

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Utilization Review – Prior Authorization, Concurrent Review, and Retrospective Review	Policy No.: HS-MM49
Department: Medical Management	
Cross-Functional Departments: Member Services	
Effective Date: 01/2024	Last Revision Date: 10/2023
P&P Require DHCS Approval? Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
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I. Purpose:

To outline how CenCal Health conducts Utilization Review, which includes Prior Authorizations, Concurrent Reviews, and Retrospective Reviews.

II. Policy:

- A. CenCal Health ensures that its Utilization Management (UM) authorization decisions for its Members' care are based on Medical Necessity of a requested health care service, consistent with clinical criteria and/or guidelines supported by sound, evidence-based medical principles.
- B. CenCal Health and any entity with which it contracts for services that include Utilization Review (UR) or UM functions, that prospectively, concurrently, or retrospectively reviews and approves, modifies, delays, or denies, based in whole or in part on Medical Necessity, requests by Providers prior to, concurrently with, or retrospectively to the provision of health care services to Members, or that delegates these functions to other contracted entities, conducts these activities in accordance with Cal. H&S Code §1367.01.
- C. CenCal Health's UM activities are performed in accordance with Cal. H&S Code §§1363.5 and 1367.01, as well as 28 C.C.R. §1300.70(b)(2)(H) and (c), and as outlined in the Plan's UM program description (UMPD). CenCal Health develops, implements, updates (as needed, but at least annually), and improves its UM program to ensure appropriate processes are used to review and approve provision of Medically Necessary Covered Services for its Members.
- D. CenCal Health's Chief Medical Officer (CMO) or the CMO's medical director designee is responsible for the UR process in accordance with Cal. H&S Code §1367.01, ensuring:
 1. Medical Necessity determinations are made by qualified medical personnel;
 2. Medical Necessity determinations are not influenced by fiscal or administrative management; and

3. Compensation of individuals or entities that conduct UM activities are not structured to provide incentives to deny, limit, or discontinue Medically Necessary services.
- E. CenCal Health ensures that decisions and Appeals are made in a timely manner and are not unduly delayed when a Member's medical condition requires time-sensitive services.
- F. CenCal Health's authorization requirements comply with the requirements of parity and mental health and Substance Use Disorder (SUD) benefits in 42 C.F.R. §§ 438.900, et seq., by ensuring:
 1. That the Plan's policies, processes, strategies, evidentiary standards, and other factors used for UM or UR are consistently applied to medical/surgical, mental health, and SUD services and benefits; and
 2. That they do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and SUD services than are imposed on medical/surgical services.
- G. CenCal Health discloses or provides for disclosure the UR process as well as the criteria and/or guidelines used to determine whether to authorize, modify, or deny health care services as appropriate, in accordance with Cal. H&S Code §1363.5.

III. Procedure:

A. Application of Utilization Review

1. **Medical Necessity Review.** When reviewing service requests for Medical Necessity, for decision-making CenCal Health uses approved, written UM criteria and/or guidelines based on sound clinical practices and processes, in accordance with the UM Program Description (UMPD).
2. **Application of Criteria and/or Guidelines.** In accordance with the Plan's "Clinical Criteria for Utilization Management Authorization Decisions" policy, MM-UM22, CenCal Health applies approved criteria and/or guidelines in a consistent and appropriate manner, based on available relevant information, including but not limited to the needs of individual Members, and the characteristics of the local healthcare delivery system.
3. **Appropriate Decision Makers**
 - a. CenCal Health personnel, or individuals under contract to the Plan to review requests by Providers, may approve a Provider's request, so long as the established and approved UR process and written UM criteria and/or guidelines are followed and met.
 - b. When deciding to deny or to authorize an amount, duration, or scope that is less than requested, CenCal Health ensures that all decisions are made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition and disease or Long-Term Services and Supports (LTSS) needs.
 - i. Appropriate clinical expertise may be demonstrated by relevant specialty training, experience, or certification.

- ii. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.
 - c. CenCal Health's qualified health care professionals supervise the review of decisions, including service reductions, and review all denials that are made, in whole or in part, based on Medical Necessity.
- B. Implementing Utilization Review.
 - 1. Services Requiring Authorization.
 - a. CenCal Health notifies its Network Providers, Members, and potential Members upon request, of all services that require PA, concurrent authorization, or retrospective authorization.
 - b. CenCal Health maintains telephone access for Providers to request authorization for health care services.
 - c. CenCal Health trains its Network Providers, within thirty (30) days of CenCal Health's execution of a contract with DHCS or within 30 days of contracting with a Network Provider, on the procedures and services that require PA for Medically Necessary services and ensures that all Network Providers are aware of the procedures and timeframes necessary to obtain PA, concurrent authorization, or retrospective authorization for Medically Necessary services.
 - d. If CenCal Health requests medical information from a Provider in order to determine whether to approve, modify or deny a request for authorization, the Plan only requests the information reasonably necessary to make the determination.
 - e. CenCal Health conducts PA review, Concurrent Review, and Retrospective Review by consistently applying approved clinical criteria and/or guidelines in accordance with the Plan's "Clinical Criteria for Utilization Management Authorization Decisions" policy, MM-UM22.
 - f. In determining whether to approve, modify, or deny requests by a Provider prior to, concurrent with, or retrospectively to the provision of health care services to a Member, based in whole or in part on Medical Necessity, CenCal Health complies with all required authorization notification requirements, as stated in the Plan's "Notification of Utilization Management Determinations" policy, MM-UMXX, and pursuant to Cal. H&S Code §1367.01 (h).
 - 2. Prior Authorizations.
 - a. In accordance with the Plan's pre-service operating procedures, CenCal Health conducts PA review by applying approved clinical criteria and/or guidelines to determine Medical Necessity prior to scheduled/elective admissions, rendering services, or starting a course of treatment that requires PA.
 - b. CenCal Health consults with Providers as needed for PA requests for the purposes of determining Medical Necessity for medical services unless doing so would lead to undue delay in care.

- c. Applicability
 - i. CenCal Health does not apply PA requirements to Emergency Services, basic prenatal care, initial mental health and SUD assessments, family planning services, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, Preventive Care services (including immunizations), Minor Consent Services, Indian Health Service Programs, or medication management.
 - ii. The Plan is not responsible for review of PAs for physician-administered drugs, medical supplies, enteral nutritional products, and covered outpatient drug claims billed on a pharmacy claim by an outpatient pharmacy.
 - iii. The Plan reviews PAs for physician-administered drugs, medical supplies, and enteral nutritional products billed on a medical claim.
 - d. Specialty Referral System.
 - i. CenCal Health implements a specialty referral system to track and monitor referrals requiring PA and ensures that all Network Providers are aware of the specialty referral processes and tracking procedures.
 - ii. When PA is delegated to Subcontractors and Downstream Subcontractors, CenCal Health ensures that Subcontractors and Downstream Subcontractors have systems in place to track and monitor referrals requiring PA and, upon request, the Plan provides to DHCS documentation of Subcontractor's and Downstream Subcontractor's referrals.
 - iii. CenCal Health's specialty referral system, as well as the systems used by its Subcontractors and Downstream Subcontractors, include authorized, modified, deferred, or denied referrals, and the timeliness of the referrals, as well as information on requested out-of-network services.
 - e. Record Retention. CenCal Health ensures that any records relating to PA requests, including NOAs, are maintained for a minimum of ten (10) years from the final date of the phaseout period or from the date of completion of any audit, whichever is later, in accordance with 42 C.F.R. §§ 438.3(h) and (u), 438.230(c).
3. Concurrent Review
- a. In accordance with the Plan's Concurrent Review operating procedures, CenCal Health conducts Concurrent Review to evaluate a Member's care by applying approved clinical criteria and/or guidelines to determine Medical Necessity for outpatient observation status, admission to acute care hospitals or extended care facilities, or approval of continuing stay.
4. Retrospective Review
- a. In accordance with the Plan's Retrospective Review operating procedures, CenCal Health conducts Retrospective Review of

rendered services by applying approved clinical criteria and/or guidelines to determine whether the services provided were Medically Necessary, a covered benefit, or exceeded coverage limitations.

5. Appeals. CenCal Health's Appeals procedure for both Providers and Members, in accordance with the Plan's "Member Grievance and Appeals System" policy, MS-20, is published on CenCal Health's website and shared upon request.

C. Notification, Distribution, and Disclosures

1. Notification of Determination to Providers. In accordance with the Plan's "Notification of Utilization Management Determinations and Timeliness" policy, HS-UM07, CenCal Health notifies the requesting Provider of any decision to approve, modify, delay, or deny a Service Authorization Request, or when authorizing a service in an amount, duration, or scope that is less than requested.
2. Notification of Determination to Members. In accordance with the Plan's "Notification of Utilization Management Determinations and Timeliness" policy, HS-UM07, CenCal Health notifies Members regarding modified, deferred, or denied referrals or requests for PA in accordance with 42 C.F.R. §438.210(c) and 22 C.C.R. §§ 51014.1 and 53894 by providing a Notice of Action (NOA) to Members and/or their Authorized Representative, regarding any modification, deferral, or denial of a request for approval to provide a health care service.
3. Utilization Review Process. In accordance with Cal. H&S Code §1363.5, the Plan's "Notification of Utilization Management Determinations and Timeliness" policy, HS-UM07, and the UMPD, CenCal Health discloses or provides for disclosure the UR process that the Plan and its delegates, as applicable, use to authorize, modify, or deny Covered Services and benefits, including coverage for subacute care, transitional inpatient care, or care provided in Skilled Nursing Facilities (SNFs).
 - a. CenCal Health discloses or provides for the disclosure of its UR process, including the policies, procedures, and description of the UR process to DHCS, pursuant to Cal. H&S Code §1367.01.
 - b. CenCal Health discloses or provides for the disclosure of its UR process to its Network Providers and makes available to Network Providers all relevant UM policies and procedures upon request.
 - c. The Plan provides the CenCal Health UR process, including all relevant UM policies and procedures, to its Members, or their designees, or any other person or organization, upon request. Members can access this information on CenCal Health's website or by requesting this information from the Plan's Member Services Department.
4. Clinical Criteria and/or Guidelines. In accordance with Cal. H&S Code §1363.5, the Plan's "Clinical Criteria for Utilization Management Authorization Decisions" policy, MM-UM22, and the UMPD, CenCal Health discloses UM criteria and/or guidelines as follows:

- a. If used as the basis of a decision to modify, delay, or deny services in a specified case under review, UM criteria and/or guidelines are disclosed to the Provider (inclusive of Network Providers as well as out-of-network Providers) and the Member in that specified case; and
- b. Are available to the public upon request. For public disclosure:
 - i. CenCal Health is only required to disclose the criteria and/or guidelines for the specific procedures or conditions requested and may charge reasonable fees to cover administrative expenses related to disclosing criteria and/or guidelines, limited to copying and postage costs.
 - ii. The Plan may also make the criteria and/or guidelines available through electronic communication means.
 - iii. This disclosure is accompanied by the following notice: "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

D. Auditing and Monitoring

1. As part of its Quality Program, CenCal Health assesses and evaluates its compliance with Cal. H&S Code §1367.01. This auditing and monitoring activity includes provisions for the following:
 - a. Evaluation of complaints;
 - b. Assessment of trends;
 - c. Implementation of actions to correct identified problems;
 - d. Mechanisms to communicate actions and results to appropriate CenCal Health staff and Network Providers; and
 - e. Evaluation of any corrective action plan and measurements of performance.
2. As part of its Quality Improvement and Health Equity Transformation Program (QIHETP), CenCal Health integrates UM activities into the Quality Improvement System (QIS), including a process to integrate reports on the number and types of service requests, modifications, deferrals, denials, Appeals, and Grievances to the CMO or their designee.
3. DHCS reviews and issues a report regarding CenCal Health's compliance with Cal. H&S Code §1367.01 as part of its periodic onsite medical survey.

IV. Definitions:

Adverse Benefit Determination (ABD): any of the following actions taken by CenCal Health:

- A. The denial or limited authorization of a requested service, including determinations based on the type or level of a Covered Service, Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;

- B. The reduction, suspension, or termination of a previously authorized Covered Service;
- C. The denial, in whole or in part, of payment for a Covered Service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of Clean Claim is not an Adverse Benefit Determination;
- D. The failure to provide Covered Services in a timely manner;
- E. The failure to act within the required timeframes for standard resolution of Grievances and Appeals;
- F. The denial of the Member's request to obtain services out of Network when a Member is in an area with only one Medi-Cal managed care health plan;
or
- G. The denial of a Member's request to dispute financial liability.

Appeal: a review by CenCal Health of an ABD, which includes one of the following actions:

- A. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service;
- B. A reduction, suspension, or termination of a previously authorized service;
- C. The denial, in whole or in part, of payment for a Covered Service, except payment denials based solely because the claim does not meet the definition of a Clean Claim;
- D. Failure to provide services in a timely manner; or
- E. Failure to act within the timeframes provided in 42 C.F.R. §438.408(b).

Authorized Representative: any individual appointed in writing by a competent Member or Potential Member, to act in place or on behalf of the Member or Potential Member for purposes of assisting or representing the Member or Potential Member with Grievances and Appeals, State Fair Hearings, Independent Medical Reviews, and in any other capacity, as specified by the Member or Potential Member.

Concurrent Review: the process of determining Medical Necessity while treatment is being rendered in an inpatient setting.

Covered Services: those health care services, set forth in W&I Code §§ 14000 et seq. and 14131 et seq., 22 C.C.R. §§ 51301 et seq., 17 C.C.R. §§ 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the Plan's contract with DHCS, and APLs that are made the responsibility of the Plan pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS.

Medically Necessary or Medical Necessity: reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe

pain through the diagnosis or treatment of disease, illness, or injury, as required under Cal. W&I Code § 14059.5(a) and 22 C.C.R. § 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 U.S.C. § 1396d(r)(5), as required by Cal. W&I Code §§ 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support, or maintain the Member's current health condition. The Plan must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

Member: a Medi-Cal recipient who resides in the Plan's Service Area and who has enrolled with the Plan.

Minor Consent Services: those Covered Services of a sensitive nature which minors do not need parental consent to access, including but not limited to the following situations:

- A. Sexual assault, including rape;
- B. Drug or alcohol abuse for minors 12 years of age or older;
- C. Pregnancy;
- D. Family planning;
- E. Sexually transmitted diseases in minors 12 years of age or older;
- F. Diagnosis or treatment of infectious, contagious, or communicable diseases in minors 12 years of age or older if the disease or condition is one that is required by law or regulation adopted pursuant to law to be reported to the local health officer; and
- G. Outpatient mental health care for minors 12 years of age or older who are mature enough to participate intelligently in their health care pursuant to Family Code § 6924 and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the minors are the alleged victims of incest or child abuse.

Network Provider: any Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement.

Notice of Action (NOA): a notice of any action that impacts a Member's ability to obtain Covered Services or other benefits CenCal Health is required to provide under the Plan's contract with DHCS. A NOA includes, but is not limited to, a notice of ABD for a requested health care service under 42 C.F.R. §§ 438.210(d) and 438.404, including requested Community Supports the Plan has elected to cover under 42 C.F.R. § 438.3(e)(2).

Preventive Care: health care designed to prevent disease, illness, injury, and/or its consequences.

Prior Authorization: a formal process requiring a Provider to obtain advance approval the amount, duration, and scope of non-emergent Covered Services.

Provider: any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.

Quality Improvement and Health Equity Transformation Program (QIHETP): the systematic and continuous activities to monitor, evaluate, and improve upon the Health Equity and health care delivered to Members in accordance with the standards set forth in applicable laws, regulations, and the Plan's contract with DHCS.

Retrospective Review: the process of determining Medical Necessity after treatment has been given.

Service Area: the county or counties that the Plan is approved to operate in under the terms of its contract with DHCS. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county.

Service Authorization Request: request by a Member or a Member's Provider for the provision of a Covered Service.

Substance Use Disorder (SUD): those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

Utilization Management (UM) or Utilization Review (UR): the evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

V. References:

- A. 42 C.F.R. §§ 438.210(c), 438.900 et seq.
- B. Cal. H&S Code §§ 1367.01, 1363.5
- C. 22 C.C.R. §§ 51014.1, 53894
- D. 28 C.C.R. §1300.70(b)(2)(H) and (c)
- E. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, §2.3.1 Prior Authorizations and Review
- F. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, §5.1.5 Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests
- G. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit E, §1.2.2 Inspection and Audit of Records and Facilities
- H. DHCS Fee-for-Service Provider Manual

VI. Cross References:

- A. Policy and Procedures (P&Ps):
 1. MM-UM22: Clinical Criteria for Utilization Management Decisions

2. HS-UM07: Notification of Utilization Management Determinations and Timeliness
 3. HS-MM48: Standing Referrals
 4. MS-22: Member Grievances
 5. MS-23: Member Appeals
 6. MS-24: G&A Communication and Education
 7. MS-25: G&A Monitoring and Oversight
- B. Program Documents
1. CenCal Health's Utilization Management Program Description

VII. Attachments: N/A

Revision History:

P&P Revision Date	Leaders who Reviewed and Approved P&P Revisions	Reason for P&P Revisions	P&P Revision Effective Date (date P&P is operationalized)	DHCS P&P Approval Date
10/2023	Chris Hill, MBA, BS, RN Health Services Officer; Emily Fonda, MD, MMM, CHCQM Chief Medical Officer	2024 Template Migration	01/2024	N/A
01/2023	Chris Hill, MBA, BS, RN Health Services Officer;	P&P Established for OR Deliverables R.0062 R.0065 R.0066 R.0067	01/2024	2023