POLICY AND PROCEDURE	
Policy # and TITLE: UM07 Notice of Action for Delayed, Denied, Modified, or Terminated Services	
Primary Policy owner: Utilization Management	**POLICY #:** UM07
Impacted/Secondary policy owner: Select the department(s) that are responsible for compliance with all, or a portion of the policy or procedure as outlined	
1) ☐All Departments 2) ☒Behavioral Health (BH) 3) ☐Benefits Administration (BA) 4) ☒Care Management (CM) 5) ☐Claims (CLMS) 6) ☐Community Marketplace & Member Engagement (MAR) 7) ☐Compliance (CMP/HPA) 8) ☐Configuration (CFG) 9) ☐Provider Contracting (CONT) 10) ☐Cultural & Linguistics (CL) 11) ☐Customer Service (CS)	12) ☐Facilities (FAC) 13) ☐Finance (FIN) 14) ☒Health Equity (HEQ) 15) ☐Human Resources (HR) 16) ☐Information Technology / Core Systems (IT) 17) ☒Pharmacy (PH) 18) ☐Provider Networks (PRO) 19) ☒Quality Management (QM/GRV/HE) 20) ☒ Utilization Management (UM)
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** Policy # and Policy Title

I. PURPOSE

Health Plan of San Joaquin (HPSJ) provides timely notification of Notice of Action letters to providers and members for decisions on requested services. The Department of Health Care Services (DHCS) and

Department of Managed Health Care (DMHC) require health plans to notify their members and providers when pre-service, concurrent, or post-service authorization requests are delayed, denied, or modified. In addition, members and providers are notified when the health plan intends to take action to reduce or terminate services already being rendered.

II. POLICY

A. Utilization Management staff will follow the review process and timeframes for routine and urgent pre-authorization and inpatient review requests as stated in policy and procedure UM 01. All medical necessity denial determinations will be made by a physician. HPSJ provides practitioners with the opportunity to discuss any UM denial decision based on Medical Necessity with an appropriate Physician Reviewer.

B. Utilization management decisions are based only on appropriateness of care, service, and the existence of coverage. There are no rewards or incentives for practitioners or other individuals for issuing denials of coverage, service, or care. There are no financial incentives for utilization management decision- makers to encourage decisions that would result in underutilization.

III. PROCEDURE

A. Notice of Action Letters

a. Members and Providers are provided with written notification (Notice of Action Letters) for denial, deferral, modification, and termination determinations which clearly document and communicate the reasons for the decision so that Members and Providers receive sufficient information in easily understandable language to be able to understand the decision and decide whether to Appeal the decision.

b. The written NOA must meet all language and accessibility standards, including translation, font and format requirements, as set forth in APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, federal and state law, and all requirements in the DHCS contract.

c. All Member and Provider notification requirements are outlined in Policy UM 01.

d. If HPSJ fails to adhere to the state and federal notice and time from requirements for a NOA, including failure to provide a fully translated notice, the member is deemed to have exhausted the internal appeals process and may initiate a state hearing.

B. Denials

a. Denial Notice of Action (NOA) letters sent to Members and requesting Practitioners contain:

i. The determination

ii. The specific reasons for the determination in easily understandable language including the clinical reasons for a decision regarding medical necessity. In addition, the following information is contained for the specified circumstances:

1. Medical Necessity Criteria Not Met: The notification must state how the reason for the determination pertains to the Member's particular case to ensure that Members and Practitioners understand why the decision was made and have enough information to decide about appealing the determination.
2. Requested Information Not Received: If there is NO clinical information whatsoever, the letter will note the inability to reference any specific Utilization Management Criteria.
3. Condition or service is covered by another service agency and not by the Health Plan: HPSJ will provide details of other payer, including effective date or Service Authorization Request (SAR) number, when known.
4. Medication request is not a Formulary Drug: Appropriate alternative formulary medication will be

indicated with a notation that the physician and pharmacy have been notified.

iii. A reference to the Medical Necessity Criteria, benefit provision, guideline, protocol, or other similar criteria, including a citation of the specific regulations or HPSJ's administrative procedures supporting the action on which the deferral, modification, denial, or termination decision is based.

iv. All required DHCS/DMHC appeal requirements information applicable to the Medi-Cal member, including:

    1. A description of the appeal rights available to the member according to their product line, including the right to submit written comments, documents, or other information relevant to the appeal.

v. A description of the expedited appeal process for urgent pre- service or urgent concurrent delays, denials, modifications, or terminations

vi. The right to request an Independent Medical Review (IMR). Including the current IMR form, application instructions, Department of Managed Health Care's (DMHC) toll-free telephone number and an envelope addressed to DMHC.

vii. For Medi-Cal members specifically:

1. The member's right to, and method of obtaining, a fair hearing and expedited fair hearing to contest the denial, deferral, modification, or terminate action including the most current state fair hearing form.
2. The member's right to represent himself/herself at the fair hearing or expedited fail hearing or to be represented by legal counsel, friend, or another spokesperson.
3. The name and address, the state toll-free telephone number for obtaining information on legal service organizations for representation.

viii. For concurrent and post-service denials, denial NOA letters are sent to all Members.

ix. For urgent concurrent denial decisions at a hospital level of care, HPSJ may verbally inform the hospital UR department of the determination. This verbal notification is followed by a written notification to both the Hospital and the treating Practitioner. Practitioner notices may be sent to the hospital but must be addressed to the attention of the attending/treating practitioner.

x. For benefit denials, or denials completed without medical necessity review, the RN will review and sign the denial of a requested service that is specifically excluded from a

member's benefit plan and is not covered by HPSJ under any circumstances. Members < 21 years old are not subject to benefit denials due to EPSDT.

xi. If there is a benefit that has quantity or benefit limits and additional services outside of the limit are requested, HPSJ will review the request for medical necessity. All services are based solely on medical necessity for the individual member's needs.

C. Reconsideration Process for Denials, Deferrals, Modifications, and Terminations

a. At any time, a requesting practitioner may call to discuss the case with a Peer Reviewer or may write to supply additional information for the Peer Reviewer.

b. HPSJ UM Department responds to reconsideration requests within one (1) business day of the receipt of the requesting Practitioner telephone call or written request.

c. If the Peer Reviewer reverses the original UM determination based on the discussion with, or additional information provided by, the Practitioner, the case will be closed.

d. If reconsideration does not resolve a difference of opinion, and the previous UM determination remains or a modification results, or if the Practitioner does not request reconsideration, the Practitioner may submit a request for review through the Provider Dispute process (see Policy CLMS 07: Provider Dispute Resolution)

or may Appeal on behalf of the member, if appropriate on the condition that provider has a written consent from the member.

D. Delay/Defer

a. A Delay/Defer NOA letter will be generated and mailed to the Member and requesting Practitioner when:
    i. Additional clinical information is required to apply the UM criteria. These letters will contain the following:
        1. Reference to the clinical criteria that has not been met because of inadequate information. The letter must specifically describe the information needed to render a decision in a manner that the Member can understand what is needed.
    ii. Consultation by an expert reviewer is necessary:
        1. The letter will explain why an expert reviewer is necessary and the date expected to make the final decision. Additional examination or tests that need to be performed. The letter will indicate the specific tests or exam needed and that when complete, to resubmit the request along with the test or exam findings.
    iii. For cases without an open SAR a referral is made to CCS for eligibility determination:
        1. The letter will state that the service requested is covered by the California Children's Services as a

carve-out and the request has been forwarded to CCS for review and/or approval. Additionally, HPSJ will forward the request to CCS for review. The letter must inform the member that he/she will continue to receive medically necessary, benefit covered services from the health plan until CCS reaches a decision.

iv. For cases with a with an open SAR:

1. The letter will state that the service requested is denied and covered by CCS. HPSJ will forward the request to CCS and notify both the member and the provider of the decision.

E. Modification, Reduction

a. HPSJ will issue a NOA letter when it decides to modify, or reduce, care, or terminate services. The time frame for such mailing is described in Policy #UM 01.

i. The Modify, Reduce, Terminate NOA letter will include the Member's right to appeal, and the appeal process the right to request an independent Medical Reviewer (IMR), the current IMR form, application instructions, DMHC toll-free telephone number and an envelope addressed to DMHC.

F. Member Grievance and Appeals Processes Described

a. All NOA letters described in this policy will include a description of the Member appeal process, the right to a state fair hearing, the state fair hearing form, the right to request an IMR (Independent Medical Review), the current IMR form, application instructions, DMHC toll-free telephone number and an envelope addressed to DMHC and the steps to take, including:

   i. How to file a Grievance or Appeal with HPSJ.

   ii. How a fair hearing can be obtained from the state.

      1. That the Member has a right to continuation of benefits during the State Fair Hearing, and that Contractor is obligated to continue benefits as long as the requirements of 42 CFR section 438.420 are met.

   iii. That the Member may be either self-represent or be represented by an authorized third party such as legal counsel, relative, friend or another person.

   iv. The time limits for filing a Grievance or Appeal and for requesting a fair hearing.

   v. The right to request an IMR or a review of Contractor's decision by DMHC, and that the IMR must be requested before there is a final State Fair Hearing decision.

vi. The Department of Managed Health Care (DMHC) member notification information (Health and Safety Code, Section 1368.02).

vii. The DHCS-approved "Your Rights" attachments.

b. The HPSJ Grievance Coordinator will handle all grievances filed by a Member, Member Representative, or Practitioner acting on behalf of the Member.

G. Processing and Retention of Notice of Action Letters (NOA's)

a. NOA letters will be processed as required in order to comply with timeliness standards.

i. NOA letters for modified or denied requests based on medical necessity will be reviewed and signed by the Medical Director.

b. All Provider NOA letters will include instructions for contacting the UM Department or Physician.

c. All NOAs are retained for 10 years per HPSJ policy CMP 02: Records Management and Retention.

H. Quality Improvement Performance Measuring

a. On a quarterly basis using NCQA Audit tool, five (5) randomly selected cases with associated letters from each utilization staff member will be audited for compliance with most restrictive standard and documentation timeliness.

b. The audit results will be discussed with appropriate staff, aggregated, and included as part of the quality improvement data.
c. Appropriate action, such as staff education, counseling and/or disciplinary action, as appropriate to the situation, will take place as required when performance standards are not met.
d. Reports will be forwarded to the department leadership.

I. UM Record Retention Requirements

a. UM Records, including any Notices of Action letters, shall meet current federal, State, and DHCS Medi-Cal record retention requirements.
b. DHCS Medi-Cal record retention requirements are as follows:
    i. UM Records shall be maintained for a minimum of ten years from the end of the Fiscal Year:
        1. In which the date of the service occurred.
        2. In which the record or data was created or applied; and for which the financial record was created, or the Contract is terminated, or
    ii. In the event HPSJ has been duly notified that DHCS, DMHC, DOJ, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of HPSJ's Agreement with DHCS for the provision of Medi-Cal

Services, until such time as the matter under audit or investigation has been resolved, whichever is later.

IV. ATTACHMENT(S)

a. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
b. Glossary of Terms Link
c. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

A. APL 21-011
B. APL 21-004
C. CL05 Translation of Written Informing Materials
D. DHCS Contract, Exhibit A, Attachment 13, #8
E. DHCS MMCD ALL Plan Letter 05005
F. Health and Safety Code, Sections 1368.02, 1367.01
G. NCQA Standard UM 2: Clinical Criteria for UM Decisions
H. NCQA Standard UM 4: Appropriate Professionals
I. NCQA Standard UM 5: Timeliness of UM Decisions
J. NCQA Standard UM 6: Clinical Information
K. NCQA Standard UM 7: Denial Notices
L. NCQA Standard UM 8: Policies for Appeals N. APL 17-006
M. Title 22, CCR, Sections 51014.1, 51014.2, 51003, 51303, 53894

N. UM 01 Authorization and Referral Review

O. UM 06 Medical Review Criteria

P. UM 65 UM Appeals

VI. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date
000	09/01, 08/02, 10/04, 11/05, 09/08, 03/09, 07/12, 12/13, 09/14, 1/15, 10/15, 12/15, 03/16, 10/16, 04/18, 08/18, 04/20, 03/21, 02/22, 11/22	N/A
001	Moved UM07 to new template	06/13/2023
002		
Initial Effective Date: 02/01/1996		

VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	001	05/18/2023
• Privacy & Security Oversight Committee (PSOC)		
• Risk Management		
• Delegation Oversight		

• Policy Review	001	4/19/2023
Quality and Utilization Management	001	
• Quality Of Care		
• Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	JoAnn Wright	001	12/09/2022
Department of Managed Care (DMHC)			

IX. Approval *signature**

Signature	Name Title	Date
	PRC Chairperson	
	Policy Owner	
	Department Executive	
	Chief Executive Officer	

*Signatures are on file, will not be on the published copy

X. Addendum

Health Plan of San Joaquin ensures system controls are in place for all Medical Management Systems including the system used to process UM denials and appeals. Date of receipt date is when a fax, email, phone call, or mail correspondence is received by HPSJ. This receipt date, and written notification dates are hard stamped and cannot be modified. **-UM 12A 1**

a. Health Plan of San Joaquin system controls ensure the written notification dates meet all applicable timeframes. Upon creation of UM Denial, and appeal written notifications the date is auto generated by the system and cannot be modified. **-UM 12A 2**
b. Health Plan of San Joaquin system controls ensure that upon written notification generation the creation date is recorded by the system and cannot be modified. **-UM 12A 3**
c. Only Health Plan of San Joaquin Authorized Medical Management Staff are allowed access within the system to enter initial case correspondence when received. Authorized staff include Intake Processors, Grievance Coordinators, Medical Management Nursing Staff, and MM Leadership staff including Directors, Managers, Supervisors, and Leads. This staff is also allowed to enter and edit case information. Once initial case information is entered the case creation date is auto generated by the system, and then cannot be modified. Case entries, and edits are allowable within the system,

but there can be no modifications to case receipt, and written notification dates. **UM 12 4**

d. Case documentation tracking will include how information was modified, who made the modification, and why the information was modified. **-UM12 5**
e. The Medical Management Department protects physical access to all medical management information in accordance with IT 30 Physical and Environmental Security. This includes ensuring that only authorized individuals with the proper credentials can enter the building. Health Plan of San Joaquin Medical Management system controls are in place to ensure security and system access are protected from unauthorized entry in accordance with HPSJ policy IT 402 Information Systems Access Management. This includes ensuring all users have proper username and passwords. **UM12 6**
f. To ensure system controls and procedures are being met the Medical Management System Administrator will monthly randomly select 10% of all UM denials and appeals for audit. All results are forward to MM supervisors and Leads. The audits will ensure the following are met **UM 12 7**
    i. Written notification, and case receipt dates are consistent with applicable timeframes.
    ii. Only authorized individuals have accessed UM denial, and appeal cases.
    iii. No unauthorized modification of have occurred.

iv. Cases manually entered have appropriate documentation uploaded in the system to compare the actual receipt date to the system generated receipt date.

The Medical Management Department has the oversight, and responsibility of the audits.

Notice of Action Notification Timeframe			
Type of Request	**Decision**	**Initial Notification (Notification May be Oral and/or Electronic)**	**Written/Electronic Notification of Denial and Modification to Practitioner and Member**
Routine (Non-urgent) Pre-Service • All necessary information received at time of initial request	Within 5 working days of receipt of all information reasonably necessary to render a decision	Practitioner: Within 24 hours of the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision.
Routine (Non-urgent) Pre-Service **– Extension Needed** • Additional clinical information required • Require consultation by an Expert Reviewer • Additional examination or tests to be	Within 5 working days from receipt of the information reasonably necessary to render a decision but no longer than 14 calendar days from the receipt of the request • The decision may be deferred, and the time limit extended an additional 14 calendar days only	Practitioner: Within 24 hours of making the decision Member: None Specified Practitioner:	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision Practitioner:

performed (AKA: Deferral)	where the Member or the Member's provider requests an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest • Notify member and practitioner of decision to defer, in writing, within 5 working days of receipt of request & provide 14 calendar days from the date of receipt of the original request for submission of requested information. Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered **Additional information**	Within 24 hours of making the decision Member: None Specified	Within 2 working days of making the decision Member: Within 2 working days of making the decision

	received • If requested information is received, decision must be made within 5 working days of receipt of information, not to exceed 28 calendar days from the date of receipt of the request for service **Additional information incomplete or not received** • If after 28 calendar days from the receipt of the request for prior authorization, the provider has not complied with the request for additional information, the plan shall decide with available information.		
Expedited Authorization (Pre-Service) • Requests where provider indicates or the Provider Group/Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to	Within 72 hours of receipt of the request a decision shall be made in a timely fashion appropriate for the nature of the enrollee s condition, not to exceed 72 hours	Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service

attain, maintain or regain maximum function. • All necessary information received at time of initial request			
Expedited Authorization (Pre-Service) - Extension Needed • Requests where provider indicates or the Provider Group/Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. • Additional clinical information required	**Additional clinical information required**: Upon the expiration of the 72 hours or as soon as you become aware that you will not meet the 72-hour timeframe, whichever occurs first, notify practitioner and member using the "delay" form, and insert specifics about what has not been received, what consultation is needed and/or the additional examinations or tests required to make a decision and the anticipated date on which a decision will be rendered • Note: The time limit may be extended by up to 14 calendar days if the Member requests an extension, or if the Provider Group / Health Plan can provide justification upon request by the State for the need for additional	Practitioner: Within 24 hours of making the decision Member: None specified Practitioner: Within 24 hours of making the decision Member: None specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision

	information and how it is in the Member's interest **Additional information received** • If requested information is received, decision must be made within 1 working day of receipt of information. **Additional information incomplete or not received** • Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.		
Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulator y services) In the case of concurrent review, care shall not be discontinued until the enrollee's treating	Within 5 working days or less, consistent with urgency of Member's medical condition NOTE: When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 24 hours of making the decision Member: Within 2 working days of making the decision

provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process… would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination **CA H&SC 1367.01 (h)(2)**		
Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days from receipt or request	Member & Practitioner: None specified	Member & Practitioner: Within 30 calendar days of receipt of the request

Post-Service-Extension Needed •Additional clinical information required	**Additional clinical information required (AKA: deferral)** • Decision to defer must be made as soon as the Plan is aware that additional information is required to render a decision but no more than 30 days from the receipt of the request **Additional information received** • If requested information is received, decision must be made within 30 calendar days of receipt of information Example: Total of X + 30 where X = number of days it takes to receive requested information **Additional information incomplete or not received** • If information requested is incomplete or not received, decision must be made with the information that is available by the end of the 30th	Member & Practitioner: None specified Member & Practitioner: None Required	Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination Member & Practitioner: Within 30 calendar days from receipt of the information necessary to make the determination

	calendar day given to provide the information		
Hospice - Inpatient Care	Within 24 hours of receipt of request	Practitioner: Within 24 hours of making the decision Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision