Policy Title: Referral and Authorization **Policy Number: UM 100**

Department: Utilization Management (UM) **Version: 8**

Product Line(s):	☒ All	☐ Medi-Cal	☐ Medicare
Age Limitations:	☒ None	☐ Under 21	☐ Other

Purpose

The purpose of this policy is to establish a standardized process used to determine medical necessity of non-urgent admissions; selected outpatient and office procedures; durable medical equipment; ancillary activities (i.e. Home Health, Physical Therapy, Occupational Therapy, Speech Therapy, etc.); and other selected services. AmericasHealth Plan (AHP) performs pre-authorization review as delegated in its contract and/or Memorandum of Understanding (MOU) with health plan partners and other entities. This policy shall also ensure the timeliness of the authorization process in compliance with local, state, and federal regulatory requirements.

Definitions

1. **Urgent/Emergent Care** – Required when a member's condition is such that the member faces an imminent and serious threat to his or her health.
2. **Medically Necessary** – Medical, vision, dental, behavioral, rehabilitative, or other health care services which:
    - Are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitation in function, cause illness or infirmity, endanger life, or worsen a disability.
    - Are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's medical conditions.
    - Are consistent with the diagnoses of the conditions.
    - Are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency and independence.
    - Will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age.
3. **Organization Determination** – Any decision made by a health plan with respect to any of the following:
    - Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services.
    - Payment for any other health services furnished by a provider other than the health plan that the enrollee believes are a covered benefit, or, if not a covered benefit, should have been furnished, arranged for, or reimbursed by the health plan.
    - The health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the health plan.
    - Reduction or premature discontinuation of a previously authorized ongoing course of treatment.

- Failure of the health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

4. **Standard Request** – A standard treatment authorization request from a member's PCP or specialist. Standard requests should be processed as soon as medically indicated, and not to exceed a maximum of within fourteen (14) calendar days after receipt of request.
5. **Expedited Request** – A treatment request when applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or if a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. Expedited requests may also apply to prescription injectable/infusion drug pre-service requests that fall under AHP's division of responsibility, such as Part B, and must be made in a timely fashion, not to exceed seventy-two (72) hours after receipt of request, in compliance with CA Health & Safety Code 1367.241(a).
6. **Quality Improvement Organization (QIO)** – Organizations comprised of practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities (SNF), home health agencies (HHA), Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs, and comprehensive outpatient rehabilitation facilities (CORF).
7. **Reconsideration** – The enrollee's first step in the appeal process after an adverse organization determination; a health plan or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
8. **Representative** – An individual appointed by an enrollee or other party, or authorized under state or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of an enrollee or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described in 42 CFR Part 405.
9. **Partially Favorable Decision** – A decision made when an item or service was partially covered. For example, if a claim has multiple line items, some of which were paid and some of which were denied, it would be considered partially favorable. Also, if a pre-service request for ten (10) therapy services was processed, but only five (5) were authorized, this would be considered partially favorable.
10. **Adverse Decision** – A decision made when an item or service was denied in whole.
11. **Reopening** – Remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.
12. **Cancellation** – Occurs when an authorization request was entered in error (i.e. Duplicate entry, data entry error, etc.) and requires no review. Upon cancellation, physicians may be notified verbally, in writing, or electronically.
13. **Post-Service Decision** – Any review for care or services that have already been received.
14. **Concurrent Review** – Any review for an extension of a previously approved ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care. In the event of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of AHP's decision and an appropriate care plan has been agreed upon by the treating provider.

Policy

The determination of medical necessity directs the process for authorization of all covered services that require pre-authorization for all members enrolled with, or otherwise assigned to, AmericasHealth Plan

(AHP). AHP maintains established processes to manage authorization requests, utilizing properly experienced and credentialed staff with clearly defined roles, expectations, and turnaround times.

Procedures

UM STAFF, QUALIFICATIONS, AND RESPONSIBILITIES

The Utilization Management (UM) Department shall maintain staff ratios sufficient to support AHP's needs. The UM staff shall be comprised of, at minimum, but not exclusive to, the following positions:

Chief Medical Officer (CMO) / Medical Director

The Chief Medical Officer/Medical Director is the designated senior physician with a current unrestricted license to practice in the State of California. The CMO shall have oversight authority of both professional and clinical operations of the UM Department and shall be responsible for development and implementation of the UM Program. UM staff shall have the ability to confer with the CMO and utilize the CMO's expertise as a resource to provide direction for interpretation of benefits and coverage. Additionally, the CMO shall conduct, at minimum, weekly prospective, concurrent, and retrospective review with UM staff.

The CMO shall maintain the right and authority to approve, modify, defer, or deny services based upon medical necessity, timeliness, and appropriateness of treatment. The CMO shall review all cases and requests that do not meet criteria for approval and denies services when not a covered benefit or not medically indicated.

The CMO is responsible for the ongoing monitoring and evaluation of the UM Department. To this end, the CMO shall have active participation in the inter-rater reliability auditing process to verify the consistent application of utilization review criteria and decision-making, as well as issue corrective actions, as necessary.

The CMO shall have the authority to designate a Physician Reviewer; a physician with a current unrestricted license to practice in the State of California to perform reviews and make determinations, including denial, of all cases and requests that do not meet criteria for approval based on established clinical criteria and/or health plan covered benefits. The CMO, or their designated physician reviewer, is available to discuss UM decisions with physicians and providers involved in the request or provision of services to AHP members.

Physician Reviewer(s)

AmericasHealth Plan (AHP), or its delegated entity, has California licensed physician reviewers, designated by the Chief Medical Officer (CMO), involved in utilization review and/or clinical decision-making. AHP's physician reviewer(s) are available to the requesting provider for consultation regarding clinical issues, practice guidelines, utilization review criteria, or UM determinations made by the physician reviewer(s). AHP maintains a list of board-certified physicians with which the physician reviewer(s) or CMO may consult. AHP's Physician Reviewer(s) shall not, under any circumstances, be involved in the handling, processing, or decision-making related to Grievances and Appeals (G&A). AHP shall maintain full separation of responsibilities between the Physician Reviewer and the physician responsible for overseeing the G&A process.

Director of Utilization Management / Medical Management

The Director of Medical Management (the Director) holds an unrestricted California Registered Nurse license, is certified in utilization review, and is responsible for the operational execution of the UM Program under the direction of the CEO and the Chief Medical Officer/Medical Director. The Director assists in the development and maintenance of the UM Program in conjunction with the Chief Medical Officer/Medical Director and the Director of Health Services. The Director oversees clinical and utilization studies. The scope of the Director's UM responsibilities include the following:

1. Maintaining compliance with regulatory and accreditation standards.
2. Managing and training UM staff.
3. Coordinating monitoring activities, both internal and external, of UM metrics including turn-around-times, denial rates, appeal rates, over/under utilization data including admissions, readmissions, bed days, ER rates, length of stay, catastrophic, observation days, administrative days, Long Term Acute Care (LTAC) utilization, Acute Rehabilitation Unit (ARU) utilization, and Skilled Nursing Facility (SNF) utilization.
4. Maintaining professional relationships with colleagues from other Medi-Cal Managed Care Plans and sharing information about requirements and successful evaluation strategies.
5. Maintaining communications with the Department of Health Care Services (DHCS), Department of Managed Health Care (DMHC), and Centers for Medicare and Medicaid (CMS), as applicable.
6. Maintaining professional relationships with health plan partners, ensuring coordination of referrals, and providing assistance with complex case management, as needed.
7. Developing and maintaining professional relationships with California Children Services (CCS) and Tri-Counties Regional Centers.
8. Acting as a resource to all departments that have involvement with UM-related activities.
9. Coordinating after-hours and/or weekend staff availability sufficient to respond to inpatient transfer requests or other urgent matters for which a delay in response may result in adverse outcomes to the member.
10. Support all regulatory audit and delegation oversight activities relating to Utilization Management, including the procurement of documents, developing corrective action plans, implementation of interventions, and ongoing monitoring.
11. Manage UM staff and provide oversight for outbound call campaigns to outreach members recently discharged from an acute facility or Emergency Department to assist member with care coordination and post-discharge follow-up care.
12. Oversee Case Management Department activity involving the outreach, care coordination, and case management of high-risk members identified via disease-specific claims data (i.e. members with End-Stage Renal Disease, members receiving dialysis services, members pre- and post-procedure for major organ transplant services, etc.).

Manager of Case Management

Under the direction of the Director of Medical Management, the Manager of Case Management is responsible for the daily oversight and management of case managers and care coordinators. The Manager of Case Management's duties include, but are not limited to, the following:

1. Manages inpatient and outpatient case management activities aimed to improve delivery of clinical services, as well as meet government and regulatory requirements.
2. Continuously evaluates data outcomes, identifying alternatives, preventing unnecessary costs and services while ensuring quality care, and patient satisfaction.
3. Responsible for performance improvement monitoring.
4. Reviews DOFR and delegation grids for application in work processes.
5. Ensures compliance with regulatory requirements and application of clinical decision support criteria for utilization activities deemed by Federal, State and other regulatory and accreditation agencies. This includes use of appropriate letters, (i.e. denial letters, NOMNC, DENC letters, etc.).
6. Assist and help with gathering information for the Managed Care Accountability Set (MCAS), Medicare Five Star, Corrective Action Plans, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcome Surveys (HOS).
7. Performs supervisory audits as necessary to ensure compliance with all external and internal CM requirements and ensures the quality of CM provided to members/beneficiaries.
8. Hires, trains, coaches, counsels, and evaluates the performance of direct reports.
9. Improves on the effectiveness and efficiency of CM staff, through process improvements activities.
10. Participates in on-site and/or web-based health plan audits as scheduled.
11. Responds to Corrective Action Plan (CAP) as issued by contracted health plans.

12. Collaborates with compliance team to ensure audit thresholds are met and compliance issues are identified for prompt resolution.
13. Participates in interdepartmental and cross-functional meetings as needed.
14. Supports and oversees the Complex Case Management Program.
15. Manages and provides oversight for the Transitional Care Program and activities.
16. Oversees the Model of Care (MOC) program, in conjunction with health plan partners and in support of Special Needs Plan (SNP) population.
17. Participates in projects and activities outlined by the UM Work Plan and QI Work Plan.
18. Contributes to quality of care projects including, but not limited to, the following:
    A. Post-Emergency Room (ER) Discharge Project
    B. Improvement of quality measures (i.e. MCAS, Five Star) and providing or participating in educational activities and improvement projects/programs focused on quality.

Manager of Utilization Review

Under the direction of the Director of Medical Management, this position is responsible for overseeing and managing the day-to-day operations of the Utilization Management Department, health plan delegated activities, and medical management initiatives.

1. Oversees referral/authorizations, denial processes, and correspondence with member and provider.
2. Responsible for performance improvement monitoring.
3. Reviews DOFR and delegation grids for application in work processes.
4. Ensures compliance with regulatory requirements and application of clinical decision support criteria for utilization activities deemed by Federal, State and other regulatory and accreditation agencies.
5. Ensures proper interpretation, application, housing, and upkeep of UM clinical criteria and guidelines.
6. Performs trouble-shooting when difficult situations arise and takes independent action to identify a resolution.
7. Assist and help with gathering information for the Managed Care Accountability Set (MCAS), Medicare Five Star, Corrective Action Plans, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcome Surveys (HOS).
8. Manages special projects, i.e. Osteoporosis HEDIS measure, etc.
9. Oversees activities of utilization review as applicable to delegated entities which include retroactive authorizations and retroactive claims.
10. Reviews policies and procedures and desktop procedures annually for regulatory compliance.
11. Develops desktop procedures and workflows and ensures education is completed.
12. Monitors and analyzes the productivity and quality of utilization management operations, while providing ongoing feedback and education for the staff.
13. Performs audits of utilization management based on health plan compliance needs.
14. Assist with coordinating delegation oversight audit requests, focus audit requests, and/or corrective action plans.
15. Works collaboratively with the entire organization to be in a state of continual readiness for Delegation Oversight Audits performed by health plans for various functions.
16. Uses and/or oversees the use of data analysis and process improvement tools to monitor and improve performance.
17. Participates in projects to identify and address outlier metrics in authorization processing.
18. Oversees programs related to prior authorization, retro authorization, and claims review processes.
19. Assists with Provider Dispute Resolutions (PDR), as needed.

Clinical UM Staff

Clinical UM staff members include Utilization Management/Case Management Nurses. California licensed Registered Nurses may authorize services under the direction of the Chief Medical Officer/Medical Director, but do not make medical necessity or benefit denial determinations. UM/CM Nurses apply UM criteria to make decisions and utilize their clinical knowledge while considering the individual needs of the members. The UM/CM Nurses manage cases for both inpatient and outpatient members with illnesses/diseases requiring medical care coordination. The UM/CM Nurses collaborate with physicians, providers, vendors, members, community agencies, and others as appropriate to effectively coordinate the members medical care. The Chief Medical Officer/Medical Director or their designee is available to the nurses for consultations and determines all medical necessity and benefit determination denials.

Non-Clinical UM Staff

Non-clinical UM staff include UM Coordinators, UM Clerks, and Administrative Assistants. Non-clinical staff process approvals and referrals that do not require clinical interpretation. Non-clinical staff triage incoming referrals with guidance from a licensed nurse. The UM Program has staff support for administrative, computer, and analytical work, such as coordinating data for UM studies and reports. Staff members who are not qualified healthcare professionals may collect data for preauthorization and concurrent review under the supervision of appropriately licensed healthcare professionals. They may also have the authority to approve (but not to deny) services (auto authorization list) for which there are explicit rules and processes established.

REQUESTING AUTHORIZATION

Authorization requests shall be submitted to AmericasHealth Plan (AHP) via web portal, fax, mail, or phone. The member, the member's authorized representative, or member's physician may submit an authorization request to AHP for review. If submitting by hard copy, an AHP provider shall use the standardized prior authorization request form.

Providers shall obtain authorization for all services that are *not* listed on the Direct Referral List. The Direct Referral List includes, but may not be limited to, the following:

1. Emergency services
2. Preventive services
3. Direct access to in-network women's health for routine and preventive services
4. Crisis stabilization (including mental health)
5. Urgent care (outside of the service area)
6. Routine Hospice
7. Out-of-area renal dialysis services (Medicare)

The requesting physician shall submit timely authorization requests with the required information for processing, such as member information and medical necessity documentation. The physician shall indicate whether the request is standard or expedited based on the urgency of the requested service(s). In the event of an expedited or urgent request, the form shall be marked "Urgent" and the UM Department shall be notified via telephone that an urgent request has been submitted.

Providers shall determine member eligibility, benefit coverage, medical appropriateness, necessity and level of care prior to submitting the request. Providers shall be educated on AmericasHealth Plan (AHP) processes and protocols regarding authorization referrals through various methods such as the AHP provider manual, AHP website, and in-person training with AHP Provider Relations staff at time of contracting. These delivery methods and trainings shall ensure the delivery of detailed instructions describing the authorization process for standard, expedited, and other elements, as well as the specific services that require prior authorization. The necessary documents, forms, and templates needed to submit an authorization request shall be shared with all contracted providers. Any updates to the process, such as the pre-established algorithm list, industry changes, and so forth, shall be communicated in writing to all contracted providers and affected departments at least thirty (30) days prior to any changes taking effect.

Referral requests received from a member or a member's authorized representative shall be received through Member Services. Member Services shall communicate between the member and the Utilization Management Department. Member Services shall inform the member of required elements to properly request the service. The member must have a completed Authorization of Representative Form, and will follow the same required procedures as all requesting providers.

Members shall be referred to providers within AHP's network, which include only those providers listed on the specialist roster. The specialist roster is a list of all AHP contracted and credentialed providers. In the event that AHP does not have an active contract in place with a specific specialty, or the location of the specialist office does not meet the member's needs, the UM Coordinator shall work with appropriate department/designee, such as Network Contracting, to locate a specialist and sign a Letter of Agreement (LOA). In some cases, the UM Coordinator and Provider Services may contact the appropriate health plan partner for direction to a provider that is contracted with the health plan partner.

PROCESSING AUTHORIZATION REQUESTS

The Utilization Management (UM) Coordinator shall receive standard and expedited requests for prospective, concurrent, and retrospective services. Upon receipt of an authorization request, the UM Coordinator shall verify eligibility, benefits, and required information for processing. This includes, but is not limited to, the verification of the following elements:

1. Member Name
2. Member Address
3. Member Telephone Number
4. Member ID
5. Diagnosis codes (ICD-10 or other) being requested
6. Service codes (CPT or other) being requested
7. Requested Provider Name
8. Requesting Provider Name
9. Requesting Provider Tax Identification Number (TIN)
10. Requesting Provider Phone Number
11. Requesting Provider Fax Number
12. Relevant clinical information (for utilization review purposes)

Once the required information and eligibility have been verified, the UM Coordinator shall ensure that all requests, including verbal requests, are documented and maintained in case-specific files within the prior authorization application in the UM system (QuickCap). The UM Coordinator shall refer each case appropriately based on the information available. The UM Coordinator may determine any of the following:

1. **The member is not eligible** – If the member is not eligible, the UM Coordinator shall contact the referring provider and direct them to contact the member for clarification of coverage/assigned PCP.
2. **The requested service is not a covered benefit** – If the requested service is not a covered benefit, the UM Coordinator shall forward the case to a UM Nurse for further review.
3. **The requested service does not meet criteria** – If the requested service does not meet criteria, the UM Coordinator shall refer the authorization to a UM Nurse for further review.
4. **The requested service meets criteria** – If the requested service meets criteria, the UM Coordinator shall approve the authorization under the direction of a UM Nurse.
5. **The requested provider is non-contracted / out-of-area** – If the requested provider is non-contracted or out-of-area, the UM Coordinator shall forward the case to a UM Nurse for further review.
6. **The requested service cannot be approved for other reasons** – If the requested service cannot be approved for any other reasons not listed above, the UM Coordinator shall forward the case to a UM Nurse for further review.

The UM Coordinator utilizes pre-established algorithms to make approval determinations. Only a physician with an unrestricted license to practice in California may make the decision to deny an authorization request.

Routine authorization requests shall be reviewed in the order in which they are received. Expedited requests shall be given priority and shall be reviewed on the date of receipt.

UTILIZATION REVIEW PROCESS & DECISION-MAKING

Qualified licensed health professionals assess clinical information to support UM decisions. AHP consistently gathers information in order to support the UM decision-making process. AHP also includes collection of relevant clinical information to support behavioral healthcare UM decision-making and support pharmacy UM decision-making. The clinical information to be obtained shall include, but not be limited to, the following:

1. History of presenting problem
2. Clinical exam
3. Findings, diagnostic testing results, treatment progress notes, and psychosocial history
4. Consultations with the treating practitioner
5. Evaluations from other health care practitioners and providers
6. Photographs, operative reports, and pathological reports
7. Rehab evaluations
8. Printed copy of criteria related to the request
9. Relevant information regarding benefits for services or procedures
10. Relevant information regarding the local delivery system
11. Relevant information from patient, authorized representative, and/or responsible family members.

Using approved guidelines, the UM Nurse reviews the authorization request to confirm that it meets the established criteria. The UM Nurse shall apply approved guidelines and criteria in a systematic hierarchy when reviewing each case. The UM Nurse shall make a determination to approve the authorization request if it meets criteria. If the authorization request does *not* meet criteria, then the UM Nurse shall forward the case to the Physician Reviewer. The authorization request may fail to meet criteria if:

1. The requested service is not medically necessary.
2. The requested service is not a covered benefit.
3. The requested service is considered experimental or investigational.
4. The requested provider is out-of-network.

Upon receipt of the authorization request from the UM Nurse, the Physician Reviewer shall review the information necessary to make a determination. A panel of board-certified specialists is available to the Physician Reviewer or Medical Director for consultation to assist in making determinations of medical appropriateness. The Physician Reviewer's determination will result in one of the following:

1. **Approve** (Favorable Decision)
2. **Deny** (Adverse Decision) for lack of medical necessity.
3. **Modify** (Partially Favorable) if only a portion of the request is approved.
4. **Deny** because the service is not a covered benefit.

Only a licensed physician, psychiatrist, or doctoral level clinical psychologist may deny or modify a request based on medical appropriateness.

The Physician Reviewer shall document their decision in the UM system and shall submit the case to the UM Nurse with appropriate instruction. The UM Nurse shall make changes to the status field to approve or deny the request based upon the Physician Reviewer's instruction.

SNF service requests shall not be denied based on the absence of potential for improvement or restoration of the member's condition.

DECISION-MAKING TIMEFRAMES

AmericasHealth Plan (AHP) adheres to the following timeframes for timeliness of Non-Behavioral, Behavioral, and Pharmacy UM decision-making:

- For **urgent concurrent** review, the organization makes decisions within twenty-four (24) hours of receipt of the request.
- For **urgent preservice** decisions, the organization makes decisions within seventy-two (72) hours of receipt of the request.
- For **non-urgent preservice** decisions, the organization makes decisions within fifteen (15) calendar days of receipt of the request.
- For **post-service** decisions, the organization makes decisions within thirty (30) calendar days of receipt of the request.

Determinations for expedited authorization requests shall be made by AHP as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours after receiving the request.

INSUFFICIENT INFORMATION

An authorization request may be placed in a "pended" or "extended" status if the UM Department is unable to make a determination with the information available. If an authorization request is "pended" or "extended," then the decision may be delayed relative to expected turnaround times. Authorization requests may be "pended" or "extended" for the following reasons:

1. Information was requested but not received.
2. Consultation by an expert reviewer is required.
3. Additional examinations or tests are required.

If submitted clinical information is incomplete, the UM Coordinator shall contact the requesting provider (or other requester), under the guidance of the UM Nurse, to request the additional information required for utilization review. For routine/standard authorization requests, the additional information shall be requested within two (2) calendar days of receipt of the request. For expedited authorization requests, the additional information shall be requested immediately, at the time of receipt of the request. The attempts to contact the requesting provider shall occur during normal business hours (in the provider's time zone), when possible. All attempts to contact the requesting provider should be timed in a manner that maximizes the chance of making contact with the provider (i.e. Calling during non-peak hours; Requesting specific time to call back as a follow-up; Obtaining the name of the office representative that can assist; Coordinating a call time for a peer-to-peer discussion, etc.). The UM Coordinator or other UM staff shall make a minimum of three (3) attempts to contact the requesting provider to obtain the required information—one (1) attempt via phone and two (2) attempts via fax or email, depending on the provider's ability to receive communications.

In all cases, the UM Coordinator shall document outreach attempts and correspondence with providers regarding the collection of medical information. Records of documented attempts shall incorporate specific information including, but not limited to, the following:

1. The provider or individual being contacted.
2. The specific information or records being discussed.
3. The information successfully obtained by AHP.

In the event that the UM Coordinator, after three (3) documented attempts, is unable to reach the requesting provider, then the UM Coordinator shall notify the Physician Reviewer regarding the lack of response from the requesting provider. Prior to issuing a decision to deny in writing, the Physician Reviewer shall attempt to communicate with the requesting provider. The Physician Reviewer shall document:

1. The date/time of the outreach.
2. Whether a voicemail or other message was left.

3. Name and title of person to whom they spoke (if applicable).
4. Whether the attempt to speak with the requesting provider was successful.
5. Whether the information was endorsed or will be sent.

Members shall be informed of all authorization extensions. The member notification shall include an expected date of decision, type of expert reviewer required (if applicable), and outstanding information that is needed to make a decision. In the event that the requested information is received, complete or not, a decision shall be made in a timely fashion, as appropriate for the member's condition, not to exceed forty-eight (48) hours from receipt of the additional information. In the event that no additional information is received within the forty-eight (48) hours given to the practitioner and member to supply the information, the case is submitted to the Physician Reviewer or Medical Director, at which point a determination must be made within five (5) business days. All extended authorizations must have a determination made within twenty-eight (28) calendar days from receipt of the authorization request.

AmericasHealth Plan (AHP) shall identify providers that repeatedly fail to provide complete information or details needed to establish medical necessity. Identified providers shall receive education and follow-up from the Physician Review, Medical Director, Provider Relations Representative, or Director of Medical Management / Utilization Management.

OTHER EXTENSIONS

The UM Coordinator and the Manager of Utilization Review shall review "pended" or "extended" cases throughout the day, and again at the close of business. UM staff shall reprioritize their case load to meet regulatory turnaround times, as necessary.

In the event that the referring provider classifies an authorization as expedited, but the Medical Director requires additional information to establish medical necessity for expediting the case, the UM Coordinator shall place the case into "pend" status and send a fourteen (14) day extension letter (if the referring provider agrees that the extension is in the best interest of the member). Written notification (i.e. "Expedited Criteria Not Met" letter) shall be sent to member. The notification shall inform the member of their right to file an expedited grievance, as well as their right to re-submit the authorization request for an expedited determination. The UM coordinator shall document their actions related to the extension.

Authorizations may only be extended in the event that a) The member requests the extension, or b) AmericasHealth Plan (AHP) can provide sufficient justification for the extension (i.e. Additional information is needed to make a decision; Extension is in the interest of the member, etc.). If an authorization is extended, a decision shall be reached within a maximum of twenty-eight (28) calendar days from receipt of the request.

CANCELLATION

Specific authorization requests may require cancellation due to a variety of reasons. In all cases of cancellation, the requesting practitioner shall be notified verbally, in writing, or electronically. Reasons for an authorization being cancelled include, but are not limited to, the following circumstances:

1. The provider requests the cancellation.
2. The request is a duplicate.
3. The requested service is not AHP's financial responsibility (i.e. In the event that the requested service is not AHP's financial responsibility, the authorization request may be cancelled. The service may need to be authorized directly by the entity that is financially responsible).
4. The benefit or service is "carved out."

In the case that an authorization request is cancelled, AHP shall notify the member and the requesting provider. AHP shall use the notification process as a means to communicate with the member and provider to ensure that appropriate care is not withheld or delayed for any reason.

NOTIFICATION & TIMEFRAMES

Members shall be notified of a UM decision using the applicable CMS-approved and/or DHCS-approved templates for both standard and expedited authorizations. AHP shall follow the Health Industry Collaboration Effort (HICE) guidelines for decision and notification timeframes, found here: https://www.iceforhealth.org/library.asp?sf=&scid=702#scid702

In the event that an authorization request is **approved** (favorable determination):

1. A written CMS approval authorization letter is sent to the member and provider.

In the event that an authorization request is **modified** (partially favorable determination):

2. A written CMS approval authorization letter is sent to the member and provider.
3. A denial (adverse) notification is sent to the member and provider using the CMS-approved letter "Notice of Denial of Medical Coverage" (NDMC). The NDMC shall include the reason for the denial, the criteria used, and the member's appeal rights.

In the event that an authorization request is **denied** (unfavorable determination):

1. A denial (adverse) notification is sent to the member and provider using the CMS-approved letter "Notice of Denial of Medical Coverage" (NDMC). The NDMC shall include the reason for the denial, the criteria used, and the member's appeal rights.

With respect to expedited authorization requests, the member shall receive prompt oral notice of the decision and a written notification shall be sent to the member within three (3) calendar days. Voicemails are NOT an acceptable form of oral notification. UM staff shall document their name, title, and name of the person to which they spoke (member or authorized representative).

AmericasHealth Plan (AHP) adheres to the following timeframes for notification of Non-behavioral, Behavioral, and Pharmacy UM decisions:

- For **urgent concurrent** decisions, AHP gives electronic or written notification of the decision to practitioners and members within twenty-four (24) hours of the request.
- For **urgent preservice** decisions, AHP gives electronic or written notification of the decision to practitioners and members within twenty-four (24) hours of the request.
- For **non-urgent preservice** decisions, AHP gives electronic or written notification of the decision to practitioners and members within seventy-two (72) hours of the request.
- For **post-service** decisions, AHP gives electronic or written notification of the decision to practitioners and members within thirty (30) calendar days of the request

In the case that a standard/routine authorization request is approved, the member, requesting provider, and requested provider shall be notified of the favorable determination within fourteen (14) days of the date of the determination. In the case that an expedited authorization request is approved, the member, requesting provider, and requested provider shall be notified of the favorable determination within seventy-two (72) hours from the date/time of the determination. Notification can be done verbally for expedited authorizations and may be done as quickly as the member's health condition requires.

In the event that an expedited authorization request, upon review, is changed to a standard request, a fax is sent to the requesting provider. Additionally, the member shall be sent a CMS-approved form titled, "Expedited Criteria Not Met." This form is meant to deliver the following information to the member:

1. The member's right to file an expedited grievance.
2. The member's right to resubmit for expedited determination.
3. Instructions about the expedited grievance process and its timeframe.

Members shall be informed of all authorization extensions. The member notification shall include an expected date of decision, type of expert reviewer required (if applicable), and outstanding information that is needed to make a decision. The written notification shall inform the member of their right to file an expedited grievance in the event that the member disagrees with the decision to grant an extension.

The UM Coordinator shall document their actions related to an extension, as well as all communications with the member or referring provider.

CONTENT OF NOTIFICATION

Communications regarding behavioral, non-behavioral, and pharmacy decisions shall include, but not be limited to, the following information:

1. The health care service approved.
2. Clear, concise explanation of reasons for AHP's decision.
3. A description/reference of the criteria or guidelines used to make the decision.
4. The clinical reasons for the decisions regarding medical necessity.

In the event of an adverse determination, the decision notification to the provider shall include the name and direct phone number of the health care professional responsible for making the decision.

AmericasHealth Plan determination notifications shall include appropriate templates (i.e. Your Rights, Non-Discrimination Notice, etc.) and notification forms with appeals information as required by local, state, and federal law. AHP ensures that CMS-mandated notices be utilized appropriately to notify members of non-coverage, termination of services, reduction of level of service, or exhaustion of benefits. Notices include, but are not limited to, the following:

- Notice of Denial of Medical Coverage (NDMC)
- Detailed Notice of Discharge
- Notice of Medicare Non-Coverage (NOMNC)
- Detailed Explanation of Non-Coverage (DENC)

The DENC must be provided no later than the close of business on the day of the QIO's notification.

Notices include information regarding the reason for the denial, alternative treatment plans, and the Medicare appeals process as follows:

1. Name, address, and phone number of the entity making the decision (located at the top of the notice).
2. Member Name
3. Date the notice was generated
4. Member ID Number
5. Type of service being terminated
6. Facts used to make the decision
7. Detailed explanation of why the current services are no longer covered

ACCESS TO CARE

Once an authorization has been approved, the member is notified and directed to receive the appropriate care. In the case that a network specialty provider is not available to see the member within the access timeframes, there is a process for arranging specialty care outside of the network. The UM Nurse shall discuss the case with the Medical Director or Physician Reviewer and contact a non-contracted provider to make the referral. The non-contracted provider shall be within the same geographic area as the originally requested provider. The UM Nurse shall ask the provider if they will accept 100% Medicare or Medi-Cal Fee-for-Service (FFS) rates, depending on the line of business with which the member is enrolled. If the provider agrees to the rates, the UM Nurse shall contact Provider Network/Contracting to obtain a Letter of Agreement (LOA).

Authorizations shall not be rescinded or modified for any reason *after* the provider renders the health care services in good faith and pursuant to the authorization. AHP will adhere to AB 1324 guidelines which requires that payment be made for such authorized covered services, even in the event that the member is later determined to be ineligible. AHP shall revoke such authorizations *prior* to services being rendered, if required.

REOPENING

Reopenings may occur based on the awareness of new or material evidence, the identification of a clerical error, and/or in the event that evidence clearly demonstrates that an obvious error was made at the time of the decision that may have impacted the conclusion of the Physician Reviewer or other practitioner responsible for the decision. The request for reopening made by a party must be clearly stated in writing, include the specific reason for the reopening, and filed within the prescribed timeframes.

Prescribed timeframes for reopening:

- Within one (1) year from the date of the decision or reconsideration for any reason.
- Within four (4) years from the date of the decision or reconsideration for good cause as defined in the Medicare Managed Care Manual (i.e. Any of the three reporting categories).
- At any time if the decision is unfavorable, in whole or in part, but only to correct a clerical error on which that decision was based.
- At any time to effectuate a decision issued under the appeals process.
- At any time if there exists reliable evidence (i.e. Relevant, credible, and material) that the decision was procured by fraud or similar fault.

Appropriate reasons for reopening may include any of the following:

- Receipt of New and Material Evidence
- Clerical Error
- Error on the Face of Evidence
- Favorable or adverse Organization Determinations, pre-service and post-service
- Favorable or adverse reconsideration

Reopening effectuation:

- Standard – As expeditiously as the member health condition requires, but no later than thirty (30) calendar days from the date the case is reopened.
- Expedited – As expeditiously as the member health condition requires, but no later than seventy-two (72) hours from the date the case is reopened.

MEDICARE APPROVED FACILITIES

In cases where a favorable determination (approval) takes place for any of the following procedures:
1. Carotid artery stenting
2. Certain oncologic PET scans in Medicare-specified studies
3. Lung-volume reduction surgery.
4. Ventricular assist device (VAD) destination therapy

The Nurse or delegated staff first confirms that the facility that is being authorized is a Medicare Certified facility to perform the specified procedure. This can be validated at the CMS website: www.cms.gov/MedicareApprovedFacilitie/BSF/list.asp

EMERGENCY SERVICES

Emergency services do not require authorization. Emergency services are never denied.

OB/GYN REFERRALS

Female members may self-refer on a limited basis to OB/GYN within her Capitated Physician Group (CPG) network. Women enrollees have the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

CONCURRENT AND POST-ADMISSION REVIEW

In the event of concurrent or post-admission review, it is the hospital, PCP, treating physician, or other network provider that shall notify AHP's UM Department of the member's admission to an acute care facility for a medical condition or required service.

Regulatory References/Authorities

CA Health & Safety Code 1367.241(a)

42 CFR Part 405

AB 1324

42 CFR 422.204 (b)

42 CFR 422.568 (a)

42 CFR 422.570

42 CFR 422.572

42 CFR 422.584

42 CFR 422.590

42 CFR 422.618

42 CFR 422.619

Medicare Managed Care Manual – Chapter 13

28 CCR Section 1300.71.4

NCQA Standards and Guidelines

ICE Library: UM Timeliness Standards

- ICE Library: http://www.iceforhealth.org/library.asp?sf=&scid=1389#scid1389

Reviewers, Approvers, Review, Revisions History

The reviewer of this Policy is the Director of Health Services.

This Policy must be reviewed and approved by the UM Committee.

Original Creation Date:	**05/01/2015**
Reviewer Name: Denise Templin	Reviewer Department:
Reviewer Title:	Owner Department: Utilization Management
Committee/BOD Approval Date (if applicable): 05/01/2015	
1st Revision Date:	**01/01/2016**
Reviewer Name: Denise Templin	Reviewer Department:
Reviewer Title:	Owner Department: Utilization Management
Committee/BOD Approval Date (if applicable): 01/01/2016	
2nd Revision Date:	**01/01/2017**
Reviewer Name: Linda Baker, RN	Reviewer Department: Medical Management
Reviewer Title: Director of Medical Management	Owner Department: Utilization Management
Committee/BOD Approval Date (if applicable): 01/01/2017	
3rd Revision Date:	**01/01/2018**
Reviewer Name: Linda Baker, RN	Reviewer Department: Medical Management
Reviewer Title: Director of Medical Management	Owner Department: Utilization Management
Committee/BOD Approval Date (if applicable): 01/01/2018	
4th Revision Date:	**08/03/2018**
Reviewer Name: Linda Baker, RN	Reviewer Department: Medical Management
Reviewer Title: Director of Medical Management	Owner Department: Utilization Management
Committee/BOD Approval Date (if applicable): 08/03/2018	
5th Revision Date:	**08/01/2019**
Reviewer Name: Darin Montgomery	Reviewer Department: Health Services
Reviewer Title: Director of Health Services	Owner Department: Utilization Management
Committee/BOD Approval Date (if applicable): 08/01/2019	
6th Revision Date:	**05/01/2022**
Reviewer Name: Corey Stephenson	Reviewer Department: Health Services
Reviewer Title: Director of Health Services	Owner Department: Utilization Management
Committee/BOD Approval Date (if applicable): 05/03/2022	
7th Revision Date:	**07/27/2022**
Reviewer Name: Corey Stephenson	Reviewer Department: Health Services
Reviewer Title: Director of Health Services	Owner Department: Utilization Management
Committee/BOD Approval Date (if applicable):	