POLICY AND PROCEDURE	
Policy # and TITLE: Medical Review Criteria	
Primary Policy owner: Utilization Management	**POLICY #:** UM06
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 & Social Services (BH/SS) 3) ☐ Benefits Administration (BA) 4) ☒ Case 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) ☐ Human Resources (HR) 15) ☐ Information Technology / Core Systems (IT) 16) ☐ Pharmacy (PH) 17) ☐ Provider Networks (PRO) 18) ☒ QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) ☒ Utilization Management (UM) 20) ☐ Procurement (PRM) 21) ☐ Administration (SAF/BC/EM) 22) ☐ Medical Management (MM)
PRODUCT TYPE: ☒Medi-Cal	**Supersedes Policy Number:** *N/A*

I. PURPOSE

This policy describes the process for review, acceptance, application and disclosure of medical necessity criteria utilized by Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") to make decisions about care requests.

II. POLICY

A. The definition of Medical Necessity for individuals 21 and older is services that are "reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain".

B. Medically Necessary services for members less than 21 years of age include all services necessary to achieve, support, or maintain (ameliorate)age-appropriate growth and development, attain, regain, or maintain functional capacity, or improve, support, or maintain the member's current health condition. Health Plan determines Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.

C. Annually, Health Plan's Quality Improvement Health Equity Committee (QIHEC) reviews and adopts guidelines and licensed, evidence-based medical review criteria used to determine medical necessity and the clinical appropriateness of medical, behavioral health and pharmaceutical services.

1. The review and development of criteria or guidelines require involvement from actively practicing health care providers and are consistent with sound clinical principles and processes.
2. Clinical criteria regarding pharmaceutical management are initiated and investigated through the Pharmacy and Therapeutics (P&T) Committee prior to review by the QIHEC Committee, in accordance with Health Plan Policy PH 05 Prior Authorization Review.

D. Health Plan utilization management (UM) clinical staff, including physician reviewers, consider the following when applying criteria to a given individual during the authorization review process:

1. Age
2. Comorbidities
3. Complications
4. Progress with treatment
5. Psychosocial situation
6. Home environment, when applicable
7. The member's individual needs

E. For Members under age 21, Early, Periodic, Screening, Diagnosis and

Treatment (EPSDT) guidelines are applied in accordance with Health Plan Policy UM48 Requirements for Coverage of EPSDT Services for Medi-Cal Beneficiaries.

1. For Members under 21, receiving Behavioral Health Treatment (BHT) EPSDT guidelines are applied in accordance with BH08: Behavioral Health Treatment Utilization Management.

F. UM staff also consider characteristics of the local delivery system, such as the:
   1. Availability of skilled nursing facilities, sub-acute care facilities or home care within the service area to support the patient after hospital discharge.
   2. Local hospitals' ability to provide all recommended services within the estimated length of stay.
   3. Availability of outpatient services such as a surgery center instead of an inpatient facility.
   4. Availability of highly specialized services, such as transplant facilities or cancer centers.

G. Written UM procedures direct decision makers to alternatives when the above factors indicate that UM guidelines are not appropriate.

H. Through participation on a committee or by written comments from practitioners to whom criteria has circulated, practitioners with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on development or adoption of UM criteria and on instructions for applying the criteria.

III. PROCEDURE

A. Hierarchy of Medical Necessity Review Criteria
   1. The following medical necessity review criteria are used when evaluating specific authorization requests for medical treatment, in the following order:
      a. The State of California's Medi-Cal Provider Manual Criteria serves as the primary reference for benefit coverage determinations and authorization criteria when available.
      b. MCG, Health Plan's licensed source for nationally accepted, evidence-based guidelines.

c. EPSDT requirements per Health Plan Policy UM48 Early and Periodic Screening, Diagnosis and Treatment.
d. Nationally recognized, peer reviewed, published guidelines, such as, but not limited to the United States Preventive Services Task Force (USPSTF) Recommendations, American Academy of Pediatrics (AAP).
e. UM policies or internally developed guidelines.

B. Health Plan ensures that medical criteria are cited in Notice of Action letters mailed to members, practitioners, and providers when requests for services are delayed, denied, or modified because medical criteria are not met, whether in part or in whole, in accordance with Health Plan policy UM07 Notification to Members of Denial, Deferral or Modification.
C. For the specific case under review, upon request, criteria or guidelines cited in a delay, denied or modified request are disclosed to the provider and member by postal mail or facsimile.
D. Practitioners/providers are notified in writing that medical necessity criteria are available upon request through the Health Plan quarterly newsletter, included in each NOA (notification of action) and available in the Health Plan Provider Manual.
E. Criteria can be made available to the public upon request. Health Plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. Health Plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines, limited to copying and postage costs. Health Plan may also make the criteria or guidelines available through electronic communication means.
    1. Disclosure of specific criteria or guidelines must be accompanied by the following notice:
        a. “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.”
F. Oversight and Reporting

1. Inter-rater Reliability (IRR) Testing is conducted at least annually to assess determinations made by UM staff, including physician advisors or consultants and medical directors, to evaluate the consistency in applying criteria.
    a. If the report findings indicate that there is inconsistency in criteria application, corrective education and/or individual action plans are implemented in an effort to improve consistency in applying criteria.
    b. The requirement for passing IRR is 90%. This is a mandatory test.
        i. Any nurses or physicians who score below 90% are required to be re-trained and re-audited in 6 months.
        ii. Any physician reviewer not completing the IRR are removed from the panel of reviewers until successful completion of IRR.

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. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members under the Age of 21.
B. Health and Safety Code, Sections 1367.01 and 1363.5
C. Health Plan Policy BH08 Behavioral Health Treatment Utilization Management
D. Health Plan Policy PH 05 Prior Authorization Review
E. Health Plan's Policy QM38 Quality Improvement and Health Equity Committee (QIHEC)
F. Health Plan Policy UM07 Notification to Members of Denial, Deferral or Modification

G. Health Plan Policy UM48 Early and Periodic Screening, Diagnosis and Treatment
H. NCQA Standard UM 2, Clinical Criteria for UM Decisions
I. NCQA Standard UM 4, Appropriate Professionals
J. Welfare and Institutions Code, Section 14087.41

VI. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date
001	09/02, 09/04, 10/10, 06/12, 12/13, 09/14,11/14, 02/16, 06/17, 05/19, 07/20, 10/21, 11/21, 10/22, 06/23, 08/23	N/A
002	Moved UM06 to new template	10/13/2024
003	Added language for the DMHC KKA Policy Filing Project	11/30/2024
004	Inclusion of reference to BHT policy	03/01/2024
005	Revision to clarify and update references to EPSDT and expanded definition of ameliorate; Revised medical necessity review criteria hierarchy	08/13/2024
006		
Initial Effective Date: 02/01/1996		

VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	005	02/20/2025
• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review	005	12/18/2024

Quality Improvement Health Equity Committee (QIHEC)	005	02/05/2025
• Quality Operations Committee		
• Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manager File & Use	002	10/03/2023
Department of Managed Care (DMHC)	DMHC Attorney	004	09/12/2024

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