

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Clinical Criteria for Utilization Management Authorization Decisions	Policy No.: MM-UM22
Department: Medical Management	
Cross-Functional Departments: Quality	
Effective Date: 02/2011	Last Revision Date: 06/2024
P&P Require DHCS Approval? Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Director or Officer Signature: Christopher Hill, RN, MBA Health Services Officer	Officer Signature: Emily Fonda, MD, MMM, CHCQM Chief Medical Officer

I. Purpose:

To outline CenCal Health's process for the development, adoption, application, review, revision, and distribution of clinical criteria and/or guidelines used for the authorization, modification, or denial of requests for services. The clinical criteria and guidelines apply to the prospective, concurrent, and retrospective utilization review processes.

II. Policy:

- A. CenCal Health ensures that its Utilization Management (UM) authorization decisions for its Members' care are based on the 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 ensures that its policies, processes, strategies, evidentiary standards, and other factors used for UM or Utilization Review (UR) are consistently applied to medical/surgical, mental health, and Substance Use Disorder (SUD) services and benefits.
- C. The criteria and/or guidelines used by CenCal Health to determine whether to authorize, modify, or deny health care services are developed with involvement from actively practicing health care providers, are consistent with sound clinical principles and processes, and are evaluated, and updated, if necessary, at least annually, in accordance with Cal. H&S Code §1363.5.
- D. 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.
- E. 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).

III. Procedure:

- A. Adoption and Application

1. CenCal Health considers the characteristics of the local healthcare delivery system, including, but not limited to, Member access and the availability of services (or lack thereof) in the local delivery system, in the development, adoption, and application of criteria and/or guidelines.
2. CenCal Health considers at least the following characteristics when applying criteria to each individual:
 - a. Age
 - b. Comorbidities
 - c. Complications
 - d. Progress of Treatment
 - e. Psychosocial situations
 - f. Home environment, when applicable
3. When reviewing requests for services, CenCal Health ensures that the unique health care needs of the members are taken into account, and takes access and availability standards into consideration, when applying UM criteria to determine medical necessity.
4. Approved Criteria and/or Guidelines for Medical Necessity Determinations:
 - a. When reviewing service requests for Medical Necessity, CenCal Health uses approved, written UM criteria and/or guidelines that are objective and based on sound medical evidence as well as clinical principles and processes for decision-making, in accordance with the UM Program Description (UMPD).
 - b. CenCal Health applies a hierarchy of approved criteria and/or guidelines, including the following:
 - i. California State criteria, including the California Medi-Cal Provider Manual, which includes information on Medi-Cal services, programs, and claim reimbursement guidelines; as well as California Children's Services (CCS) Program criteria, guidelines, and numbered letters, when applicable.
 - ii. CenCal Health medical policies.
 - iii. Milliman Care Guidelines (MCG), which includes Behavioral Health Criteria.
 - iv. For physician-administered drugs, Magellan Rx Management Library of Medical Necessity Criteria, which are applicable evidence-based clinical guidelines based on medical literature, nationally recognized guidelines published in all fields of medicine, practice observations, and database analyses. These criteria are vetted through Magellan's Medical Necessity Criteria (MNC) committee and CenCal Health's Pharmacy & Therapeutics Committee.
 - v. Nationally recognized health care and professional organizations, which includes evidence-based clinical guidelines published by national entities, such as the National Guideline

Clearinghouse, National Institute for Health, American College of Obstetricians and Gynecologists (ACOG), and other professional medical associations.

B. Review and Revision

1. Review for Applicable Updates to Criteria and/or Guidelines

- a. CenCal Health may consider new clinical criteria and/or guidelines for development and/or adoption. Board-certified internal and external network practitioners from appropriate specialties are involved in criteria and/or guidelines development if the criteria or guidelines are not from recognized sources.
- b. On a regular and ongoing basis, Medical Management staff monitor recognized professional sources of clinical criteria and guidelines for applicable updates and provides relevant information to the Medical Management Director and CMO or the CMO's physician designee.
- c. CenCal Health's Health Services, Provider Services, and Member Services Departments are informed about updates to criteria and/or guidelines. Staff from these departments may meet on an ad hoc basis for strategic discussions on the application and/or distribution of the criteria and/or guidelines.

2. Process for Updating Criteria and/or Guidelines.

- a. When an update or revision to the criteria and/or guidelines is proposed, it is first presented to the UM Committee (UMC).
 - i. The presentation to the UMC provides input from all CenCal Health Departments regarding any possible issues, including, but not limited to, access, benefits, UM criteria and/or guidelines, health education, and reimbursement.
 - ii. CenCal Health's Medical Management team reviews the proposed update or revision, and the Medical Management Director and CMO or the CMO's Physician designee determines appropriate next steps. If approved, they refer to it in a timely manner for review by the Quality Improvement and Health Equity Committee (QIHEC).
- b. Referral to the Quality Improvement and Health Equity Committee (QIHEC)
 - i. Suggested changes to criteria and/or guidelines made by appropriate practitioners and/or the Plan's Medical Management Director and CMO or the CMO's physician designee are presented to the QIHEC for review, comments, recommendations, and approval.
 - ii. For the adoption of criteria and/or guidelines, the QIHEC considers current nationally accepted evidence-based criteria and/or guidelines of professional medical academies, colleges, societies, and associations.

- iii. At least annually, the QIHEC reviews and approves CenCal Health's UM criteria and/or guidelines, in accordance with Cal. H&S Code §1363.5.

C. Distribution and Disclosures

1. In accordance with Cal. H&S Code §1363.5 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.
 - 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. CenCal Health 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."
2. Additional Support for Providers and Members
 - a. At least annually, Network Providers and Members are notified that CenCal Health's approved UM criteria and/or guidelines are available upon request by contacting CenCal Health.
 - b. Providers (inclusive of Network Providers as well as out-of-network Providers) can request CenCal Health's UM criteria and/or guidelines by contacting the Plan's UM Department.
 - c. When a Provider requests UM criteria and/or guidelines, CenCal Health's UM staff documents the request.
 - d. When a Member requests UM criteria and/or guidelines, CenCal Health's Member Services staff documents the request.

D. Auditing and Monitoring

1. In accordance with the UMPD, CenCal Health ensures consistent application of approved criteria and/or guidelines through annual reviews. When these reviews reveal opportunities to improve, CenCal Health documents and implements actions toward such improvement.
2. In accordance with its policy regarding delegating UM (MM-UM06 Delegation of Utilization Management) as well as the UMPD, CenCal Health ensures the consistent application of approved criteria and/or

guidelines at all levels of delegation by periodic retrospective review, UM rounds, or periodic audits of UM authorization determinations.

IV. Definitions:

California Children's Services (CCS)-Eligible Condition: a medical condition that qualifies a Child to receive medical services under the CCS Program, as specified in 22 C.C.R. §41515.1 et seq.

CCS Program: a State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.

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.

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.

Primary Care Provider (PCP): a Provider responsible for supervising, coordinating, and providing initial and primary care to Members, for initiating referrals, for maintaining the continuity of Member care, and for serving as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, non-physician medical practitioner, or obstetrician-gynecologist (OB-GYN). For SPD Members, a PCP may also be a Specialist or clinic.

Prior Authorization (PA): 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 Committee (QIHEC): a committee facilitated by CenCal Health's medical director, or the medical director's designee, in collaboration with the Health Equity officer, to meet at least quarterly to direct all QIHETP findings and required actions.

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.

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.

Substance Use Disorders (SUDs): 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. Cal. H&S Code §§ 1363.5, 1367.01
- B. 22 C.C.R. §§41515.1-41518.9 (CCS Program Criteria and/or Guidelines)
- C. 28 C.C.R. §1300.70(b)(2)(H) and (c)
- D. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, § 2.3 Utilization Management Program
- E. DHCS Provider Manual
- F. DHCS Manual of Criteria for Medi-Cal Authorization
- G. Milliman Care Guidelines
- H. Magellan Rx Management Library of Medical Necessity Criteria
- I. NCQA Standard UM 2- Clinical Criteria for Decision Making

VI. Cross References:

- A. Policy and Procedures (P&Ps):
 - 1. HS-MM43: Care Coordination with Out-of-Network Providers
 - 2. QU-01: Detecting Over and Under Utilization of Services
 - 3. HS-UM07: Notification of UM Determinations and Timeliness

4. HS-MM49: Utilization Review - Prior Authorization, Concurrent Review and Retrospective Review
5. HS-MM48: Standing Referrals

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	DHCS P&P Approval Date
05/2024	Christopher Hill, RN, MBA Health Services Officer; Emily Fonda, MD, MMM, CHCQM Chief Medical Officer; Carlos Hernandez, Executive Quality & Population Health Officer	Annual P&P Review, NCQA standard terminology	01/2024	N/A
10/2023	Christopher Hill, RN, MBA Health Services Officer	2024 Template Migration	01/2024	N/A
01/2023	Eric Buben, Emily Fonda, Carlos Hernandez, Christopher Hill.	Updated for compliance with 2024 DHCS Contract (R.0062, R.0065, R.0066, R.0067, R.0068)	01/2024	01/2023
08/2022	Ana Stenersen, Christopher Hill, Amanda Flaum	Updated for compliance with 2024 DHCS Contract (R.0080)	08/2022	08/2022
04/2022	Karen Hord, MD	Updated for compliance with APL 21-011	05/2022	08/2022
04/2011	Director	P&P Established	2011	2011