

POLICY AND PROCEDURE	
Title: Authorization and Referral Review	
Primary Policy owner: Utilization Management	POLICY #: UM01
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) <input type="checkbox"/> All Departments 2) <input checked="" type="checkbox"/> Behavioral Health & Social Services (BH/SS) 3) <input type="checkbox"/> Benefits Administration (BA) 4) <input checked="" type="checkbox"/> Case Management (CM) 5) <input type="checkbox"/> Claims (CLMS) 6) <input type="checkbox"/> Community Marketplace & Member Engagement (MAR) 7) <input type="checkbox"/> Compliance (CMP/HPA) 8) <input type="checkbox"/> Configuration (CFG) 9) <input type="checkbox"/> Provider Contracting (CONT) 10) <input type="checkbox"/> Cultural & Linguistics (CL) 11) <input type="checkbox"/> Customer Service (CS)	12) <input type="checkbox"/> Facilities (FAC) 13) <input type="checkbox"/> Finance (FIN) 14) <input type="checkbox"/> Human Resources (HR) 15) <input type="checkbox"/> Information Technology / Core Systems (IT) 16) <input checked="" type="checkbox"/> Pharmacy (PH) 17) <input type="checkbox"/> Provider Networks (PRO) 18) <input checked="" type="checkbox"/> QI Health Equity (GRV/HE/HEQ/PHM/QM) 19) <input checked="" type="checkbox"/> Utilization Management (UM) 20) <input type="checkbox"/> Procurement (PRM) 21) <input type="checkbox"/> Administration (SAF/BC/EM) 22) <input type="checkbox"/> Medical Management (MM)
Product Type: <input checked="" type="checkbox"/> Medi-Cal <input type="checkbox"/> D-SNP	Supersedes Policy Number: N/A

I. PURPOSE

This policy describes the process for authorizing services that require a medical necessity review. It also describes timeframes and qualifications

for the staff who process the reviews and those that can make denial determinations.

II. POLICY

- A. Health Plan of San Joaquin and Mountain Valley Health Plan (“Health Plan”) requires all covered services for physical and behavioral health conditions, including major organ transplant and physician and facility administered drugs, that require authorization, be submitted to Health Plan’s Utilization Management (UM) department, or it’s delegated entities, for review for medical necessity.
- B. Emergency services never require authorization, whether provided by a participating or non-participating provider.
- C. Medi-Cal services not subject to Prior Authorization (PA) Requirements
 - 1. Services not requiring PA for Out-of-network (OON) and in-network (INN) services:
 - a. Family Planning Services
 - b. STD Services
 - c. HIV Counselling and Testing Services
 - d. Minor Consent Services for all Members < 18
 - e. Immunizations provided by local health departments
 - f. Hospice Care
 - i. Routine home care
 - ii. Continuous home care
 - iii. Respite care
 - iv. Hospice physician services
 - 2. Services not requiring PA for INN services:
 - a. Preventive Services
 - b. Basic Prenatal Care for 18+

- c. Initial Mental Health and Substance Use Disorder (SUD) assessment
 - d. Referral for Screening, Brief Intervention and Referral to Treatment (SBIRT) services for Members whose PCP does not offer SBIRT
 - e. Dyadic Services
 - f. Biomarker testing associated with FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer or recurrent cancer, and
 - g. First 3 levels of care (out of 4) of hospice care.
- D. Requests for services subject to medical necessity review are evaluated in accordance with Health Plan Policy UM06 Medical Necessity Criteria.
- E. Requests for services subject to medical necessity review are evaluated in accordance with Health Plan Policy UM06 Medical Necessity Criteria and UM 48 EPSDT.
- F. Only licensed healthcare professionals competent to evaluate the specific clinical issues involved in the healthcare services requested by the provider have the authority to approve, defer, or modify authorization requests.
- G. Health Plan uses licensed health care professionals to supervise UM activities. These licensed health care professionals:
- 1. Provide day-to-day supervision of assigned UM staff.
 - 2. Participate in staff training.
 - 3. Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
 - 4. Monitor documentation for adequacy.
 - 5. Are available to UM staff on site or by telephone.
- H. Only the Chief Medical Officer, (r), medical director, peer physician reviewers, and other contracted physician reviewers, with unrestricted licenses to practice medicine in California, have the authority to deny, defer or modify requested services based on medical necessity.

- I. Health Plan does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual supports or tends to support the denial of benefits.
- J. Utilization management decisions are based only on the appropriateness of care and 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 utilization management decision-makers to encourage decisions that would result in underutilization.
- K. Health Plan allows a second opinion from an in-network provider.
 - 1. If an in-network provider is not available, Health Plan approves Out of Network (OON) provider per Health Plan's policy UM 016: Second Medical Opinion.
- L. Health Plan's Primary Care Providers (PCP) may request a standing or extended access referral to a non-network specialist or to a specialty care center for a member who has ongoing specialty care needs. Refer to Health Plan's policy UM 11 Standing referral/Extended Access to Specialty Care.
- M. Health Plan discloses to the DMHC and network providers the policies and procedures and criteria used in utilization review functions to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. Health Plan discloses these policies and procedures and criteria used to enrollees or persons designated by the enrollee, or to any other person or organization, upon request.
- N. Health Plan does not require a referral or prior authorization from a PCP for an initial mental health assessment performed by a network mental health provider.

- O. Health Plan does not require authorization for a member to see a local in-network specialist.
 - 1. The PCP makes a referral to the in-network specialist.
- P. Health Plan is prohibited from rescinding or modifying an authorization after the authorized service has been rendered.
- Q. Indian Health Services providers (IHCP), whether in-network or OON, can provide referrals directly to INN providers without requiring a referral from a network PCP or prior authorization.
 - 1. Health Plan allows American Indian Members access to an OON IHCP without requiring a referral from a Network PCP or prior authorization.
- R. American Indian Health Plan member can request to receive services from an IHCP and can choose a network IHCP as a primary care provider.
 - 1. Services from an OON IHCP may be received even if there is an in-network IHCP available.
 - 2. Health Plan assists the American Indian member in locating and connecting with an OON IHCP if there are no in-network IHCP available.
- S. Health Plan has a tribal liaison who is responsible for coordinating referrals and payment for services provided to American Indian Health Plan members who are qualified to receive services from an IHCP.
- T. When placing members for long-term services, Health Plan takes into consideration timely access and time and distance standards and complies with all timely access requirements per Health Plan's policy PRO28 Access and Availability Standards and Monitoring.
- U. Intermediate Care Facilities (ICF) are carve-out services for the plan, however Health Plan coordinates care with the member and monitors timely access.
- V. Service requests that require authorization may be reviewed for medical necessity.

1. An administrative denial may be determined as outlined in Section III, I, 2 of this policy.
 2. Community support services are reviewed based on requirements outlined in the current version of the Community Supports Policy Guide –published by DHCS per Health Plan Policy UM 50 Community Supports
- X. A Benefit beyond the DHCS imposed frequency limits may be approved if determined to be medical necessary. Y. Providers may submit requests for services by phone, fax, or provider portal.
1. The provider portal is the preferred method of submitting a request.
 2. Requests from members may be made by phone.
- W. Health Plan complies with timely access to appointments standards per Health Plan's policy PRO 28 Access and Availability Standards and Monitoring.
1. Pre-service authorization requests for care or services to non-contracted or OON providers are reviewed for medical necessity Health plan ensures Members obtain medically necessary covered services from an OON provider if services cannot be provided by an INN in accordance with contractual and timely access requirements.
 2. Health plan shall authorize and arrange for OON access when a member is unable to receive an appointment within timely access standards, unless it is determined the delay shall not have detrimental impact to the health of the Member. Please refer to Health Plan policy PRO 28: Access and Availability Standards and Monitoring
- X. Health Plan provides instructions for members that present in an emergency department for non-urgent care to both contracted and non-contracted emergency departments, which includes:

1. Instructions for follow-up with their PCP, Behavioral Health, and Social Services for follow-up care,
 2. Information on the availability of Health Plan's Nurse Advice Line that members can access to ask questions 24 hours a day-7 days a week.
 - a. A licensed Registered Nurse provides medical advice that includes, but is not limited to:
 - i. Need for urgent care services,
 - ii. Determine how soon the member needs to see their PCP for evaluation, and
 - iii. How the member can take care of their symptoms at home.
- Y. Health Plan covers care for a member who is outside California and needs service on an emergency or urgent basis.
1. Health Plan's Evidence of Coverage (EOC) includes instructions on how to access urgent or emergency services when the member is out of the service area, including outside California.
 2. If the member is outside of California and needs service on an emergency or urgent basis, but that service is not available in the area or state where the member is physically located, the member may be unable to access urgent/emergency care in a timely manner unless the member is transported to an area where services are available.
 - a. Health Plan arranges for the members to receive services in a timely manner, consistent with Health Plan's policy PRO 28: Access and Availability Standards and Monitoring. b. This may include member reimbursement for travel, including to another state, to access care.
- Z. Health Plan shall cover, without cost sharing and without prior authorization or other utilization management, the costs of the following health care services to prevent or mitigate a disease when

the Governor of the State of California has declared a public health emergency due to that disease:

1. An evidence-based item, service, or immunization that is intended to prevent or mitigate a disease as recommended by the United States Preventive Services Task Force that has in effect a rating of “A” or “B” or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention.
 2. A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the Federal Food and Drug Administration or is recommended by the State Department of Public Health or the Federal Centers for Disease Control and Prevention.
 3. Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for the disease.
- AA. The item, service, or immunization covered pursuant to paragraph W shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization.
- BB. Health Plan shall provide members who have been displaced or whose health may otherwise be affected by a state of emergency as declared by the Governor pursuant to Section 8625 of the Government Code, or health emergency, as declared by the State Public Health Officer pursuant to Section 101080, access to medically necessary health care services.
1. The Behavioral Health Treatment benefit shall comply with all regulatory requirements within this policy, h and in Health Plan policy BH01 Behavioral Health for Health Plan of San Joaquin Medi-Cal Members.
- CC. Health Plan does not require prior authorization for outpatient Medi-Cal Fee-For-Service program hospice services, except for inpatient

admissions per Health Plan Policy UM 02 Inpatient Concurrent Review and as outlined in state law.

1. Health Plan adhere to the Utilization Review standards as required by federal law.

III. PROCEDURE

A. Review Procedures for All Requests

1. This procedure covers all pre-service, concurrent, concurrent urgent, retrospective, and post-service determinations.
2. UM staff applies the appropriate Utilization Management Criteria to determine if the request meets criteria for authorization or continued authorization.
3. UM staff collect sufficient information to apply Utilization Management Criteria
 - a. When making a determination of coverage based on medical necessity, relevant clinical information is obtained and consultation with the treating practitioner occurs as necessary.
 - b. Licensed clinical staff makes or supervises all UM authorization decisions.
 - c. Staff who are not qualified health care professionals and under the supervision of appropriately licensed health professionals may approve authorization requests when there are explicit UM criteria, and no clinical judgment is required.
 - d. Medical Director(s) or Physician Peer Reviewer(s) make all denial, delay/deferral, and modification, decisions based on medical necessity.
 - e. Decisions are consistent with criteria or guidelines that are supported by clinical principles and processes.

4. Non-approval decisions for continued coverage may be made for the following reasons:
 - a. Treatment is not (or is no longer) Medically Necessary.
 - b. Medical Necessity Criteria are not (or are no longer) met.
 - c. Administrative Criteria are not (or are no longer) met.
 - d. There is insufficient information to determine if Utilization Management Criteria are met.
 - e. An exclusionary criterion has been met.
5. Approval decisions must be communicated to members and providers and must specify the specific health care service approved.
6. Adverse decisions are communicated to members and practitioners. Refer to Health Plan policy UM 07 Notice of Action for Delayed, Denied, Modified, or Terminated Services for procedures on denial notification process.
7. All decisions to approve, modify, terminate and deny) and notifications to providers and members must adhere to required timeframes outlined in detail in [Exhibit A: Decisions and Communications Timeframes – Medi-Cal listed below](#).
8. Any decision delayed beyond the regulatory time limits is considered a denial and must be immediately processed as such.
 - a. Notification to the member must include the “Your Rights” so that members may appeal the adverse determination.
 - b. Decision and notification requirements are included in [Exhibit A](#).

B. Pre-Service Review Determination Process

1. Practitioners are required to submit pre-service authorization requests and supporting clinical documents for review at least five business days prior to the anticipated service date using the Medical Management System, fax, or by phone to Health Plan’s UM Department.

2. The appropriate UM staff member reviews the request and supporting documentation and apply the appropriate Utilization Management Criteria to determine if the case meets criteria for authorization. The UM staff member may:
 - a. Approve the treatment as medically necessary.
 - b. Refer the case for review to a Medical Director, Peer Physician Reviewer, or Licensed Pharmacist because of an inability of the UM staff member to authorize the care based on the information available.
3. Services described in Section II, C, 1 & 2 of this policy are excluded from medical necessity review.
 - a. If an authorization request for such services is received, the requesting provider shall be notified that no authorization is required.
 - b. If the request for service, treatment, or equipment is determined to be medically necessary and an in-network provider is available and accessible, the authorization request is:
 - i. Referred to the Medical Director or Peer Physician Reviewer for determination.
 - ii. Redirected to a mutually acceptable in-network provider.
 - c. If the request for service, treatment, or equipment is determined to be medically necessary and an in-network provider is NOT available and/or accessible, authorization is given and a request for evaluation for care management and/or care coordination is entered.
4. If the request for service, treatment, or equipment is determined to be medically necessary and the servicing provider is out of Health Plan's network, the UM staff determines if there is a continuity of care issue present in accordance with Health Plan policy CM 69 Continuity of Care.

5. When a pre-existing relationship with the OON provider, the member may receive for up to 12 months from when the member became eligible with Health Plan until services can safely be transferred to an in-network provider.
 - a. Services may continue to be authorized for the purpose of continuity of care for up to 12 months.
 - b. UM and Case Management (CM) staff works with the member, provider, and Health Plan medical directors to develop a safe and appropriate transition plan.
 - c. If the OON referral is not related to continuity of care, Health Plan's UM team identifies an in-network provider, if available, that can provide the authorized services, and the member is re-directed to that provider with the approval of Health Plan's Medical Director.
 - d. If an in-network provider cannot provide the same services and within time or distance standards, then the OON services is authorized.
6. Health Plan adheres to the access and availability standards outlined in Health Plan's policy PRO 28 Access and Availability Standards and when processing authorization requests.
 - a. OON providers are authorized if Health Plan does not have a provider who can treat the members' condition within timely access standards. This includes providers not available in adjoining counties and those providers outside the network if the services are not available within Health Plan's network.
 - b. Transportation is provided for members who are seeing an OON provider in accordance with Health Plan's policy UM 55 Emergency Transportation, Non-Emergency Medical Transportation and Related Expenses
 - c. Members may also seek OON family planning services.
7. Health Plan provides clinical protocols and evidence-based practice guidelines governing Prior Authorization, Utilization

Management, and Retrospective Review to all OON Providers providing services to our members.

8. Health Plan arranges to provide these protocols and guidelines at the time that Health Plan enters into an agreement with an OON provider.
9. Health Plan provides Care coordination and continuity of care for all receiving services and/or programs from an OON provider.

C. Concurrent Review Determination Process

1. In accordance with Health Plan Policy UM 02 Inpatient and Concurrent review, practitioners or Facilities are required to submit appropriate documentation to support ongoing care or admission to an acute or long-term care facility to justify delivery of the requested care.
2. Practitioners are required to submit a request for continued authorization and supporting documentation for review prior to the expiration of the previous authorization period.
3. The appropriate UM staff member reviews the request and supporting documentation, applying the appropriate Utilization Management Medical Review Criteria to determine if the case meets criteria for continued authorization. The UM staff member may:
 - a. Approve the treatment as medically necessary.
 - b. Refer the case for review by a Medical Director/Peer Advisor if needed.
4. In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of Health 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.
5. Health Plan conducts concurrent review activities and discharge planning on all members receiving care at both in-network and OON acute care hospitals.

- a. Health Plan Concurrent Review Nurse uses mutually agreed upon policies and procedures for discharge planning and transitional care services between the contractor and OON provider.

D. Retrospective Review Process

1. A Provider or Practitioner may request retrospective authorization for Covered Services rendered to a member as long as such request is made within thirty (30) calendar days after the initial date of service and if one of the following conditions apply:
 - a. If the service requested retrospectively does not require PA as outlined in Section II, 3, 1 & 2, no further review is necessary, otherwise, determine the following.
 - b. The Member has Other Health Coverage (OHC);
 - c. A retrospective eligibility segment; or
 - d. The Member's medical condition is such that the Provider or Practitioner is unable to verify the Member's eligibility for Medi-Cal, and Health Plan eligibility at the time of service.
 - e. Any request for NEMT provided to must include a completed Health Plan PCS form validating the need for this type of service.
2. Out-of-network/non-contracted providers are not eligible to access the retrospective review process.
3. If while doing an Outpatient procedure, the MD notices that another procedure is necessary but has not been authorized, it is ok to submit a retrospective authorization ASAP, but within 30 calendar days of the service being rendered.
4. Review process identified in section III.B is followed in reviewing retrospective requests.

E. Post-Service Review/Medical Necessity Determination (MND) Process

1. Post-Service reviews are conducted to determine the medical necessity of treatment that was rendered without Health Plan's knowledge.
2. The Member, treating Practitioner, or other Member Representative can initiate a post-service review.
3. Review determinations are based on the information available to the clinical reviewer at each stage of the treatment.
4. Post-service reviews require the complete medical record for the episode of care under review.
5. The appropriate UM clinical staff member reviews the medical record, applying the appropriate Utilization Management Criteria to determine if the case meets criteria for authorization. The UM staff member may:
 - a. Approve the treatment as medically necessary.
 - b. Refer to the case for review by the Medical Director or Peer Clinical Reviewer because of an inability of the UM staff member to authorize the care based on the information available.
6. The Peer Clinical Reviewer can either:
 - a. Determine that the treatment was medically necessary.
 - b. Deny coverage for part or all of the treatment.

F. Deferral/Delay

1. A determination may be deferred by a Health Plan Medical Director when additional information is necessary to make a determination and is in the member's best interest.
2. A determination may be deferred when any one of the following criteria is met:
 - a. Specific information needed to make a determination is missing and is requested in writing from the Practitioner and Member.

- b. Requesting only additional information reasonably necessary to make a determination.
 - c. The Member or Member's Practitioner requests an extension after the request has been submitted or,
 - d. The Medical Director requests a consultation by an expert reviewer.
 - e. The Medical Director requests additional testing or specialty examination prior to making a decision.
3. When additional information has been received (even if it is incomplete) or at the expiration of the time period for supplying the information, a determination is made following the review process outlined in section III.B above and the timeframes outlined in [Exhibit A](#) attached to this policy.

G. Modification

1. An authorization request may be modified by the Medical Director or Peer Clinical Reviewer for the following reasons:
 - a. If portions of the requested services meet for medical necessity, however others do not meet for medical necessity
 - b. A determination may be modified when the quantity of the requested services does not meet medical necessity.

H. Terminations, Suspensions, or Reductions

1. Health Plan notifies members at least ten calendar days before the date of any terminations, suspensions, or reductions of previously authorized services to allow time for the member to request Aid Paid Pending.

I. Denial

1. An authorization request may be denied by the Medical Director, Peer Clinical Reviewer, or Pharmacist for the following reasons:
 - a. If requested services do not meet medical necessity

- b. If the requested services are not a covered Medi-Cal benefit
 - c. If supporting clinical information to meet medical necessity has not been received
2. An authorization request may be denied by the Authorization/Referral Nurse (RN) as an administrative denial for the following reasons:
- a. If Health Plan of San Joaquin is not the primary coverage
 - b. If the member's eligibility has been terminated
 - c. If retrospective request does not meet the Retrospective Protocol.
3. Denials for experimental health care services for terminally (defined as "an incurable or irreversible condition that has a high probability of causing death within one year or less) ill members includes the following along with the Member NOA:
- a. A statement setting forth specific medical and scientific reasons for denying coverage.
 - b. A description of alternative treatment, services or supplies covered, if any.
 - c. Copies of our IMR (grievance) form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC is sent with the Member NOA.

J. Terminal Illness

1. When Health Plan denies coverage or request for authorization for a member with terminal illness, Health Plan provides 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 complaint forms, or both.

K. Reports and Oversight

1. The Turn-Around-Time (TAT) for routine and urgent services is reviewed monthly to evaluate the adherence to timeliness standards and is reported to Health Plan management and executive team monthly, as well as the Quality Improvement and Health Equity Committee (QIHEC) at each regularly held meeting.
2. Timelines of authorization processing is monitored through daily tracking of aging inventory to ensure that processes to provide authorization do not impede the ability for an appointment to be scheduled per the timely access and network Reporting statuses and Regulations.

L. Affirmative Statement about Incentives

1. Health Plan's UM decision making is based only on appropriateness of care and service and existence of coverage. Health Plan does not reward practitioners or other individuals for issuing denials of coverage.
2. Any financial incentives for UM decisions makers do not in any way encourage decisions that result in underutilization.
3. Staff involved in UM decision making complete/sign attestation at hire and annually thereafter.

IV. ATTACHMENT(S)

- A. DHCS Medi – Cal Managed Care Plans Definitions (Exhibit A, Attachment I, 1.0 Definitions)
- B. [Exhibit A: Decision and Communication Timeframes – Medi-Cal](#)
- C. [Glossary of Terms Link](#)
- D. Medi-Cal Managed Care Contract Acronyms List (Exhibit A, Attachment I, 2.0 Acronyms)

V. REFERENCES

- A. Department of HealthCare Services All Plan Letter (APL) 21-011 (Revised) Grievance and Appeal Requirements, Notice and "Your Rights" Templates
- B. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-010: Cancer Biomarker Testing
- C. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-006: Timely Access Requirements
- D. Department of Health Care Services (DHCS) All Plan Letter (APL) 25-008: Hospice Services and Medi-Cal Managed Care
- E. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (supersedes APL 09-009).
- F. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-003 Abortion Services
- G. Department of Health Care Services (DHCS) Community Supports Policy Guide.
- H. Department of Managed Health Care (DMHC) All Plan Letter (APL) 22-027: Timely Access to Emergent and Urgent Services When an Enrollee is Outside of California.
- I. Department of Managed Health Care (DMHC) All Plan Letter (APL) 23-008: Health Plan Requirements to Timely Pay Claims.
- J. DHCS Contract Exhibit A, Attachment III Section 4.3.22 Indian Health Services, 3.3.7 Federally Qualified health Center, Rural Health Center, and Indian Health Service Facilities.
- K. California Government Code Section 8625, 101080
- L. Health and Safety Code Section 1363.5, 1367.01, 1368.1, 1374.16, 1374.30
- M. Health Plan Policy BH01 Behavioral Health for Health Plan Medi-Cal Members
- N. Health Plan Policy IT402 Information Systems Access Management
- O. Health Plan Policy CM02 Sensitive Healthcare Services
- P. Health Plan Policy CM69 Continuity of Care

- Q. Health Plan policy PRO 028: Access and Availability Standards and Monitoring
- R. Health Plan policy UM 02 Inpatient Admissions and Concurrent Review
- S. Health Plan Policy UM06 Medical Review Criteria
- T. Health Plan Policy UM07 Notice of Action for Delayed, Denied, Modified, or Terminated Services
- U. Health Plan Policy UM11 Standing Referral/Extended Access to Specialty Care
- V. Health Plan Policy UM16 Second Medical Opinion
- W. Health Plan Policy UM48 EPSDT
- X. Health Plan Policy UM 50 Community Supports
- Y. Health Plan Policy UM55 Emergency Transportation, Non-Emergency Medical Transportation and Related Expenses
- Z. Knox Keene Act California Code of Regulations Rule 1300.67.2.2©(7)(C)
- AA. Knox Keene Act Health and Safety Code 1367.03(a)(1)
- BB. Knox Keene Act Health and Safety Code Sections 1367.03(a)(7)(A) & (B)
- CC. NCQA Standard UM 2: Clinical Criteria for UM Decisions
- DD. NCQA Standard UM 4: Appropriate Professionals
- EE. NCQA Standard UM 5: Timeliness of UM Decisions
- FF. NCQA Standard UM 6: Clinical Information
- GG. Title 22 Section 53261
- HH. Title 22 Section 53857

VI. REVISION HISTORY

Version*	Revision Summary	Date
000	11/00, 04/02, 06/02, 08/04, 01/09, 02/11, 06/12, 12/13, 11/14, 09/15, 03/16, 06/17, 01/18, 05/18, 05/1, 03/20, 11/20, 03/21, 10/21, 11/21, 11/21, 11/18, 12/22, 02/23, 05/23, 06/23, 01/24, 04/24	N/A
001	Updated to include requirements from DHCS APL 24-002. Verbiage added regarding Behavioral Health Treatment Benefits as part of Behavioral Health Insourcing.	04/16/2024

002	Added Reference to APL 24-003 Abortion Services	06/12/2024
003	Updated the provider notification timeframe to align with UM07, added retro protocol to administrative denial reasons for Referral Nurses and removed “after business hours” from retrospective protocol for NEMT.	06/17/2024
004	Strengthened language to ensure policy and process are compliant with accreditation and regulatory requirements.	02/20/2025
005	Clarified that services do not required authorization for both network and out of network providers.	03/21/2025
006	Updated to comply with APL 25-006: Timely Access Requirements. Clarified services that do not require PA for both In-network and Out-of-Network providers.	07/11/2025
007	Updated to comply with prior authorization requirements outlined in APL 25-008 Hospice Services and Medical Care	9/12/2025
Initial Effective Date: 02/01/1996		
Published Date: 02/03/2026		

VII. Committee Review and Approval to be Completed by Compliance

Committee Name	Version	Date
Compliance Committee (CC)	007	02/02/2026
<ul style="list-style-type: none"> Privacy & Security Oversight Committee (PSOC) 		
<ul style="list-style-type: none"> Program Integrity Committee (PIC) 		
<ul style="list-style-type: none"> Audits & Oversight Committee (AOC) 		
<ul style="list-style-type: none"> Policy Review Committee (PRC) 	003	11/27/2024

Quality Improvement Health Equity Committee (QIHEC)		
<ul style="list-style-type: none"> Quality Operations Committee (QOC) 		
<ul style="list-style-type: none"> Grievance Committee (GC) 		

VIII. REGULATORY AGENCY APPROVALS

Department	Reviewer	Version	Date
Department of Healthcare services (DHCS)	DHCS Contract Manager	007	12/23/2025
Department of Managed Care (DMHC)	DMHC Attorney	003	09/26/2024

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

Exhibit A: Decision and Communication Timeframes – Medi-Cal

		Notification Timeframe	
		Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
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 <ul style="list-style-type: none"> All necessary information received at time of initial request 	Within 5 working days of receipt of all information reasonably necessary to render a decision, but no longer than 14 calendars from the receipt of the request.	Practitioner: Within 24 hours of the decision (for approvals and denials) Member: None Specified	Practitioner: Within 2 working days of making the decision Member: Within 2 working days of making the decision, not to exceed 14 calendar days from the receipt of the request for service (includes approval decisions)
Routine (Non-urgent) Pre-Service – Extension Needed <ul style="list-style-type: none"> Additional clinical information required Require consultation by an Expert Reviewer Additional examination or tests to be performed. (AKA: Deferral) 	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 <ul style="list-style-type: none"> The decision may be deferred, and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or 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 best interest. Notify members and practitioners 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 		

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
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	<p>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.</p> <p>Additional information received.</p> <ul style="list-style-type: none"> If requested information <u>is received</u>, 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 <p>Additional information incomplete or not received.</p> <ul style="list-style-type: none"> 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 provide the member notice of denial. 	<p><u>Practitioner:</u> Within 24 hours of making the decision</p> <p><u>Member:</u> None Specified</p> <p><u>Practitioner:</u> Within 24 hours of making the decision</p> <p><u>Member:</u> None Specified</p>	<p><u>Practitioner:</u> Within 2 working days of making the decision</p> <p><u>Member:</u> Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service</p> <p><u>Practitioner:</u> Within 2 working days of making the decision</p> <p><u>Member:</u> Within 2 working days of making the decision, not to exceed 28 calendar days from the receipt of the request for service</p>
Expedited Authorization	Within 72 hours of receipt of the request	<u>Practitioner:</u> Within 72 hours of receipt of the request	<u>Practitioner:</u> Within 2 working days of making the decision

		Notification Timeframe	
		Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
<ul style="list-style-type: none"> 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. All necessary information received at time of initial request 		<u>Member:</u> None specified	<u>Member:</u> Within 2 working days of making the decision, not to exceed 3 working days from the receipt of the request for service (includes approval decisions)
Expedited Authorization - Extension Needed <ul style="list-style-type: none"> 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: 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 <ul style="list-style-type: none"> Note: The time limit may be extended by up to 14 calendar days if the Member 		

		Notification Timeframe	
		Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
<ul style="list-style-type: none"> Additional clinical information required. 	<p>requests an extension, or if the Provider Group / Health Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest</p> <p>Additional information received</p> <ul style="list-style-type: none"> If requested information <u>is received</u>, decision must be made within 72 hours of receipt of information, not to exceed 14 calendar days from receipt of the request. 	<p><u>Practitioner:</u> Within 24 hours of making the decision</p> <p><u>Member:</u> None specified</p> <p><u>Practitioner:</u> Within 24 hours of making the decision</p> <p><u>Member:</u> None specified</p>	<p><u>Practitioner:</u> Within 2 working days of making the decision</p> <p><u>Member:</u> Within 2 working days of making the decision</p> <p><u>Practitioner:</u> Within 2 working days of making the decision</p> <p><u>Member:</u> Within 2 working days of making the decision</p>
<p>Concurrent review of treatment regimen already in place– (i.e., inpatient, ongoing/ambulatory services)</p> <p>In the case of concurrent review, care shall not be discontinued until the enrollee's treating 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</p>	<p>Within 5 working days or less, consistent with urgency of Member's medical condition.</p> <p>NOTE: When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but 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</p>	<p><u>practitioner:</u> Within 24 hours of making the decision</p> <p><u>Member:</u> None Specified</p>	<p><u>Practitioner:</u> Within 2 working days of making the decision</p> <p><u>Member:</u> Within 2 working days of making the decision (includes approval decisions)</p>

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
<p>medical needs of that patient. CA H&SC 1367.01 (h)(3)</p>	<p>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)</p>		
<p>Post-Service / Retrospective Review- All necessary information received at time of request (decision and notification is required within 30 calendar days from request)</p>	<p>Within 30 calendar days from receipt of information that is reasonably necessary to make a determination</p>	<p>Member & Practitioner: None specified</p>	<p>Member & Practitioner: The decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, (includes approval decisions)</p>
<p>Post-Service - Extension Needed</p> <ul style="list-style-type: none"> Additional clinical information required 	<p>Additional clinical information required (AKA: deferral)</p> <ul style="list-style-type: none"> 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 of receipt of information reasonably necessary to make a determination. <p>Additional information received.</p> <ul style="list-style-type: none"> If requested information <u>is received</u>, decision must be 	<p><u>Member & Practitioner:</u> None specified.</p>	<p><u>Member & Practitioner:</u> The decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to</p>

		Notification Timeframe	
		Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
	<p>made within 30 calendar days of receipt of information reasonably necessary to make a determination.</p> <p>Example: Total of X + 30 where X = number of days it takes to receive requested information</p> <p>Additional information incomplete or not received.</p> <ul style="list-style-type: none"> 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 	<p><u>Member & Practitioner:</u> None Required</p>	<p>make this determination (includes approval decisions)</p> <p><u>Member & Practitioner:</u> The decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination</p>

		Notification Timeframe Working day(s): mean State calendar (State Appointment Calendar, Standard 101) working day(s)	
Type of Request	Decision	Initial Notification (Notification May Be Oral and/or Electronic)	Written/Electronic Notification of Denial and Modification to Practitioner and Member
Standing Referrals Extended Access to Specialists / Specialty Care Centers - All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. NOTE: Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	<u>Practitioner and Member:</u> <u>Refer to appropriate service category (urgent, concurrent, or non-urgent) for specific notification timeframes for approvals and denials.</u>	<u>Practitioner and Member:</u> <u>Refer to appropriate service category (urgent, concurrent, or non-urgent) for specific notification timeframes for approvals and denials.</u>
Hospice - Inpatient Care	Within 24 hours of receipt of request	<u>Practitioner:</u> Within 24 hours of making the decision <u>Member:</u> None Specified	<u>Practitioner:</u> Within 2 working days of making the decision <u>Member:</u> Within 2 working days of making the decision