

CENCAL HEALTH POLICY AND PROCEDURE (P&P)	
Title: Notification of Utilization Review Determinations	Policy No.: HS-UM07
Department: Medical Management	
Cross-Functional Departments: Member Services	
Effective Date: 01/2024	Last Revision Date: 05/2024
P&P Require DHCS Approval? Y <input checked="" type="checkbox"/> N <input type="checkbox"/>	
Director or Officer Signature: Sue Fischer, RN, MA Director of Medical Management	Officer Signature: Christopher Hill, RN, MBA Health Services Officer

I. Purpose:

To outline how CenCal Health notifies Members and requesting Providers of Utilization Review determinations within regulatory timeframes.

II. Policy:

- A. CenCal Health and any entity with which it contracts for services that include Utilization Review (UR) or Utilization Management (UM) functions, that prospectively, concurrently, or retrospectively reviews and approves, modifies, delays, or denies, based in whole or in part on Medical Necessity, requests 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.
- B. 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.
- C. 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.
- D. CenCal Health sends a Notice of Action (NOA) to the Member and requesting Provider for all authorization decisions; this includes, but is not limited to, a notice of Adverse Benefit Determination (ABD) for a requested health care service under 42 C.F.R. §§ 438.210(d) and 438.404, including Community Supports that CenCal Health has elected to cover under 42 C.F.R. §438.3(e)(2).
- E. CenCal Health notifies Members of a decision to approve, modify, defer, or deny requests for Prior Authorizations (PAs), in accordance with 42 C.F.R. §438.210(c) and 22 C.C.R. §§ 51014.1 and 53894 by providing an NOA to Members and/or their Authorized Representatives (ARs), regarding any approval, modification, deferral, or denial of a request for approval to provide a health care service.

III. Procedure:

- A. Communicating Authorization Decisions

1. When an authorization decision to approve a request by a Provider prior to, concurrently with, or retrospectively to the provision of health care services, the communication specifies the specific health care services approved.
 2. When an authorization decision to approve, modify, delay, or deny health care services requested by a Provider prior to, concurrently with, or retrospectively to with the provision of health care services, CenCal Health communicates the decision:
 - a. To Members in writing, through the issuance of an NOA within two (2) working days in accordance with the Health and Safety Code (H&S) sections 1367.01(h)(1) and 3; and
 - b. To the requesting Provider within 24 hours of determination. Any written communication to a Provider of a modification, delay, or denial of a request includes the name and telephone number of the health care professional responsible for the modification, delay, or denial.
 - c. The telephone number provided is a direct number or an extension, to allow the Provider easily to contact the professional responsible for the modification, delay, or denial.
- B. Notice of Action (NOA)
1. When an authorization decision is made, CenCal Health sends a written NOA to the Member.
 2. NOA Required Timeframes
 - a. CenCal Health renders a decision and sends a written NOA to the Member within the required timeframes in Section III.C.2. (listed below). Failure to abide by these timeframes:
 - i. Is considered a denial of the requested service, constituting an Adverse Benefit Determination (ABD) on the date the timeframe for approval expires in accordance with 42 C.F.R. §438.404(c)(5); and
Permits the Member to immediately request an Appeal with CenCal Health, and CenCal Health sends the Member written notice of all Appeal rights, in accordance with CenCal Health's policy and procedures MS-22: Member Grievances, MS-23: Member Appeals, MS-24: Communication and Education and MS-25: Monitoring and Oversight
 3. Notice of Action (NOA) Content
 - a. All NOAs informing a Member of an Adverse Benefit Determination, (ABD) resulting from prospective, concurrent, or retrospective review, including modification, deferral, or denial of the request, is in writing, in a format and language that, at a minimum, meets the standards set forth in 42 C.F.R. §§ 438.10, 438.404, and 438.4.08, Cal. W&I §14029.91, and 22 C.C.R. §53876.
 - b. The NOA includes all the following:
 - i. A clear and concise explanation of the action CenCal Health or its Network Provider has taken or intends to take including a fully translated

written notice providing clinical rationale for the decision at the point of each determination.

- ii. The reason for the action, including notification to the Member of their right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information CenCal Health relied on for the decision, including clinical criteria, Medical Necessity criteria, and any processes, strategies, or evidentiary standards relied on for the decision.
- iii. Information as to how the Member may file a grievance with CenCal Health and how to request an administrative hearing and aid paid pending, pursuant to 22 C.C.R. §§51014.1 and 51014.2.
- iv. The Member's right to request an Appeal of an Adverse Benefit Determination (ABD) within 60 calendar days from the date on the NOA and information on exhausting CenCal Health's one-level Appeal system;
- v. That an expedited Appeal is available if the Member's health condition requires resolution in less than 72 hours and how to request an expedited Appeal;
 - 1) An expedited review is required when the Appeal involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, as defined by 22 C.C.R. §1300.68.01.
- vi. The Member's rights, and information on the process to request a State Fair Hearing (SFH) after having exhausted CenCal Health's internal Appeal Process and having received notice that CenCal Health is upholding its action (known as "Deemed Exhaustion" pursuant to 42 C.F.R. §438.402(c)(1)(i)(A)).
 - 1) The NOA advises the Member may request a SFH in cases where CenCal Health fails to send a Notice of Appeal Resolution (NAR) or notice of extension in response to the Appeal within thirty (30) calendar days of the Member's request for an Appeal;
- vii. The Member's right to continue receiving Covered Services pending the resolution of the Appeal, and CenCal Health's obligation to continue benefits, as required by 42 C.F.R. §438.420; and
- c. CenCal Health is not permitted to make any changes to the DHCS NOA templates or the NOA "Your Rights" Attachment without prior review and approval from DHCS, except to insert the specific reasons for the CenCal Health's action to the Member, as required.

C. Standard Authorization Requests

1. Applicability: Prior Authorization and Concurrent Review
2. Timeframe for Decision
 - a. Prior Authorizations

- i. CenCal Health responds to standard or routine requests as expeditiously as the Member's condition requires, but no later than five (5) Working Days from receipt of the information reasonably necessary and requested by CenCal Health to render a decision, and no longer than fourteen (14) calendar days from the receipt of the request, in accordance with 42 C.F.R. §438.210 and 438.404(c)(3) Cal. H&S Code §1367.01.
 - ii. CenCal Health may extend this deadline up to an additional fourteen (14) days only if the Member or the Provider requests an extension, or if CenCal Health justifies, to DHCS upon request, a need for additional information and how the extension is in the Member's interest, in accordance with 42 C.F.R. §438.210.
 - 1) CenCal Health must have documented at least one attempt to obtain the necessary information.
 - iii. CenCal Health notifies the Provider and the Member in writing of any authorization request delayed beyond the five (5) Working Day time frame, including the anticipated date on which a decision may be rendered, in accordance with Cal. H&S Code §1367.01.
- b. Concurrent Review
- i. CenCal Health responds to a concurrent authorization request within five (5) Working Days or less, consistent with the urgency of the Member's medical condition in accordance with Cal. H&S Code §1367.01(h)(1).
 - ii. During Concurrent Review, care is not discontinued until the treating Provider has been notified of CenCal Health's decision and a care plan has been agreed upon by the treating Provider that is appropriate for the medical needs of that Member.
3. Notifications
- a. When approving, modifying, or denying a Provider's prior Authorization or concurrent request for health care services (excluding pharmacy services, but including Community Supports) for a Member, CenCal Health:
 - i. Sends a written NOA to the Member within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five (5) Working Days from CenCal Health's receipt of information reasonably necessary and requested by CenCal Health to make a determination, not to exceed fourteen (14) calendar days following receipt of the request for service, in accordance with 42 C.F.R. §§ 438.210(d)(1) and 438.404(c)(5); and
 - ii. Notifies the requesting Provider of CenCal Health's authorization decision within 24 hours of the decision and sends the written NOA within two (2) Working Days, in accordance with Cal. H&S §§ 1367.01(h)(1) and (3).
 - b. Unless the Member requests an extension of the initial fourteen (14) calendar day authorization timeframe, CenCal Health either sends the written NOA approving, modifying, or denying the authorization request or

documents its justification of the need for extension to obtain additional information and demonstrate how the extension is in the Member's interest, in accordance with 42 C.F.R. §438.210(d)(2)(ii).

- c. If CenCal Health requires an extension, CenCal Health sends the written NOA to the Member and the requesting Provider requesting the specific information needed to determine if the requested service is Medically Necessary. The NOA also advises the Member of their right to file a Grievance if they disagree with the extension. Following this notification and request for specific information, CenCal Health will approve, modify, or deny the request, and sends the written NOA to the Member:
 - i. Within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than five (5) Working Days from CenCal Health's receipt of information reasonably necessary and requested by CenCal Health to make a determination, not to exceed an additional fourteen (14) calendar days following receipt of the request for service, in accordance with 42 C.F.R. §§ 438.210(d)(1) and 438.404(c)(5); and
 - ii. With sufficient time to allow for continuation of benefits pursuant to 42 C.F.R. §438.420.
- D. Expedited Authorization Requests and Urgent Concurrent Requests (ongoing care for treatment, i.e., Inpatient care)
 1. Applicability: CenCal Health makes expedited authorization decisions for service requests where a Provider indicates, or CenCal Health, CenCal Health's Subcontractor, Downstream Subcontractor, or Network Provider determines that following the standard timeframe for prior authorizations or concurrent requests could seriously jeopardize the Member's life; health; or ability to attain, maintain, or regain maximum function, in accordance with 42 C.F.R. §438.210 and Cal. H&S Code §1367.01.
 2. Timeframe for Decision
 - a. CenCal Health provides its authorization decision as expeditiously as the Member's health condition requires, but no longer than 72 hours after receipt of the request for services.
 - b. CenCal Health may extend this deadline up to an additional fourteen (14) calendar days only if the Member or the Member's Provider requests an extension or if CenCal Health justifies, to DHCS upon request, a need for additional information and how the extension is in the Member's interest, in accordance with 42 C.F.R. §438.210. This justification is documented in the Member's record. CenCal Health must have documented at least one attempt to obtain the necessary information.
 3. Notifications
 - a. CenCal Health sends the written NOA to the requesting Provider and Member, in a timeframe which is appropriate for the nature of the Member's condition, but no longer than 72 hours from receipt of the authorization request, in accordance with 42 C.F.R. §438.210(d)(2)(i) and Cal. H&S §1367.01(h)(2).

- b. CenCal Health notifies requesting Provider and the Member in writing of any authorization request delayed beyond the 72-hour time frame, including the anticipated date on which a decision may be rendered, in accordance with Cal. H&S Code §1367.01.
 - i. CenCal Health also sends the written NOA to the Member and the requesting Provider requesting the specific information it needs to determine if the requested service is Medically Necessary. The NOA advises the Member of their right to file a Grievance if they disagree with CenCal Health's need for an extension.
 - ii. Following this notification and request for information, CenCal Health approves, modifies, or denies the request within the shortest applicable timeframe that is appropriate for the nature of the Member's condition, but no longer than 72 hours from the receipt of additional information requested by CenCal Health to make a determination, unless the Member requests an extension or CenCal Health can document justification of the need to extend the timeframe, not to exceed fourteen (14) calendar days, in accordance Cal. H&S §§ 1367.01(h)(1) and (3).
- E. Retrospective Authorization Request
1. Applicability: CenCal Health accepts requests for retrospective authorization requests within a reasonably established time limit, not to exceed 365 calendar days from the date of service.
 2. Timeframe for Decision: CenCal Health approves, modifies, or denies a retrospective authorization request for health care services provided to a Member within thirty (30) calendar days from receipt of information that is reasonably necessary to make that determination.
 3. If CenCal Health is unable to make a determination because CenCal Health is not in receipt of all the information reasonably necessary and requested, CenCal Health will notify the Provider and Member within the required timeframe and specific information required and the anticipated date of the determination in accordance with 42 CFR section 438.404(a) and H & S Code section 1367.01(h)(1).
 - a. The delay time for a Member and Provider to submit the requested information is 30 calendar days.
 - b. If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th calendar day given to provide the information
 4. Notifications: CenCal Health communicates decisions to the requesting Provider and to the Member who received the services or to the Member's designee within thirty (30) calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 C.F.R. §438.404(a) and Cal. H&S Code §1367.01(h)(1).
- F. Other Timeframes for Medical Authorization

1. Emergency Care: CenCal Health does not require PA for emergency care for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.
2. Post Stabilization Care: CenCal Health responds to a Provider's request for authorization for Post-Stabilization Care Services within thirty (30) minutes or the respective service(s) are deemed approved in accordance with 22 C.C.R. §53855(a).
3. Non-Urgent Care Following an Exam in the Emergency Room: CenCal Health responds to a Provider's request for Post-Stabilization Care Services within thirty (30) minutes or the service is deemed approved.
4. Hospice Services: CenCal Health only requires PA for inpatient hospice care. CenCal Health makes a determination regarding inpatient hospice care authorization requests within five (5) Working Days for routine requests and within 72 hours for expedited requests, in accordance with 22 C.C.R. §51003 and all applicable DHCS APLs.
5. Therapeutic Enteral Formula and Physician Administered Drugs
 - a. For medical authorization of Medically Necessary therapeutic enteral formula or physician administered drugs billed on a medical or institutional claim, CenCal Health requires pre-service authorization and complies with the same timeframes as for other medical services: no longer than five (5) Working Days for routine requests and no longer than 72 hours for expedited requests.
 - b. Authorization of Medically Necessary therapeutic enteral formula includes the formula as well as the supplies necessary for delivery of enteral formula billed on a medical or institutional claim. CenCal Health complies with the respective timeframes for medical authorization, as set forth in all applicable DHCS PLs and APLs, Cal. W&I Code §14103.6, and Cal. H&S Code §1367.01.

G. Terminations, Suspensions, or Reductions

1. For terminations, suspensions, or reductions of previously authorized services, CenCal Health notifies Members at least ten (10) calendar days before the date of the action, pursuant to 42 C.F.R. §431.211, with the exception of circumstances permitted under 42 C.F.R. §§ 431.213 and 431.214.
2. For the purpose of auditing, the date on the notice to the Member will be used to confirm compliance with all authorization request timeframes and notice requirements set forth above.

H. Auditing, Monitoring & UM Program integration with the Quality Improvement System

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).

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, CenCal Health's contract with DHCS, and APLs that are made the responsibility of CenCal Health 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.

Downstream Subcontractor: an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. A Network Provider is not a Downstream Subcontractor solely because it enters into a Network Provider Agreement.

Independent Medical Review (IMR): a review of CenCal Health's denial of a Member's request for health care service as not Medically Necessary, experimental, or investigational by an independent physician(s) who is contracted with DMHC. The IMR decision is binding on CenCal Health but not the Member who may still request a State Fair Hearing after an IMR pursuant to Cal. H&S Code §1374.30 and 28 C.C.R. §1300.74.30.

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. CenCal Health 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 CenCal Health's Service Area and who has enrolled with CenCal Health.

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 CenCal Health'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 CenCal Health has elected to cover under 42 CFR §438.3(e)(2).

Post-Stabilization Care Services: Covered Services related to an Emergency Medical Condition that are provided after a Member's condition is stabilized, in accordance with 42 C.F.R. §438.114 and 28 C.C.R. §1300.71.4, to improve or resolve the Member's condition.

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 CenCal Health's contract with DHCS.

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

Service Area: the county or counties that CenCal Health is approved to operate 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.

Subcontractor: an individual or entity that has a Subcontractor Agreement with CenCal Health that relates directly or indirectly to the performance of CenCal Health's obligations under CenCal Health's contract with DHCS. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement.

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.

Working Days: Monday through Friday, except for state holidays as identified at the California Department of Human Resources State Holidays page.

V. **References:**

- A. 42 C.F.R. §§ 438.210, 438.404(a), 438.900 et seq.
- B. Cal. H&S Code §§ 1367.01, 1363.5
- C. Cal. W&I Code § 14103.6
- D. 22 C.C.R. §§ 51003, 51014.1, 51340, 51340.1, 53855(a), 53894
- E. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, § 2.3.2 Timeframes for Medical Authorization
- F. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, § 4.6.3 Notice of Action
- G. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, § 5.1 Member Services
- H. 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

- I. DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit E, § 1.2.2 Inspection and Audit of Records and Facilities

VI. Cross Reference:

A. Policy and Procedures (P&P):

1. MM-UM11: Hospice Services
2. MM-UM22: Clinical Criteria for UM Decisions
3. MM-UM38: Post Stabilization Care Services Authorizations and After-Hours Availability of Medical Director
4. HS-MM49: Utilization Review – 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	Annual P&P Review & NCQA Updates	01/2024	N/A
10/2023	Christopher Hill, RN, MBA Health Services Officer; Emily Fonda, MD, MMM, CHCQM Chief Medical Officer	2024 Template Migration	01/2024	N/A
12/2022	Christopher Hill; Amanda Flaum	Updated for compliance with 2024 DHCS Contract (R.0062 and R.0067)	01/2024	2022
10/2022	Christopher Hill; Amanda Flaum	Updated for compliance with 2024 DHCS Contract (R.0173)	01/2024	2022
09/2022	Christopher Hill, Director of Medical Management Amanda Flaum, Chief Operating Officer	Updated for compliance with 2024 DHCS Contract (R.0070)	01/2024	2022