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 & Social Services (BH/SS) 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) ☐ 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

Health Plan of San Joaquin and Mountain Valley Health Plan ("Health Plan") 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 Health Plan intends to take action to reduce or terminate services already being rendered.

II. POLICY

A. Utilization Management staff follows the review process and timeframes for routine and urgent pre-authorization and inpatient review requests as stated in Health Plan policy UM 01.
   1. All medical necessity denial determinations is made by a physician.
   2. Health Plan 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.
   1. There are no rewards or incentives for practitioners or other individuals for issuing denials of coverage, service, or care.
   2. There are no financial incentives for UM decision-making management to encourage decisions that would result in underutilization.

C. The provision of the Behavioral Health Treatment (BHT) benefit follows the procedural process outlined in this policy. The deviation from this policy regarding the types of professionals for appropriate decision making is outlined in BH08: Behavioral Health Treatment Utilization Management.

III. PROCEDURE

A. **Notice of Action Letters**
   1. Members and Providers are provided with written notification (Notice of Action Letters) for denial, deferral, modification, Carve Out 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.

2. 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.
3. All Member and Provider notification requirements are outlined in Health Plan policy UM 01.
4. All decisions to deny, delay or modify requests must be communicated to members in writing, and to providers initially by telephone or facsimile, except with regards to retrospective requests and decisions, and then in writing.
5. If Health Plan fails to adhere to the state and federal notice and time from requirements for 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**

1. Denial Notice of Action (NOA) letters sent to Members and requesting Practitioners within 24 hours of print date and contain:
    a. The determination of denied
    b. The specific reasons for the determination clear and concise language, written at a 6th grade reading level and must include the clinical reasons for a decision regarding medical necessity.
        i. The clinical reasons must explicitly state how the member's condition does not meet the criteria or guidelines.
        ii. 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 notes the inability to reference any specific Utilization Management Criteria.
3) Condition or service is covered by another service agency and not by Health Plan: Health Plan provides details of the 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 is indicated with a notation that the physician and pharmacy have been notified.

c. A reference and description to the Medical Necessity Criteria, benefit provision, guideline, protocol, or other similar criteria, including a citation of the specific regulations or Health Plan's administrative procedures supporting the action on which the deferral, modification, denial, or termination decision is based.
d. The written denial letter to the provider must include the name and telephone number of the provider responsible for the denial, delay or modification. The telephone number provided shall be a direct number of an extension, to allow the physician to contact the medical director responsible for the determination.
e. All DHCS/DMHC required appeal requirement information applicable to the Medi-Cal member, includes:
    i. A description of the appeal rights available to the member or provider according to their product line, including the right to submit written comments,

documents, or other information relevant to the appeal.

f. A description of the expedited appeal process for urgent pre-service or urgent concurrent delays, denials, modifications, or terminations
g. 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.
h. For Medi-Cal members specifically:
    i. 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.
    ii. 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.
    iii. The name and address, the state toll-free telephone number for obtaining information on legal service organizations for representation.
    iv. The member's right to request a state hearing after filing an internal appeal with Health Plan and receiving notice that the adverse benefit determination has been upheld.
    v. Circumstances under which an expedited review is available and how to request one.
    vi. The member's right to Aid Paid Pending and instructions on how to timely file for an appeal.
i. For concurrent and post-service denials, denial NOA letters are sent to all Members.
j. For urgent concurrent denial decisions at a hospital level of care, Health Plan 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.

k. For benefit denials, or denials completed without medical necessity review, the RN reviews and signs the denial of a requested service that is specifically excluded from a member's benefit plan and is not covered by Health Plan under any circumstances. Members < 21 years old are not subject to benefit denials due to EPSDT.

l. If there is a benefit that has quantity or benefit limits and additional services outside of the limit are requested, Health Plan reviews 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**

1. 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.
2. Health Plan UM Department responds to reconsideration requests within one (1) business day of the receipt of the requesting Practitioner telephone call or written request.
3. If the Peer Reviewer reverses the original UM determination based on the discussion with, or additional information provided by, the Practitioner, the case is closed.
4. 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 Health Plan 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**

1. A Delay/Defer NOA letter includes the anticipated date on which a decision may be rendered. The Delay/Defer NOA letter is generated and mailed to the Member and requesting Practitioner when:
    a. Additional clinical information is required to apply the UM criteria. These letters contain the following:
        i. 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 so that the Member can understand what is needed.
    b. Consultation by an expert reviewer is necessary:
        i. The letter explains why an expert reviewer is necessary and the date expected to make the final decision. Additional examinations or tests that need to be performed. The letter indicates the specific tests or exam needed and when complete, to resubmit the request along with the test or exam findings.
    c. Upon receipt of all information reasonably necessary and requested, Health Plan approves, modifies, or denies the request within the timeframes.
    d. For cases without an open SAR a referral is made to CCS for eligibility determination:
        i. The letter states 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, Health Plan forwards the request to CCS for review. The letter must inform the member that he/she continues to receive medically

necessary benefit covered services from Health Plan until CCS reaches a decision.

e. For cases with a with an open SAR:
    i. The letter states that the service requested is denied and covered by CCS. Health Plan forwards the request to CCS and notify both the member and the provider of the decision.

E. **Modification, Reduction**

1. Health Plan issues a NOA letter when it decides to modify, or reduce, care, or terminate services. The time frame for such mailing is described in Health Plan policy UM 01
    a. The Modify, Reduce, Terminate NOA letter includes 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**

1. All NOA letters described in this policy 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:
    a. How to file a Grievance or Appeal with Health Plan.
    b. How fair hearing can be obtained from the state.
        i. That the Member has the right to continue 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.
    c. 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.
    d. The time limits for filing a Grievance or Appeal and for requesting a fair hearing.
    e. 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.

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

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

2. Health Plan Grievance Coordinator handles 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)**

1. NOA letters are processed as required in order to comply with timeliness standards.
   a. NOA letters for modified or denied requests based on medical necessity are reviewed and signed by the Medical Director.
2. All Provider NOA letters include instructions for contacting the UM Department or Physician.
3. All NOAs are retained for 10 years per Health Plan policy CMP02 Records Management and Retention.

H. **Quality Improvement Performance Measuring**

1. On a quarterly basis using NCQA Audit tool, five (5) randomly selected cases with associated letters from each utilization staff member are audited for compliance with the most restrictive standard and documentation timeliness, as well as clear and concise languate within the NOA.
2. The audit results are discussed with appropriate staff, aggregated, and included as part of the quality improvement data.
3. Appropriate action, such as staff education, counseling and/or disciplinary action, as appropriate to the situation, take place as required when performance standards are not met.
4. Reports are forwarded to the department leadership.

I. **UM Record Retention Requirements**

1. UM Records, including any Notices of Action letters, shall meet current federal, State, and DHCS Medi-Cal record retention requirements.

2. DHCS Medi-Cal record retention requirements are as follows:
    a. UM Records shall be maintained for a minimum of ten years from the end of the Fiscal Year:
        i. In which the date of the service occurred.
        ii. In which the record or data was created or applied; and for which the financial record was created, or the Contract is terminated, or
    b. In the event Health Plan 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 Health Plan'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.

J. **Terminal Illness**

1. When Health Plan denies coverage or a request for authorization for a member with a terminal illness, health Plan needs to provide written notification within five (5) business days with all of the following information:
    a. A statement detailing the specific medical and scientific reasons for denying coverage or authorization.
    b. A description of alternative treatment, services, or supplies covered by Health Plan, if any.
    c. Copies of Health Plan's grievance procedures or complaint forms, or both.
    d. Upon receiving a complaint form requesting a conference as part of the grievance procedures, Health Plan shall provide the member, within 30 calendar days, an opportunity to attend a conference, to review the information provided to the member, conducted by Health Plan's representative having authority to determine the disposition of the complaint. Health Plan shall allow attendance, in person, at the conference, by a member, a designee of the member, or both, or, if the member is a minor or incompetent, the parent, guardian, or conservator of the member, as appropriate. The

required conference shall be held within five (5) business days if the treating participating physician determines, after consultation with Health Plan's CMO or his or her designee, based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by Health Plan, would be materially reduced if not provided at the earliest possible date.

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. DHCS APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
B. DHCS APL 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates.
C. DHCS Contract, Exhibit A, Attachment 13, #8
D. DHCS MMCD ALL Plan Letter 05005
E. Health Plan policy BH08 Behavioral Health Treatment Utilization Management
F. Health Plan policy UM 01 Authorization and Referral Review
G. Health Plan policy UM 06 Medical Review Criteria
H. Health and Safety Code, Sections 1368.02, 1367.01
I. Title 22, CCR, Sections 51014.1, 51014.2, 51003, 51303, 53894

VI. REVISION HISTORY

*Version 001 as of 01/01/2023

Version*	Revision Summary	Date
001	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
002	Moved UM07 to new template	06/13/2023
003	Annual Review, no substantive changes	08/16/2024
Initial Effective Date: 09/01/2001		

VII. Committee Review and Approval

Committee Name	Version	Date
Compliance Committee	003	02/20/2025
• Privacy & Security Oversight Committee (PSOC)		
• Program Integrity Committee		
• Audits & Oversight Committee		
• Policy Review	003	12/18/2024
Quality Improvement Health Equity Committee (QIHEC)	003	02/05/2025
• Quality Operations Committee		
• Grievance		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manager	001	12/9/2022
Department of Managed Care (DMHC)	DMHC Attorney	003	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