POLICY AND PROCEDURE

Policy Number	UM-057
Policy Name	Authorization Service Request
Department Name	Health Care Services
Policy Owner	Utilization Management Director
Lines of Business	MCAL, IHSS
Effective Date	11/02/2004
Subcommittee Name	Quality Improvement Health Equity Committee
Subcommittee Approval Date	TBD
Compliance Committee Approval Date	TBD

OVERVIEW

The Alameda Alliance for Health (The Alliance/AAH) maintains current processes and guidelines for reviewing requests for authorization and making utilization management (UM) determinations for health care services (encompassing medical/surgical or behavioral health,) requiring authorization.

The Alliance UM Program will be compliant and consistent with State and Federal regulations including but not limited to **CA Health and Safety Code §1367.01, 1367.665, 1374.141**, and **42 CFR 438.900(d)** and **42 CFR Subpart K.**

POLICY

A. The Alliance develops, reviews, and approves at least annually, lists of services that are exempt from prior authorization, services rendered by the Alliance direct-network that do not require authorization, services that are appropriate for auto-authorization, and services that require prior authorization and clinical review for medical necessity.

B. The Alliance shall communicate to all contracted health care practitioners the procedures, treatments, and services that require authorization and the procedures and timeframes necessary to obtain such authorizations.

- The communication shall include the data and information The Alliance uses to make

determinations (e.g., UM criteria, patient records, conversations with appropriate physicians) and that guide the UM decision-making process.

- The Alliance publishes its Clinical Practice guidelines on the Alliance website for use by any contracted or non-contracted provider. These guidelines cover both clinical care and Preventive Care:
  - alamedaalliance.org/providers/provider-resources
  - alamedaalliance.org/providers/provider-resources/clinical-practice-guidelines/
- The Alliance provides written information on criteria and evidence-based practice guidelines used for decision making in accordance with the UM-054 Notice of Action Policy for both contracted and non-contracted providers.

C. A Member may elect to receive services via telehealth, if available, from their PCP/other provider, or from a corporate telehealth provider. All UM processes, such as PA timeframes, costs, and rights are applied in the same way, whether members receive services from in-person visits or via telehealth. Members are notified of the availability of telehealth services on the Member website and in the EOC. If the Member chooses to receive the services via telehealth through a third-party corporate telehealth provider, they will consent to the service, and if the Member is currently receiving specialty telehealth services for a mental or behavioral health condition, the Member will be given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility. If services are provided to an enrollee through a third-party corporate telehealth provider, The Alliance will do the following:

(1) Notify the Member of their right to access their medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106.

(2) Notify the Member that the record of any services provided to the enrollee through a third-party corporate telehealth provider shall be shared with their PCP, unless the enrollee objects.

(3) Ensure that the records are entered into a patient record system shared with the Member's primary care provider or are otherwise provided to the Member's PCP, unless the enrollee objects, in a manner consistent with state and federal law.

(4) Notify the Member that all services received through the third-party corporate telehealth provider are available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

D. The Alliance ensures that there is parity between the provision of medical/surgical care and behavioral health care in all aspects of UM policies and procedures. These include timeframes, classification of determinations, qualifications of decision makers, notification of outcomes, use of clinical criteria and disclosure of criteria to members and providers, authorization requirements, in-network, or out-of-network requirements, and all other regulatory requirements related to utilization management. For Group Care members receiving behavioral health services, medical necessity determinations for Group Care members are based on non-profit professional organizations guidelines (Early Childhood Intensity Service Instrument (ECSII), Child and Adolescent Level of Care (CALOCUS), Level of Care Utilization System (LOCUS), American Society of Addiction Medicine (ASAM), World Professional Association for

Transgender Health (WPATH).

E. The below services are exempt from prior authorization, based on regulatory requirements:
   - Emergency Services, whether in or out of Alameda; except for care provided outside of the United States. Care provided in Canada or Mexico are covered.
   - Urgent care, whether in or out of network
   - Primary Care Visits
   - Preventative Services
   - Immunizations/Vaccines
   - Annual Cognitive Assessment for Medi-Cal members over 65 without MediCare.
   - Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams. This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
   - Basic perinatal care – a woman can go directly to any network provider for basic perinatal care.
   - Family planning services, including counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
   - Treatment for Sexually Transmitted Diseases includes testing, counseling, treatment, and prevention.
   - HIV testing and counseling.
   - Minors do not need authorization for:
     - Sexual or physical abuse
     - Suicidal ideations
     - Pregnancy care
     - Sexual assault
     - Drug and alcohol abuse treatment
   - Biomarker testing which is FDA approved
     - For all lines of business (LOB) prior authorization is exempt for members with advanced or metastatic cancer stage 3 or 4, or for cancer progression or reoccurrence in members with advanced or metastatic cancer stage 3 or 4 (**Health & Safety Code §1367.665**).

F. The below services provided by the Alliance's direct network do not require prior authorization:
   - Specialty visits (initial and follow-up visits)
   - Mental Health and Substance Use Disorder outpatient visits
   - Services/codes that have been reviewed and approved by the Alliance UM Committee (UMC) and Quality Improvement Health Equity Committee (QIHEC) to remove prior authorization requirements

The Alliance considers the following factors in determining services that do or do not require prior authorization, concurrent review, or retrospective review:
   - Regulatory/Contractual guidelines
   - Member access to services
   - Utilization patterns:
     - Volume of authorizations
     - Volume of authorizations approved, denied, modified or deferred after medical

necessity reviews
- Patient safety
- Provider consistency in scope of utilization requests

The list of services/codes that do and do not require prior authorization is reviewed and approved at least annually at UMC and QIHEC.

G. Auto-authorization is an authorization approval process that does not require clinical review and can be completed by a non-clinical UM staff. The Alliance considers the following factors in determining services to be on auto-authorization:
   - Regulatory/Contractual guidelines
   - Member access to services
   - Utilization patterns:
     - Volume of authorizations
     - Volume of authorizations approved, denied, modified or deferred after medical necessity reviews
   - Patient safety
   - Provider consistency in scope of utilization requests

   The list of services on auto-authorization is reviewed and approved at least annually at UMC and QIHEC. UM staff will process requests in accordance with the auto-authorization guidelines after approval by UMC and QIHEC (see attachment section of the policy).

Commented [AL1]: Need to add attachment of current auto-authorization list

H. Services for which authorization is required include, but are not limited to:

   - Out-of-network providers/ services/ facilities.
   - Outpatient surgeries/procedures, except where otherwise specified (e.g., minor office procedures).
   - Selected Mental Health Care and Substance Use Disorder treatment (ex. Applied Behavioral Analysis (ABA), inpatient, residential treatment, partial hospitalization, intensive outpatient treatments, neuropsychiatric testing, ECT)
   - Selected major diagnostic tests.
   - Home Health Care/ Private Duty Nursing care.
   - Selected durable medical equipment.
   - New application of existing technology or new technology (considered investigational or experimental – including drugs, treatments, procedures, equipment, etc.).
   - Medications not on the Alliance approved drug list and/or exceeding the Alliance's monthly medication limit.
   - CBAS services.
   - Inpatient admissions (non-emergency).
   - Inpatient hospice care.
   - Inpatient abortions.
   - Skilled nursing facilities admissions.
   - Long-term care (LTC) admissions.
   - LTC Skilled nursing facilities Bed Hold/ Leave of Absence
   - Major Organ Transplant Services

- Out of Network Second opinion
- Podiatry services
- Acupuncture, greater than 4 visits per month for Adult. Limits do not apply for children under the age of 21.
- Chiropractic
- Treatment and services related to gender dysphoria

I. Immunization/Vaccination
   - Members may access immunization/vaccination services from providers in or out of network, without prior authorization. This includes Local Health Department (LHD) clinics. Upon request from the LHD clinics, The Alliance will provide available information on the status of the member's immunizations to the LHD clinic. The Alliance will pay claims from LHD clinics sent with supporting immunization records.

J. Biomarker testing is a covered benefit for the purposes of medically necessary diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment options.
   - For all LOB: members with advanced or metastatic stage 3 or 4 cancer, or for cancer progression/recurrence in a member with advanced or metastatic stage 3 or 4 are exempt from prior authorization requirements. This is intended to remove barriers for members with late-stage cancer, allowing them to access cancer biomarker testing to help inform their treatment in order to better expedite care. The Alliance will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6. The Alliance will not impose prior authorization requirements on biomarker testing that is associated with a federal Food and Drug Administration (FDA)-approved therapy for advanced or metastatic stage 3 or 4 cancer.
     - Biomarker testing codes are identified by CMS. The CMS code list is cross checked via the MediCal website to ensure DHCS lists these codes as billable and payable during any given year. As new coding updates are released by CMS, the AAH coding list will be updated at least annually. Any updates are configured in the AAH UM and Claims systems to not require PA for in-network providers for MediCal LOB only.
   - For Group Care members, as required in the Cal. Health & Safety Code section §1367.667, the Alliance covers medically necessary biomarker testing, subject to utilization review, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions. Biomarker tests that meet any of the following will be covered:
     - A labeled indication for a test that has been approved or cleared by the FDA or is an indicated test for an FDA-approved drug
     - A national coverage determination made by the Centers for Medicare and Medicaid Services
     - A local coverage determination made by a Medicare Administrative Contractor for California
     - Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of

the editorial staff
  - Standards set by the National Academy of Medicine

Biomarker testing is provided to Group Care members in a manner that limits disruption in care, including the need for multiple biopsies or biospecimen samples. Any restricted or denied use of biomarker testing for the medically necessary reasons noted above are subject to grievance and appeal processes.

K. Standard Fertility Services

- Group Care members are eligible for standard fertility preservation services for basic health care as defined in subdivision (b) of Section 1345 and are not considered within the scope of coverage for the treatment of infertility for the purposes of Section 1374.55. These services are covered for Group Care members only when a covered medically necessary treatment may directly or indirectly cause iatrogenic infertility (i.e., resulting from surgery, chemotherapy, radiation, or other medical treatment).

- For Medi-Cal members the following fertility preservation services, including but not limited to cryopreservation of sperm, oocytes, or fertilized embryos are not covered.

L. Indian Health Service Programs

- The Alliance will ensure qualified Members have timely access to IHS Providers within its Network, as required by 42 USC section 1396j, and Section 5006 of Title V of the American Recovery and Reinvestment Act of 2009 (42 U.S.C. § 1396o(a)). IHS Providers, whether in the Network or Out-of-Network, can provide referrals directly to Alliance Providers without requiring a referral from an Alliance Network PCP or Prior Authorization in accordance with 42 CFR section 438.14(b). The Alliance will also allow for access to an Out-of-Network IHS Provider without requiring a referral from an Alliance PCP or prior authorization in accordance with 42 CFR section 438.14(b).

M. Appropriate Classification of Determination

- UM determinations are responses to requests for authorization and include approvals, modifications, denials (i.e., adverse decisions), delays, and termination of services.
- Medical Necessity Determinations: Decisions regarding defined covered medical benefits, or if circumstances render it covered then a medical necessity decision is needed.
- Benefit Determinations: Decisions regarding requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

N. The Alliance service types are processed as:

- Prior Authorization
- Concurrent, inpatient
- Concurrent, Outpatient (care currently underway)
- Post-Service/Retrospective Review

O. The Alliance authorization determinations are documented as:

- Approved

- Modified
- Denied
- Delay

P. UM Decision Making
- The Alliance uses licensed health care professionals to make UM decisions that require clinical judgment. The following staff may approve services:
  - Qualified health care professionals (licensed physicians), supervise review decisions, including service reduction decisions.
  - Decisions to deny or to authorize an amount, duration or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease. Appropriate clinical expertise may be demonstrated by appropriate specialty training, experience, or certification by the American Board of Medical Specialties. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.
  - A qualified physician, doctoral Behavioral Healthcare (BH) practitioner, or pharmacist (when applicable) shall review denials, modifications, delays, terminations that are made, whole or in part, based on medical necessity.
  - UM Reviewers make UM authorization approval decisions based on UM Committee approved auto authorization criteria and other UM Committee approved UM criteria UM-001, and auto authorization criteria.
    - Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria and Policy RX 002
  - Qualified doctoral Behavioral Health (BH) Reviewer staff make BH authorization approval decisions based on QIHEC approved BH UM criteria.
    - See UM-012 Care Coordination policy regarding approved BH UM criteria.
  - A qualified physician, or doctoral behavioral healthcare practitioner as appropriate, shall review any behavioral healthcare denial of care based in whole or in part on medical necessity.
  - Authorization coordinators make UM authorization approval decisions based on UM Committee approved auto authorization criteria.
  - Administrative Denials: Qualified non-clinical staff may make non-medical necessity decisions due to non-eligibility.
    - Pharmacy technicians make pharmacy authorization approval decisions based on UM P&T Committee approved Pharmacy Guidelines and Policy RX-002

Q. In instances where The Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, The Alliance shall send out the NOA "delay" template to the provider and beneficiary within the required timeframe or as soon as The Alliance becomes aware that it will not meet the timeframe. A deferral notice is warranted if The Alliance extends the timeframe up to an additional 14 calendar days because either the beneficiary or provider requests the extension, or The Alliance justifies a need for additional information and how the extension is in the beneficiary's best interest.

R. The Alliance shall make all UM decisions and notifications within required timeframes, in accordance with regulation, licensure, contractual, and accreditation requirements and standards. If required timeframes differ, The Alliance shall adhere to the strictest standard.

S. The Alliance shall process the assessment of appropriateness of medical services on a case-by-case or aggregate basis when UM requests for prior authorization are received before services are provided taking into consideration the following:
   - Determining and ensuring response appropriate to urgency of request.
   - Determining and ensuring adequate clinical information is provided to review the request and if not, to work with the requesting provider to obtain for additional specific information needed to review the request.
   - Ensuring that correct UM criteria are selected for review of request.
   - Ensuring appropriate review of request by the appropriate level of UM staff and/or Medical Director/ Physician / doctoral BH Practitioner/ Pharmacist.
   - Ensuring timeframes are met for UM determination of the request and notifications to practitioner and member.

T. When determining medical necessity, The Alliance gathers all relevant clinical information consistently to support UM decision making. The Alliance requires enough clinical information necessary to render a decision. If all the relevant information necessary to make the determination is not available, The Alliance works with the requesting providers to obtain the information in a timely manner.

U. Rescission
   - No approved authorization shall be rescinded or modified after the provider renders services from UM decisions in good faith for any reason, including, but not limited to, subsequent rescission, cancellation, or modification of the member's contract or when The Alliance did not make an accurate determination of the member's eligibility.

V. The Alliance ensures verbal and written communications to the Member and Providers for UM decisions are provided using the appropriate approved templates and within the UM timeliness standards.

W. Authorization of Enhanced Care Management (ECM)
   - Determination decision on time frame for authorization requests for ECM will follow the regulatory UM timelines, for example:
     - Routine requests not to exceed 5 days.
     - Expedited requests not to exceed 72 hours.
   - Notification time frames for authorization request determination decisions for ECM will follow regulatory UM timelines, for example:
     - Provider notification not to exceed 24 hours, (oral or written) after decision.
     - Written notification to provider and member not to exceed 2 working days after decision.
   - The Alliance will authorize ECM for a minimum of 6 months for each request.
     - Delegated ECM Providers and/ or their subcontractors must follow The Alliance authorization requirements, including adjudication standards and referral documentation.
   - ECM Provider may request re-authorization for ECM services at the end of the previously authorized request.
   - The Alliance will identify members who meet the criteria as a member of a population of

focus and refer the member to an ECM provider for outreach.

- The Alliance will not implement presumptive authorization and will require a prior authorization request when the member consents to be enrolled.

X. Authorization of Community Supports (CS) Services

- Determination decision on time frame for authorization requests for CS will follow the regulatory UM timelines, for example:
  - Routine requests not to exceed 5 business days.
  - Expedited requests not to exceed 72 hours.

- Notification time frames for authorization request determination decisions for CS will follow regulatory UM timelines, for example:
  - Provider notification not to exceed 24 hours, (oral or written) after decision.
  - Written notification to provider and member not to exceed 2 working days after decision.

Y. Post Service/Retrospective Review Process

The Alliance does not accept post-service or retrospective authorization requests for non-emergent or non-urgent services that would require prior authorization more than 90 days past the date of service. The exception criteria under which a post service / retrospective request greater than 90 days after the date of service which may be considered are:

- Member eligibility issues, i.e., retrospective eligibility, unable to validate eligibility at time of service, incorrect eligibility information at time of service.
- In-patient services where the facility is unable to confirm enrollment with the Alliance.

Z. On January 1, 2024, Alameda County will transition to a Single Plan Model county, and Medi-Cal recipients will transition from a previous MCP to Alameda Alliance for Health (The Alliance) as their Medi-Cal Managed Care Plan (MCP). Before and during the transition, The Alliance will adhere to the requirements of APL 23-018 Managed Care Health Plan Transition Policy Guide (Policy Guide), which establishes the 2024 Managed Care Plan Transition Policy Guide as the DHCS authority, along with the applicable Contract, and any incorporated APLs or guidance documents incorporated into the Policy Guide by reference, regarding the 2024 MCP transition. The continuity of care authorization process for members transitioning into The Alliance will adhere to the requirements of the 2024 Managed Care Plan Transition Policy Guide and All Plan Letter (APL) 22-032 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.

  - The Alliance policy and procedures regarding the 2024 MCP Transition requirements are detailed in the policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care.
  - Particular attention and resources will be focused on members in Special Populations:
    - Adults and children with authorizations to receive Enhanced Care Management (ECM) services
    - Adults and children with authorizations to receive Community Supports (CS).

- Adults and children receiving Complex Care Management (CCM)
- Enrolled in 1915(c) waiver programs
- Receiving in-home supportive services (IHSS)
- Children and youth enrolled in California Children's Services (CCS)
- Children and youth receiving foster care, and former foster youth through age 25
- In active treatment for the following chronic communicable diseases: HIV/AIDS, tuberculosis, hepatitis B and C
- Taking immunosuppressive medications, immunomodulators, and biologics
- Receiving treatment for end-stage renal disease (ESRD)
- Living with an intellectual or developmental disability (I/DD) diagnosis
- Living with a dementia diagnosis
- In the transplant evaluation process, on any waitlist to receive a transplant, undergoing a transplant, or received a transplant in the previous 12 months (referred to as "members accessing the transplant benefit" hereafter)
- Pregnant or postpartum (within 12 months of the end of a pregnancy or maternal mental health diagnosis)
- Receiving specialty mental health services (adults, youth, and children)
- Receiving treatment with pharmaceuticals whose removal risks serious withdrawal symptoms or mortality
- Receiving hospice care
- Receiving home health
- Residing in Skilled Nursing Facilities (SNF)
- Residing in Intermediate Care Facilities for individuals with Developmental Disabilities (ICF/DD)
- Receiving hospital inpatient care
- Post-discharge from inpatient hospital, SNF, or sub-acute facility on or after December 1, 2023
- Newly prescribed DME (within 30 days of January 1, 2024)
- Members receiving Community-Based Adult Services (CBAS)

o See policy UM-059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care for full details on procedures for members in Special Populations and all other regulatory requirements.

AA. Providers are notified of services that require prior authorization, how to obtain prior authorization and the UM Process in several ways:

- Contracted providers are informed in the service agreements, by accessing the Provider Manual, the Prior Authorization Grid information located on The Alliance website and are available upon request.
- Non-contracted providers are informed via The Alliance website/Section – Authorization.

PROCEDURE

A. Pre-Service Review

1. Authorization requests are submitted by phone, fax,in writing, or via secure portal.
2. Upon receipt of the authorization request, the UM Authorization Coordinator (AC) will review the request for:
   a) Member eligibility
   b) Completeness of the request
      i. Presence of medical codes, e.g., ICD-10, CPT, HCPCS
      ii. Presence of medical records.

3. Once the authorization request review is complete, the AC enters the authorization request into the clinical information system and routes it to the appropriate UM processing queue.

4. Upon selecting the authorization request from the queue, the assigned AC reviews the pre-service authorization request against benefit grid, approved auto authorization criteria. The pre-service request workflow:
   a) For requests meeting auto authorization criteria, the AC approves the request following UM guidelines via Auto Authorization.
   b) For requests not meeting Auto Authorization Criteria, the AC routes the request to the UM Nurse/ doctoral BH Reviewer/ or Pharmacy technician.

5. The UM Nurse / BH Reviewer/ or Pharmacy technician performs a medical necessity review of the pre-service authorization request and clinical information presented using the appropriate UM criteria, as noted in UM-001 Utilization Management Policy and the UM Program Description.

   a) The UM Nurse / BH Reviewer/ or Pharmacy technician documents the clinical decision-making process in theclinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
   b) The UM Nurse /BH Reviewer/ or Pharmacy technician workflow includes:
   c) For authorization requests meeting criteria confirming medical necessity, the UM Nurse / BH Reviewer/ or Pharmacy technician approves the request and generates the Member and Provider approval notification.
   d) For authorization requests not consistent with the request (i.e., conflicting CPT Codes to diagnosis, conflicting HCPCs to documentation, etc.), not meeting UM / BH/ or Pharmacy Criteria, where there is a potential for delay, denial, modification, or termination, and for cases involving benefit exhaustion or benefit termination, the UM Nurse / BH Reviewer forwards the request to the UM Physician/ Medical Director/ doctoral BH/ or Pharmacist Reviewer for review.

6. Minimum Clinical Information for Review of UM Requests for Authorization
   a) Request for services shall be reviewed in accordance with approved UM criteria and the member's benefit structure.
   b) When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained and consultation with the treating practitioner shall occur as necessary.
   c) When making a determination of coverage based on medical necessity relevant clinical information shall be obtained and consultation with the treating practitioner shall occur

as necessary.

d) Clinical Information for making determination of coverage includes that which is reasonably necessary to apply relevant UM Criteria, and may include, but is not limited to, the following:
   i. Office and hospital records
   ii. A history of the present problem
   iii. A clinical exam
   iv. Diagnostic testing results
   v. Treatment plans and progress notes
   vi. Patient psychosocial history
   vii. Information on consultations with the treating practitioner
   viii. Evaluations from the other health care practitioners and providers
   ix. Photographs
   x. Operative and pathological reports
   xi. Rehabilitation evaluations
   xii. A printed copy of criteria related to the request.
   xiii. Information regarding benefits for services of procedures
   xiv. Information regarding the local delivery system
   xv. Patient characteristics and information
   xvi. Information from responsible family members
   xvii. Minimum Data Set (MDS)
   xviii. Preadmissions Screening and Resident Review (PASSR)
   xix. Bedbound Certification

B. Missing Clinical Information:
1. Formal requests for missing information can be made either by phone or in writing.
   a) Missing information includes:
      i. Incomplete name, ID number, contact information.
      ii. Diagnosis or Service codes
      iii. Incomplete Attachments
      iv. Required Title XXII forms
2. When clinical information is missing in the request and the information can be received within the same day, UM staff (i.e. Coordinators, Nurses, Pharmacists), and if needed the Physician/ Medical Directors / doctoral BH Reviewer/ or Pharmacist shall contact the requesting provider by phone to request missing clinical information.
   a) Call attempts should be documented in the authorization request case. Up to three attempts will be made:
      i. 1 Fax and 2 phone calls: The Authorization Coordinator shall make the first call and generate a fax request and make an additional phone call outreach. The UM Nurse / BH Reviewer may also attempt phone outreach, and/or the Medical Director/ Physician/doctoral BH/ Pharmacist Reviewer for a Peer-to-Peer request.

C. Request for additional information
1. Requests for additional information are considered deferrals or delays, and authorizations are pended until reasonably necessary information is received to make a determination.
2. In instances where UM clinical staff cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests

because it is not in receipt of information reasonably necessary and requested, the UM Physician/ Medical Director BH Reviewer/ or Pharmacist will identify the information necessary and shall send out the Notice of Action (NOA) "delay" template to the provider and beneficiary within the required timeframe.

3. Formal requests for additional information must be made in writing to the provider and the member using the most recent DHCS or The Alliance templates.
4. For routine or expedited requests, an extension of up to 14 calendar days from the day of receipt may be granted if either the beneficiary or provider requests the extension, or The Alliance justifies a need for additional information and how the extension is in the beneficiary's best interest.
5. The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The NOA must also include the anticipated date when a decision will be rendered.
6. Upon receipt of all information reasonably necessary and requested, UM Nurse/ Physician/ Medical Director/ BH Reviewer/ or Pharmacist may approve the request for authorization within five business days or 72 hours for standard and expedited requests, respectively.
   a) If there is no response or the requested additional information is not received, the UM Nurse Reviewer will continue the review with the available information.
7. A full description of the Member and Provider Notice of Action communication is found in UM - 054 Policy Notice of Action.

D. Medical Director/Physician Reviewer Review

1. The Medical Director/Physician /doctoral BH Reviewer reviews pre-service authorization requests that the UM Nurse / BH Reviewer has referred. The Medical Director/Physician Reviewer /doctoral BH reviews the information summary provided by the UM Nurse /BH Reviewer, the clinical information, and the appropriate UM Criteria.
   a) The Medical Director/Physician doctoral BH Reviewer documents the clinical decision-making process in the clinical information system using the standardized template. The documentation must include a review of the clinical information and application of the appropriate criteria used in the determination.
   b) To evidence appropriate professional review, each UM case must include one of the following:
      i. The reviewer's written signature or initials
      ii. The reviewer's unique electronic signature or identifier on the denial notation
      iii. A signed or initialed noted from a UM staff person, attributing the denial decision to the profession who reviewed and decided the case.

2. Once the Medical Director/Physician doctoral BH Reviewer makes the UM Decision, the case is returned to the UM Nurse/ Coordinator /BH Reviewer/ or Pharmacy technician for processing:
   a) Approvals: The UM Nurse / Coordinator /BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes.
   b) Delays, Denials, Modifications, or Terminations: The UM Nurse / Coordinator /BH Reviewer/ or Pharmacy technician processes the request according to established processes and timeframes as described in UM Policies for UM Timeliness Standards, and UM-054 Notice of Action.

E. Peer to Peer Discussions

1. For medical necessity denials, Providers are provided with an opportunity to discuss the specific UM determination with The Alliance decision maker. Providers are notified of this process in the UM determination notifications.
   a) When provider notification is given orally, providers are also notified of the opportunity to discuss the UM determination with The AllianceUM decision maker.
   b) Oral request includes reading the standard statement for availability of the discussion exactly as identified in the Notice of Action Letter.
      i. "The Alliance has reviewed your request for <<Insert Member Name>>. The Alliance made a determination that this service is not medically necessary. You may also contact the Medical Director/ Behavioral Health/ Pharmacist reviewer to discuss the denial decision and obtain the decision criteria by calling Utilization Management unit
2. The Alliance easy access for Providers and utilizes The Alliance UM telephone number to serve as the entry point of contact.
3. UM / BH Staff/ Pharmacy will answer the UM calls and obtain the key information to have the UM decision maker return the call:
   a) Member name and ID#
   b) Referral #
   c) Name of the Physician requesting the return call.
   d) Contact number for the requesting Physician.
   e) Best time to reach the requesting Physician.
4. UM / BH/ or Pharmacy Staff will note the request for the discussion in the TrueCare Case and notify the appropriate UM decision maker.
   a) If The Alliance UM / BH/ or Pharmacy decision maker is not available, the Staff will task the request to the UM decision-maker for the day.
5. Every attempt is made to return calls on the same day.
   a) Two attempts will be made within a 24-hour period. Each attempt will be documented in the TruCare case.
   b) The Alliance Physician/ Medical Director / doctoral BH Reviewer/ Pharmacist will document all outreach attempts in TrueCare.
6. The organization notifies the treating practitioner about the opportunity to discuss a medical necessity denial:
   - In the denial notification, ***or***
   - By telephone, ***or***
   - In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.
7. The organization includes the following information in the denial file:
   - The denial notification, if the treating practitioner was notified in the denial notification.
   - The time and date of the notification, if the treating practitioner was notified by telephone.
   - Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

F. In cases where there is no available UM Criteria based on the hierarchy and guidance as described in the UM Program or the Physician/ Medical Director/ / doctoral BH Reviewer/

Pharmacy does not have the clinical expertise in treating the requested serviced to render the UM determination, the Physician/ Medical Director / doctoral BH Reviewer/ or Pharmacist may consult with a Board Certified Consultant to assist in making the medical necessity determination.

1. When using a Board-Certified Consultant, the consultant will provide a written recommendation for the applicable case. The Physician/ Medical Director/ / doctoral BH Reviewer/ or Pharmacist will utilize the recommendation in rendering the final UM determination.

G. Out of Network/Non-Contracted Providers

1. The Alliance requires services to be provided within the contracted network.
   a) Despite protocols to maintain network adequacy requirements set forth in WIC section 14197, there may be circumstances in which The Alliance does not have a contracted provider or provider type in in its contracted network in Alameda/adjoining counties, or have timely access (including DHCS approved AAS) to appointments or Long Term Care nursing facility capacity:

2. When services are not available within the network:
   a) At the time of the initial processing of the authorization request, the AC will contact the requesting provider to confirm the requested provider is non-contracted and confirm the desire of the requesting provider to continue and documents the out of network reason for the request.
   b) If the decision of the requesting provider is to withdraw the request and re-submit using a contracted provider, the AC staff notes the withdraw in the case notes and closes case.
   c) If the decision is to continue using a non-contracted provider, the AC routes the request to the UM Nurse / BH Reviewer/ or Pharmacist to determine if the service is medically necessary and the status of available providers within the network to provide the service.
   d) The UM Nurse / BH Reviewer/ Pharmacist reviews the case information for medical necessity, provider network capacity and availability within the applicable time and distance and timely access standards.
      i. If determined services are medically necessary but not available within The Alliance network within the applicable time and distance and timely access standards, the UM Nurse /BH Reviewer/ or Pharmacist reviews with the Physician/ Medical Director/ doctoral BH Reviewer/ or Pharmacist to determine if the non-contracted provider is the most appropriate and approve for initiation of one-time letter of agreement through Provider Network Operations.
      ii. If the services are medically necessary but services are available in network within the applicable time and distance and timely access standards, the UM Nurse /BH Reviewer reviews case with the Physician/ Medical Director/ /doctoral BH Reviewer/ or Pharmacist to possible re- direct into the network.
         (i) If determination is to re-direct, the UM Nurse / BH Reviewer/ Pharmacist will confirm with the newly identified provider that the services can be provided and provided within the applicable time and distance and timely access standards.
         (ii) A referral is made for care coordination to assist the member to navigate the redirected care to a contracted provider.

   e) For Out of Network Providers, Medi-Cal covered transportation to the Out of Network

provider will be provided as appropriate, through the Non-Emergency Medical Transportation (NEMT) benefit or the Non-Medical Transportation (NMT) benefit in the same manner as for an in-network provider. (WIC section 14197.04(3)(b))

H. Services that require prior authorization, but no prior authorization obtained

1. Post-Service requests that **meet** the exception criteria and are submitted within 90 calendar days from the date of service, (when there is no claim on file) will be processed through the UM / BH/ Pharmacy Department using medical necessity review criteria.
   a) Retrospective/post service requests shall not be considered urgent as the service has already been provided. The urgent requests will be reviewed by a Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist and changed to a routine urgency status.
2. Post-Service requests that **do not meet** the exception criteria and are submitted beyond 90 calendar days from the date of service, (when there is no claim on file) will be denied as services required prior authorization and no prior authorization was obtained.
   a) UM Coordinator will review post-service request to ensure:
      i. Member was eligible at the time of services.
      ii. Services required prior authorization.
      iii. Review documentation to ensure prior authorization was not given by a representative of the organization, i.e., Customer Service Notes, PCP, After Hours staff documentation.
   b) If no documentation is found to support potential prior authorization of the service, the UM Coordinator routes the case to the UM Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist for potential denial.
   c) If documentation found to support a representative provided authorization to the vendor or facility for the service, the UM Coordinator will document the findings and route the case to the UM Nurse / BH Reviewer/ or Pharmacist to confirm the services authorized match the services requested.
      i. UM Nurse / BH Reviewer/ or Pharmacist will assess the documentation and confirm the prior authorization was related to the requested service.
         (i) If the services match, the case will be completed as approved and closed according to policy.
3. Post Service/Retrospective requests that meet the exception criteria **and** are submitted <u>greater than 90 calendar days</u> from the date of service.
   a) Services are reviewed for medical necessity and if there is an exception to prior authorization based on UM Policy.
4. Post Service/Retrospective requests that do not meet the exception criteria **and** are submitted greater <u>than 90 calendar days</u> from the date of service:
   a) Services will be denied as "no authorization obtained for service that required prior authorization."
      i. For telephonic request received as inquires, Providers will be reminded of the policy and will be instructed they may submit the medical records with the claim for review.
   b) UM Coordinator will route request to the Medical Director /doctoral BH Reviewer/ or Pharmacist for potential denial.
   c) The Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist will review the services to ensure documentation elements support prior authorization was required but no authorization obtained.

i. If documentation supports prior authorization was required and not obtained, Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist will document findings and deny case as "no prior authorization obtained."

ii. If documentation supports prior authorization was required and internal documentation shows authorization was obtained, the Physician/ Medical Director /doctoral BH Reviewer/ or Pharmacist will document findings for approval along with the reasons.

d) Case is routed back to the UM Coordinator to complete the member and provider notifications.

e) UM Coordinator will complete the member and provider notifications as defined in UM-054 Policy Notice of Action.

I. Potential Quality Indicator (PQI)

1. If during a UM review process, staff identifies a potential quality of care issue, UM / BH/ Pharmacy staff will fill out the PQI Service Request (SR) referral via HealthSuite and forwards to the QI department for review in accordance QI Policy Potential Quality of Care Issues.

J. Referrals to Care Management

1. If during a UM review process, staff identifies a member may benefit from care management or care coordination, including assisting with redirecting services from an Out of Network Provider to an contracted Provider, EPSDT Care Coordination, Enrollment in an Oncology Program, CCS verification, Behavioral Health, High Risk Transitions of Care Services, or a specific Community Supports/ Complex Care Coordination/ ECM service's needs, then the UM staff will complete the Care Management / CCS/ BH Referral Form as potential candidate for care management. The form is then forwarded to the Care Management Department / BH for review and assistance in accordance with Care Management /BH Policies.

K. Reporting and Tracking

1. All pre-service requests are entered into The Alliance clinical information system, TruCare, with appropriate documentation reflecting management of the referral including time frames.
2. HealthCare Analytics has developed a series of reports which track authorization requests by type, determinations, and timeliness. Reports are produced daily to monitor staff productivity and monthly to report department performance.
3. Monthly report summaries of UM activities are reported to the UM Committee for tracking and trending activities as well as to identify opportunities for process improvements.

L. The Alliance Medical Management Referrals for Autism Services

1. A PCP, a Regional Center, or a family member may refer members to receive services by contacting the BH Department.
2. All BH related services for the treatment of autism are managed by the BH Department. Referrals received for the evaluation of autism services as defined in SB 946 will be routed to the BH Team for referral processing.
3. The Alliance will track and monitor member referrals for members requiring services through SB 946. This includes those members with pervasive developmental disorder, or

autism.

a) The BH team will submit any request for non-BH services (i.e., PT, OT, ST evaluations and treatment) to the Alliance UM Department.
b) UM Staff will process referral request as defined in Sections 3.1
c) UM Staff will make efforts to maintain same providers for services that are already in place or provided by the treating ABA provider.

M. The Alliance UM / BH/ Pharmacy departments provides oversight of delegated entities' compliance with state and federal regulations and Alameda Alliance's delegated UM activities, which includes, but not limited to, annual, focused, and supplemental audits/file reviews, and other various types of audits, such as continuous monitoring, medical record/document/log reviews and data analysis.

DEFINITIONS

A. **Administrative Decisions:** Qualified non-clinical staff may make non-medical necessity denial decisions for non-eligibility.

B. **Auto Authorizations** – pre-service authorization requests that do not require clinical review and may be completed by a non-clinical staff member using established UMC approved guidelines.

C. **Behavioral Healthcare Practitioner (BHP)** is a physician or other health professional who has advanced education and training in the behavioral healthcare field and /or BH/substance abuse facility and is accredited, certified, or recognized by a board of practitioner as having special expertise in that clinical arear of practice.

D. **Benefits Determination:** A denial of a requested service that is specifically excluded from a Member's benefit plan and is not covered by the organization under any circumstances. A benefit determination includes denials of requests for extension of treatments beyond the limitations and restrictions imposed in the Member's benefit plan, if the organization does not allow extension of treatments beyond the number outlined in the benefit plan for any reason.

E. **Biomarker:** A diagnostic test, single or multigene or an individual biospecimen, such as tissue, blood or other bodily fluids for DNA or RNA alternations, including phenotypic characteristics of a malignancy to identify an individual with a subtype of cancer to guide treatment.

F. **Criteria** means systemically developed, objective, and quantifiable statements used to assess the appropriateness of specific health care decisions, services, and outcome.

G. **Denial** means non-approval of a request for care or service based on either medical appropriateness or benefit coverage. This includes denials, any partial approvals or modifications, delays and termination of existing care or service to the original request.

H. **Doctoral Behavioral Health Reviewer** is a licensed Psychiatrist or Psychologist who has advanced education and training in the behavioral healthcare field and /or behavioral health/substance abuse and is accredited, certified, or recognized by a board of practitioners as having special expertise in that clinical area of practice.

I. **Medical Necessity:** Determinations on decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

J. **Medically Necessary (Group Care Program for Medical Care):** Those covered health care services or products which are (a) furnished in accordance with professionally recognized standards of practice; (b) determined by the treating physician or licensed, qualified provider to be consistent with the medical condition; and (c) furnished at the most appropriate type, supply, and level of service which considers the potential risks, benefits, and alternatives to the patient; (d) reasonable and necessary to protect life, prevent illness, or disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. [2013 Group Care Program EOC, page 90)

K. **Medically Necessary (Group Care Program for Behavioral Health Services):** "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
(i) In accordance with the generally accepted standards of mental health and substance use disorder care.
(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
(iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the

convenience of the patient, treating physician, or other health care provider. ((iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider. (HSC 1372.74(a)(3)(A))

L. **Medically Necessary (Medi-Cal Program):** means those reasonable and necessary services, procedures, treatments, supplies, devices, equipment, facilities, or drugs that a medical Practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease or its symptoms to protect life, to prevent significant illness or significant disability, or to alleviate severe pain that are:

i) Consistent with nationally accepted standards of medical practice:

(1) "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer- reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

(2) For drugs, this also includes relevant finding of government agencies, medical associations, national commissions, peer reviewed journals and authoritative compendia consulted in pharmaceutical determinations.

(3) For purposes of covered services for Medi-Cal Members, the term "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury and

(4) When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the requirements applicable to

(a) Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services and EPSDT

(b) Supplemental Services as defined in Title 22, 51340 and 51340.1.

M. **Medical Necessity Determination** means UM decisions that are (or which could be considered to be) covered benefits, including determinations defined by the organization; hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits; and care or service that could be considered either covered or non-covered, depending on the circumstances.

N. **Member** means any eligible beneficiary who has enrolled in the The Alliance and who has been assigned to or selected a Plan.

O. **National Committee for Quality Assurance (NCQA**) is a non-profit organization committed to evaluating and public reporting on the quality of health plans and other health care entities.

P. **Non-Contracted Provider** is a provider of health care services who is not contractually affiliated with The Alliance.

Q. **Post Service or Retrospective** is defined as utilization review determinations for medical necessity/benefit conducted after a service or supply is provided to a member.

R. **Prior Authorization**: A type of Organization Determination that occurs prior to services being rendered.

S. **Provider** means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

   i) NCQA considers a Provider to be an institution or organization that provides services for Members where examples of provides include hospitals and home health agencies. NCQA uses the term Practitioner to refer to the professionals who provide health care services, but recognizes that a "Provider directory" generally includes both Providers and Practitioners and the inclusive definition is more the more common usage of the word Provider.

T. **Qualified Health Care Professional** is a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background.

U. **Utilization Management (UM)** means the process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

V. **UM /BH Reviewer** is a Registered Nurse, Physician Assistant, Psychologist, or Licensed Mental Health clinicians (Licensed Clinical Social Workers, Licensed Marriage and Family Therapists) who is qualified by scope of practice, license, and experience in the use of criteria sets to evaluate clinical factors. They apply QIHEC approved criteria to authorize care for members meeting the criteria within their scope of practice.

AFFECTED DEPARTMENTS/PARTIES

All departments

RELATED POLICIES AND PROCEDURES AND OTHER RELATED DOCUMENTS

1. Prior Authorization Grid for Medical Benefits on The Alliance Website, Provider Section,
2. BH-001 Behavioral Health Services
3. BH-002 Behavioral Health Services
4. BH-005 Care Coordination-Behavioral Health
5. BH-006 Care Coordination-Substance Abuse
6. CM-002 Coordination of Care
7. CM-009 ECM Program Infrastructure
8. QI-133 Inter-Rater Reliability (IRR) Testing for Clinical Decision Making
9. RX-002 PA Review Process

10. UM - 054 Policy Notice of Action
11.
12. UM -059 Continuity of Care for Medi-Cal Beneficiaries Who Transition into Medi-Cal Managed Care

REVISION HISTORY

11/30/2006, 3/15/2007, 1/1/2008, 9/22/2008, 10/31/2008, 1/16/2009, 4/4/2011, 10/18/2011, 12/30/2011, 4/27/2012, 10/18/2012, 12/12/2012, 05/06/2013, 08/21/2013, 09/24/2013, 10/14/2013, 12/16/2013, 3/13/2014, 5/01/2014, 7/14/2014, 8/6/2014, 8/18/2014, 9/2/2014, 12/1/2014, 10/07/2015, 10/15/2016, 12/15/2016, 12/20/2017, 1/4/2018, 4/12/2018, 3/21/2019, 1/16/2020, 5/20/2021, 3/22/2022, 02/21/2023, 6/20/2023, 12/19/2023, 04/25/2024

REFERENCES

- SB 600, Section 1374.551. (a)
- "May directly or indirectly cause" means medical treatment with a possible side effect of infertility, as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.
- Health care coverage: fertility preservation, SB 600, Chapter 853, (2019-2020).
- DHCS Provider Manual, Family Planning, June 2022, page 1. DHCS Contract, Exhibit A, Attachments 5, 9, 13
- Title 22, Section 51159
- 28 CCR, §1300.51 (d)(I-6)
- Health & Safety Code, Section 1367.01, 1367.665; 1370.6
- 2024 Medi-Cal Managed Care Plan Transition Policy Guide
- 42 CFR 438.900(d)
- 42 CFR Subpart K
- NCQA Standards, Utilization Management
- WIC Section 14197
- APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates
- APL 22-010 Cancer Biomarking Testing
- APL 23-004 Skilled Nursing Facilities-Long Term Benefit Standardization and Transition of Members to Managed Care
- APL 23-010 Responsibilities for Behavioral Health Treatment Coverage for Members Under the Age of 21
- APL 23-018 Managed Care Health Plan Transition Policy Guide
- APL 23-022 Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-For-Service, on or after January 1, 2023.
- APL 23-023 Intermediate Care Facilities for Individuals with Developmental Disabilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care
- APL 23-027 Subacute Care Facilities -- Long Term Care Benefit Standardization and Transition of Members to Managed Care

MONITORING

1. Delegated Medical Groups
    a. The Alliance continuously monitors the utilization management functions of its delegated groups through periodic reporting and annual audit activities.
    b. The Alliance reviews reports from delegated groups of all authorized specialty and inpatient services that are the Alliance's financial responsibility.
2. Internal Monitoring
    a. The Utilization Management Department, on a routine basis, reviews:
        i. Results from the quarterly authorization audit conducted by the Alliance Compliance Department. The Department audits the timeliness of authorizations, appropriate member and provider notification, and the quality of the denial language.
        ii. Complaints and grievances to identify problems and trends that will direct the development of corrective actions plans to improve performance.
        iii. Quarterly reports of authorizations and claims for non-network specialty referrals.
    b. Inter-rater Reliability - At least annually, the Alliance evaluates the consistency of decision making for those health care professionals involved in applying UM Criteria. Consistent with HSC Section 1374.721(e)(7), the Alliance ensures interrater reliability pass rate of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability. The Alliance also ensure interrater reliability testing for all new staff before they conduct utilization review without supervision. See QI-133 for additional detail about the Inter-Rater Reliability Process.