidelines for assistance in decision-making in utilization management, member education, interpretation of covered benefits, and other areas to which the clinical guidelines are applicable.

The Utilization Management Committee reviews the guidelines annually and revises them as necessary. Any revisions are sent to Utilization Management Committee for review and final approval by the PCSD Board of Directors prior to implementation.

Annually, the Utilization Management Committee measures adherence to at least two of the guidelines.

11. Interrater Reliability Testing

The PCSD Utilization Management Committee conducts quarterly audits on all non-MD Clinicians on the Committee involved in the utilization review decision-making process. MD audits are conducted two times each year. The purpose of the evaluations are to measure the reviewer's comprehension of the Clinical practice Guidelines and to ensure accurate and consistent application of the criteria among the reviewers.

The results of the interrater reliability testing are presented to the Utilization Management Committee. A threshold of 80% agreement is needed. Measurement tools which assess reviewer interpretation and consistent application of the clinical practice guidelines are developed by the Utilization Management Committee. The measurement tools and results will be shared with contracted Medical Groups and Health Plans upon request.

12. Confidentiality Requirements

The proceedings of the PCSD Utilization Management Committee and their derivative documents are considered confidential and protected from discoverability under Section 1157 of the California Evidence Code. Members of the Committee have a duty to preserve this confidentiality. The protections afforded under EC 1157 are as follows:

- The proceedings and records of an organized medical committee having the responsibility of evaluation and improvement of the quality of care shall not be subject to discovery.
- The California Civil Code Section 43.97 also confers immunity from liability to peer reviewers in connection with peer review actions properly reported pursuant to Business and Professions Code Section 805. Additionally, the federal Health Care Quality Improvement Act (42 U.S.C. Section 11101, et seq.) confers broad immunity to the professional bodies that participate in peer review activities, pursuant to established criteria.
- All committee minutes, reports, audits, studies, and quality of care review documents are labeled "Confidential." All issues and associated documents related to Quality Improvement Program activities are considered confidential and shall be kept in an area not readily accessible to the general public.

PCSD
Psychiatric Centers
At San Diego

- Distribution of specific documents is restricted to designated administrative personnel, committee chairs, and managed care representatives. Audit/study results, either complete or a portion of, will be disseminated, as appropriate, for purposes of education, corrective action, and practitioner feedback.

The Utilization Management Committee members must abide by the Medical Information Act in maintaining the confidentiality of the patient's medical information. All employees, including all PCSD clinical staff, will maintain the standards of ethics and confidentiality regarding both patient information and proprietary information.

In reviewing authorization requests, PCSD practitioners may be asked to review patient medical records. All practitioners who participate in Utilization Review or in the committee structure are required to sign a confidentiality statement and will excuse themselves from reviewing cases in which they were actively or personally involved. If potential for conflict of interest is identified, another qualified reviewer will be designated as an Ad-Hoc Member.

Only authorized persons will be allowed access to Utilization Management Committee information. Third party reviews of minutes are restricted to state and federal auditors and accreditation teams. Contracting HMOs and review organizations shall be allowed limited access to Utilization Management Committee meetings and/or documentation related to their members. A confidentiality statement must be signed by all guests prior to the meeting.

All utilization review files and patient medical records used in reviewing information will be kept in locked cabinets located in the Utilization Management office. The cabinets are maintained by the Utilization Management Department and will be used to house any patient charts/medical records being reviewed.

Patient information may not be released to any organization without prior written consent received from the patient, unless the release of such information is required by law. Any patient specific medical information used in the utilization, quality or peer review process is protected from disclosure.

PCSD will dispose of any and all patient medical information by shredding such information. Any patient information will not be shared, sold or used for any purpose other than providing quality health care services for that patient. No patient shall be required, as a condition of receiving health care, to sign an authorization, release or consent permitting the disclosure of any medical information.

PCSD will work collaboratively with all contracted medical groups and health plans in providing and maintaining confidentiality of PHI (protected health information) in all outpatient settings. Requests for such information will not be released unless there is a signed release by the patient or their authorized agent. Patients may refuse to have consults forwarded from their PCSD provider to their primary care provider.

PCSD
Psychiatric Centers
At San Diego

13. Provider Satisfaction

PCSD conducts provider satisfaction surveys annually. The surveys are sent to all PCSD providers so that a fair assessment can be conducted on the level of satisfaction with the PCSD system. The survey requests information on the satisfaction level of providers with the Utilization Management process.

Results of the Provider Satisfaction Survey are forwarded to the Utilization Management Committee from the Quality Improvement Committee and the Board of Directors. Those areas not achieving satisfactory results are reviewed for system changes and modifications as appropriate

14. Patient Satisfaction

Patient Satisfaction Surveys are performed routinely and aggregate data is collected and presented to the Quality Improvement Committee and the Board of Directors on an annual basis.

Surveys are conducted monthly. The patient is contacted to determine his/her perception of the care they received, as well as his/her satisfaction level with the Utilization Management process. Any immediate problems identified are handled as a Quality Issue, investigated and followed up as appropriate by the Marketing/Professional Staff Liaison.

Utilization and referral issues identified are discussed in the Utilization Management Committee meetings and the Committee reviews all documentation and determines what actions, if any, are appropriate for system modifications.

15. Over/Under Utilization

PCSD is committed to assisting providers in the identification of over and under utilization of services. PCSD monitors over and under utilization by developing reports with aggregate data such as:

- Bed Days per Thousand
- Admits per 1000
- Re-admission
- Study and analysis of specific ambulatory services provided.

The Utilization Management Committee will address evaluation of over and under utilization of services, and if action is required, the Quality Improvement Committee and/or the Board of Directors will further review and approve.

- Reports are generated quarterly and submitted to the UM Committee based on claims data.
- The Committee may request focused audits to identify specific departments, providers, or sites at which the over/underutilization is occurring.

PCSD
Psychiatric Centers
At San Diego

16. New Technologies

PCSD would like to have the opportunity to provide input or influence contracted Medical Groups, in the design of behavioral healthcare benefits to include new technologies or the application of existing technologies.

In this effort PCSD will solicit responses from contracted Medical Groups regarding committee membership on an existing committee reviewing New Technologies in the evaluation of :

- Medical technologies
- Behavioral health procedures
- Pharmaceuticals
- devices

The Utilization Management Committee will review requests from any PCSD provider submitting a request for use of a new technology or new application of an existing technology. This will be accomplished by:

1. Review request in Utilization Management Committee.
2. Determine whether the request is a covered benefit.
3. Confirm that the appropriate government regulatory bodies (e.g., FDA) have assessed the new technology when such a review is required by law.
4. Conduct a complete review of available clinical literature, published scientific evidence (e.g., computerized search).
5. Seek input from relevant specialists and professionals who have expertise in the technology.

PCSD
Psychiatric Centers
At San Diego