

DHCS



California Department of
HealthCareServices

**Technical
Assistance
Guide**

for Medical Audits

Category 1 –
Utilization Management

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Introduction

In accordance with California Welfare and Institutions Code Section 14456, the Department of Health Care Services (DHCS) conducts medical audits of Medi-Cal managed care plans (MCPs) on an annual basis. Medical audits evaluate MCPs' compliance with the DHCS contractual requirements and applicable laws and regulations. DHCS' Managed Care Quality and Monitoring Division (MCQMD) is responsible for ensuring overall monitoring and oversight of MCPs. MCQMD designates the Medical Review Branch (MRB) of DHCS' Audits and Investigations Division (A&I) to perform the mandated audits. The audit scope encompasses the following six categories of review:

- Category 1 – Utilization Management
- Category 2 – Case Management and Coordination of Care
- Category 3 – Access and Availability
- Category 4 – Member's Rights
- Category 5 – Quality Improvement
- Category 6 – Administrative and Organizational Capacity

Guidance on Using the Technical Assistance Guide (TAG)

MCQMD and A&I have partnered together to create Technical Assistance Guides (TAG) for each category of review. The TAGs are designed to identify key elements that will be commonly evaluated to inform MCPs of the audit process and increase transparency. To this end, each TAG is broken down by subcategories and includes the following components, as applicable:

- **Contract Language:** This section identifies “key” contract provisions¹ that are the focus of review for each subcategory. While references to specific provisions may assist the MCP with narrowing the scope of review in preparation for the audit, it does not preclude the audit team from investigating the MCP's compliance with other contract requirements not explicitly named. MCPs are ultimately responsible for ensuring compliance with *all* provisions of the DHCS contract as well as any applicable All Plan Letters (APLs) and Plan Letters (PLs). The contract provisions included in the TAG are intended to serve as guidance only as well as a quick point of reference.
- **Documentation Reviewed:** The items listed in this section reflect common *initial* documentation requests and not subsequent follow-up requests that may be warranted after initial review and interviews with the MCP. The initial documentation request includes, but is not limited to: policies and procedures, organizational charts, committee meeting minutes, monitoring reports, data logs, etc. While the documentation provides the audit team with a general overview of the

¹ The TAGs cite language from the general Two-Plan Boilerplate Contract. Each MCP should reference its own Plan-specific contract to confirm requirements.

operational structure and the team may glean insight regarding compliance with some contractual requirements, it is not all encompassing. Therefore, to ease the burden of further document requests made onsite, the MCP is advised to submit additional pre-onsite documentation for review (even if not explicitly requested) if the MCP believes that review of such information would assist the audit team with assessing compliance in any of the subcategories.

- **Verification Study (if applicable):** This section appears within a designated subcategory when a verification study (i.e., review of specific files such as grievances, prior authorizations, claims, etc.) may be used to assist with measuring compliance. The MCP is instructed to provide data in a prescribed format (i.e., spreadsheet containing all files for the audit review period). The log will assist the audit team with selection of specific files for onsite review. The audit team is neither precluded from conducting additional verification studies as needed nor expected to consistently conduct all verification studies listed in this TAG.
- **Examples of Best Practices:** This section details examples of best practices. The examples listed include strategies that some MCPs have implemented to either demonstrate compliance with a given standard or successfully remediate an identified deficiency. Every MCP and every audit is unique and best practices do not always transfer seamlessly. While the audit team does not audit to best practices, the burden is on the MCP to demonstrate that it is meeting its contractual obligations. To this end, examples of best practices emphasize the MCP's ability to produce *documented evidence* to substantiate that the MCP is in compliance with the contract requirements. When monitoring efforts reveal patterns of non-compliance, the MCP should similarly be able to produce documented evidence of barrier analysis and remedial actions enacted to substantiate efforts to bring the MCP into compliance.

CATEGORY 1 – UTILIZATION MANAGEMENT

| 1.1 UTILIZATION MANAGEMENT PROGRAM | | | |
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| CONTRACT REQUIREMENT | DOCUMENTATION REVIEWED | VERIFICATION STUDY | EXAMPLES OF BEST PRACTICES |
| <p><u>Exhibit A, Attachment 5 – UTILIZATION MANAGEMENT</u> 1. Utilization Management Program Contractor shall develop, implement, and continuously update and improve, a Utilization Management (UM) program that ensures appropriate processes are used to review and approve the provision of Medically Necessary Covered Services. Contractor is responsible to ensure that the UM program includes:</p> | <ul style="list-style-type: none"> -UM Program Description -Policies and procedures -UM Work Plan -UM Committee meeting minutes | | |
| <p>A. Qualified staff responsible for the UM program.</p> | <ul style="list-style-type: none"> -UM Program Description -UM organization chart including key individuals and their qualifications -Medical Director and UM Director resumes | | <ul style="list-style-type: none"> -The Plan produces organizational charts that are current, updated, and include appropriately qualified <i>clinical</i> staff responsible for the UM program. -The Plan provides documented evidence of ongoing training for both new and seasoned staff. Training materials, sign-in sheets, and prospective training schedules are readily produced and address appropriate UM-related content. -During onsite audit interviews, the Plan demonstrates that key UM staff are knowledgeable in the contractual requirements and can articulate Plan processes. |
| <p>B. The separation of medical decisions from fiscal and administrative management to assure those medical decisions will not be unduly influenced by fiscal and administrative management.</p> | <ul style="list-style-type: none"> -Policies and procedures -UM Program Description -Member Handbook/EOC | | <ul style="list-style-type: none"> -The UM Program Description clearly indicates that medical decisions are not unduly influenced by fiscal and administrative management. |
| <p>C. Contractor shall ensure that the UM program allows for a second opinion from a qualified health professional at no cost to the Member.</p> | <ul style="list-style-type: none"> -Policies and procedures -UM Program Description -Member Handbook/EOC | | <ul style="list-style-type: none"> -The Plan's policies and procedures and Member Handbook/EOC clearly indicate that a second opinion from a qualified health professional is available at no cost to the Member. -The Plan provides examples of second opinions rendered without cost to the member as evidence of compliance with its own policies and procedures. |
| <p>D. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and</p> | <ul style="list-style-type: none"> -Committee meeting minutes (e.g., Board, UM, QM, Physician Advisory, etc.) | | <ul style="list-style-type: none"> -The Plan produces documentation to support provider involvement in the development and/or adoption of criteria/guidelines for use (e.g., |

| 1.1 UTILIZATION MANAGEMENT PROGRAM | | | |
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| standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor. | -Provider Manual -Provider newsletters -Policies and procedures | | committee meeting minutes demonstrate appropriate provider representation including names, titles, and specialties, and documented discussion of review and approval of criteria/guidelines). |
| E. Contractor shall communicate to health care practitioners the procedures and services that require prior authorization and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services. | -Provider Manual -Provider newsletters -Policies and procedures | | -The Plan produces documentation to support that providers are educated on an <i>ongoing</i> basis regarding prior authorization procedures and timeframes (e.g., Provider Manual, provider newsletters, fax blasts, documented outreach by Provider Services, documented trainings, etc.). |
| F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers. Contractor shall ensure that all contracting health care practitioners are aware of the referral processes and tracking procedures. | -Policies and procedures -UM Program Description -Member Handbook/EOC -Referral tracking reports -Committee meeting minutes (UM or AA) -Provider Manual -Provider newsletters | | -The Plan's UM Program Description and/or policies and procedures are consistent with the contractual requirements and commit the Plan towards tracking referrals that require prior authorization, including out-of-network providers. -The Plan generates reports that measure the numbers, types, and timeliness of authorized, denied, deferred, and modified specialty referrals <i>that require prior authorization</i> at a set frequency (e.g., monthly, quarterly, etc.). -The Plan generates reports that measure the numbers, types, and timeliness of specialty referrals to <i>out-of-network providers</i> at a set frequency (e.g., monthly, quarterly, etc.). -The Plan provides documented evidence that all generated reports are periodically reviewed for the purpose of identifying trends and conducting gap analysis (e.g., UM and/or Access committee minutes validate review of generated reports with documented discussion and follow-up action taken as necessary). -The Plan provides documented evidence that providers are aware of referral processes and tracking procedures (e.g., Provider Manual, provider newsletters, fax blasts, etc.). |
| G. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff. | -QM Program Description -UM Program Description -Committee meeting minutes (QM and UM) -Tracking Reports (e.g., appeals, denials, etc.) | | -The Plan's QM or UM Program Description and/or policies and procedures describe a process by where UM reports (regarding appeals, denials, deferrals, and modifications) are reviewed by appropriate QM staff for the purpose of identifying trends for quality improvement. |

| 1.1 UTILIZATION MANAGEMENT PROGRAM | | | |
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| These activities shall be done in accordance with Health and Safety Code Section 1363.5 and Title 28, CCR, Section 1300.70(b)(2)(H) & (c). | | | -The Plan provides documentation to support that QM staff are reviewing UM reports on a regularly scheduled basis and taking appropriate quality improvement action as necessary (e.g., QM committee meeting minutes document discussion of reports and analysis, coordination between UM and QM staff, etc.). |
| 2. Pre-Authorizations and Review Procedures C. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated. | -UM Program Description -Policies and procedures -Provider Manual -UM Committee meeting minutes | -An onsite verification of prior authorization and pharmacy files may be conducted to confirm that the Plan relies on written criteria or guidelines that is based on sound medical evidence that is consistently applied and regularly reviewed. | -The Plan provides evidence that criteria/guidelines are periodically reviewed and updated (e.g., committee meeting minutes, etc.). -Onsite verification studies of prior authorization and pharmacy files confirm that criteria/guidelines are being consistently applied. -The Plan conducts inter-rater reliability testing at a set frequency to ensure that decision makers consistently apply criteria/guidelines. When audit results demonstrate inconsistent application, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, discussion in UM Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. -The Plan conducts periodic training for all staff responsible for decision-making and can substantiate this through documentation (e.g., sign-in sheets, training materials, etc.). |
| 4. Review of Utilization Data Contractor shall include within the UM Program mechanisms to detect both under- and over-utilization of health care services. Contractor's internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS upon request. | -UM Program Description -UM Work Plan -Policies and procedures -UM Committee meeting minutes -CAPs initiated during the audit period to address under- and over-utilization -List of UM reports produced and the frequency and distribution list of each report | | -The Plan's UM Program Description, UM Work Plan, and/or policies and procedures contain robust monitoring procedures to detect both over- and under-utilization of health care services, aside from just HEDIS measures (e.g. aggregation of utilization data for a variety of medical services and/or preventive measures, tracking of specialist referrals that do not require prior authorization, etc.). -Methods and frequencies for report generation for over- and under-utilization are clearly indicated in the UM Program Description and is consistent with those same methods and frequencies described in the Plan's policies and procedures. |

| 1.1 | UTILIZATION MANAGEMENT PROGRAM | | |
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| | | | <p>-The Plan is readily able to produce all monitoring reports at the frequencies indicated by the UM Program Description, UM Work Plan, and or policies and procedures, demonstrating that it adheres to internal policies.</p> <p>-In addition to <i>generating</i> reports, the Plan demonstrates that reports are being <i>reviewed</i> and analyzed by the appropriate parties, as evidenced by documentation (e.g., UM Committee meeting minutes documenting trends and barrier analysis, etc.).</p> <p>-If the results of monitoring reports reveal notable trends, the Plan is able to provide documented evidence that appropriate discussion and follow-up action has been taken in an effort address the issues identified. The Plan conducts re-measurement activities as necessary to monitor progress.</p> <p>-The Plan regularly analyzes monthly data uploaded by DHCS (e.g., encounter data, FFS claims data, TARs, etc.) to detect member utilization patterns for newly enrolled and/or enrolled members.</p> |

| 1.2 PRIOR AUTHORIZATION REVIEW | | | |
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| <p><u>Exhibit A, Attachment 5 – UTILIZATION MANAGEMENT</u> 2. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements: A. 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.</p> | <p>-UM Program Description -Policies and procedures related to the tracking and review of denials, modifications, and deferrals</p> | <p>-An onsite verification of prior authorization and pharmacyfiles may be conducted to confirm that the Plan clearly and consistently documents the physician reviewer's name and credentials. -NOA letters to the member and provider similarly document the name and credentials of the physician reviewer.</p> | <p>-The Plan's UM Program Description and/or policies and procedures are aligned with the contractual requirement and indicate that UM decisions are to be made by a qualified health care professional with appropriate clinical expertise in treating the condition and disease.</p> |
| <p>B. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified physician or Contractor's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan medical director, in collaboration with the Plan Pharmacy and Therapeutics Committee (PTC) or its equivalent.</p> | <p>-UM Program Description -Policies and procedures related to the tracking and review of denials, modifications, and deferrals</p> | <p>-An onsite verification of prior authorization and pharmacyfiles may be conducted to confirm that the Plan consistently documents the involvement of a qualified health care professional in the decision-making of denials that are made in whole or in part on medical necessity.</p> | <p>-The Plan's policies and procedures ensure that process are in place to ensure qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity.</p> |
| <p>C. There is a set of written criteria or guidelines for utilization review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated.</p> | <p>-List of all services, procedures, or equipment that require prior authorization. -UM Program Description -Policies and procedures -Provider Manual -UM Committee meeting minutes</p> | <p>-An onsite verification of prior authorization and pharmacyfiles may be conducted to confirm that criteria/guidelines are being consistently applied.</p> | <p>-The Plan conducts inter-rater reliability testing at a set frequency to ensure that decision makers consistently apply criteria/guidelines. When audit results demonstrate inconsistent application, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, discussion in UM Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. -The Plan conducts periodic training for all staff responsible for decision-making and can</p> |

| 1.2 | | PRIOR AUTHORIZATION REVIEW | | |
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| | | | substantiate this through documentation (e.g., sign-in sheets, training materials, etc.). | |
| D. Reasons for decisions are clearly documented. | -NOA templates (denials, deferrals, modifications) | -An onsite verification of prior authorization and pharmacy files may be conducted to confirm that that NOA letters and files consistently contain reasons that are clearly documented. | <p>-Plan staff who process prior authorization requests receive initial and ongoing training that address NOA letter requirements such as including a clear and concise reason, the description of criteria/guideline, and the clinical reason for the decision. The Plan is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.).</p> <p>-The Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirements. Auditing tools specifically measure whether decisions are clearly documented and audit results can be produced at the frequencies indicated per the Plan's policies and procedures. When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, increased staffing, discussion in UM Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress.</p> | |
| <p>H. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit E, Attachment 2, Provision 19, Audit.</p> <p><u>Exhibit E, Attachment 2 – PROGRAM TERMS AND CONDITIONS</u></p> <p>19. Audit</p> <p>In addition to Exhibit C, Provision 4. Audit, Contractor also agrees to the following:</p> <p>B. Records Retention</p> <p>Notwithstanding any other records retention time period set forth in this Contract, these books and records will be maintained for a minimum of five years from the end of the current Fiscal Year in which the date of service occurred; in which the</p> | -Policies and procedures | | <p>-The Plan maintains a records retention policy that is consistent with the contractual requirement.</p> <p>-During onsite audit interviews, the Plan demonstrates that key UM staff are knowledgeable in the records retention requirements and can articulate the Plan's processes for retaining NOAs for a period of five years.</p> | |

| 1.2 PRIOR AUTHORIZATION REVIEW | | | |
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| record or data was created or applied; and for which the financial record was created or the Contract is terminated, or, in the event the Contractor has been duly notified that DHCS, DHHS, DOJ, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the Contract, until such time as the matter under audit or investigation has been resolved, whichever is later. | | | |
| I. Contractor must notify the requesting provider or Member of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing. | | -An onsite verification of prior authorization and pharmacy files may be conducted to confirm the Plan notifies the provider or member of any determination. -The Plan is able to substantiate through documentation that the notice to the provider is orally or in writing. | -The Plan's policies and procedures ensure that process are in place to ensure that the requesting provider receives oral or written notification of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested |
| 3. Timeframes for Medical Authorization F. Pharmaceuticals: 24 hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code, Section 14185 or any future amendments thereto. | -Policies and procedures -UM Committee meeting minutes | -An onsite verification study of pharmacy files may be conducted to confirm timeliness of decision-making. | -The Plan's policies and procedures regarding prior authorization timeframes are aligned with the May 2015 email guidance provided by MCQMD. The email clarifies that the Plan is required to provide a response to pharmaceutical requests (i.e., approval, denial, or request for further information) within 24 hours or 1 business day, but not to exceed 72 hours for expedited requests that pose a serious risk to the member's life, health, or function. A final determination must be made within 24 hours or 1 business day of receipt of necessary medical information, but not to exceed 72 hours from receipt of necessary medical information for expedited requests that pose a serious risk to the member's life, health, or function. Decisions may not exceed 30 calendar days from receipt of the original request. Any response or decision delayed beyond these time |

| 1.2 | PRIOR AUTHORIZATION REVIEW | | |
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| | | | <p>limits is considered a denial and must be immediately processed as such.</p> <ul style="list-style-type: none"> -The Plan's policies and procedures outline monitoring procedures at a set frequency to ensure compliance. -Plan staff who process pharmacy prior authorization requests receive initial and ongoing training that address timeliness of processing. The Plan is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). -The Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement. Auditing tools specifically measure whether decisions are made timely and audit results can be produced at the frequencies indicated per the Plan's policies and procedures. When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, increased staffing, discussion in UM Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. |
| <p>G. Routine authorizations: Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code, Section 1367.01, or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional</p> | <ul style="list-style-type: none"> -Policies and procedures -UM Committee meeting minutes | <ul style="list-style-type: none"> -An onsite verification study of routine authorizations may be conducted to confirm timeliness of decision-making. | <ul style="list-style-type: none"> -The Plan's policies and procedures regarding prior authorization timeframes are aligned with the contractual requirement. -The Plan's policies and procedures outline monitoring procedures at a set frequency to ensure compliance. -Plan staff who process prior authorization requests receive initial and ongoing training that address timeliness of processing. The Plan is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). |

| 1.2 PRIOR AUTHORIZATION REVIEW | | | |
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| information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such. | | | -The Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement. Auditing tools specifically measure whether decisions are made timely and audit results can be produced at the frequencies indicated per the Plan's policies and procedures. When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, increased staffing, discussion in UM Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. |
| <p><u>Exhibit A, Attachment 13 – MEMBER SERVICES</u></p> <p>8. Denial, Deferral, or Modification of Prior Authorization Requests</p> <p>A. Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization, in accordance with Title 22 CCR Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.</p> <p><u>Section 1367.01</u></p> <p>(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:</p> <p>(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify</p> | <ul style="list-style-type: none"> -Policies and procedures -UM Committee meeting minutes -NOA templates (denials, deferrals, modifications) | <ul style="list-style-type: none"> -An onsite verification study of prior authorization and pharmacy files may be conducted to confirm NOAs contain a clear and concise explanation, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. -NOA letters to the provider should also contain the name and direct telephone number or extension of the health care professional responsible for decision. | <ul style="list-style-type: none"> -Plan staff who process prior authorization requests receive initial and ongoing training that specifically addresses NOA letter requirements (e.g., clear and concise reason, description of criteria/guideline, clinical reason, name and telephone number of the physician reviewer, information on how to file a grievance, information on how to request a State Fair Hearing, etc.). The Plan is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). -The Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the requirements. Auditing tools specifically measure each of the required components of the NOA. Audit results can be produced at the frequencies indicated per the Plan's policies and procedures. When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, discussion in UM Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. |

| 1.2 | PRIOR AUTHORIZATION REVIEW | | |
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| <p>the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.</p> <p>Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.</p> <p>The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.</p> | | | |
| <p>5) If the health care service plan cannot make decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the</p> | <ul style="list-style-type: none"> -Policies and procedures -UM Committee meeting minutes -NOA templates (deferrals) | <ul style="list-style-type: none"> -An onsite verification study of prior authorization and pharmacy files may be conducted to confirm that: -Staff consistently request additional documentation when | <ul style="list-style-type: none"> -The Plan's policies and procedures regarding deferral procedures are aligned with the statutory requirement and outline monitoring procedures at a set frequency to ensure compliance. -Plan staff who process prior authorization requests routinely initial and ongoing training that specifically addresses deferral procedures. The Plan is able to provide documented |

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| <p>enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.</p> | | <p>there is not enough information reasonably necessary to render a medical necessity decision rather than routinely denying the request; -For all decisions that were not made timely, a deferral letter was sent to the member; -Deferral notices are consistently sent out as soon as the Plan becomes aware that it will not meet the required timeframe; -Files consistently indicate the anticipated date of the decision for deferrals, and specify the information requested but not received, or expert reviewer to be consulted, or the additional examinations or tests required.</p> | <p>evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). -Audit results can be produced at the frequencies indicated per the Plan's policies and procedures. When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, discussion in UM Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress.</p> |

| 1.3 REFERRAL TRACKING SYSTEM | | | |
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| CONTRACT REQUIREMENT | DOCUMENTATION REVIEWED | VERIFICATION STUDY | EXAMPLES OF BEST PRACTICES |
| <p><u>Exhibit A, Attachment 5 – UTILIZATION MANAGEMENT</u> 1. Utilization Management Program Contractor is responsible to ensure that the UM program includes: F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers.</p> | <ul style="list-style-type: none"> -Policies and procedures -UM Program Description -Member Handbook/EOC -Referral tracking reports -Committee meeting minutes (UM or AA) -Provider Manual -Provider newsletters | | <ul style="list-style-type: none"> -The Plan’s UM Program Description and/or policies and procedures are consistent with the contractual requirements and commit the Plan towards tracking referrals that require prior authorization, including out-of-network providers, at a set frequency. -The Plan generates reports that measure the numbers, types, and timeliness of authorized, denied, deferred, and modified specialty referrals <i>that require prior authorization</i>. -The Plan generates reports that measure the numbers, types, and timeliness of specialty referrals to <i>out-of-network providers</i>. -The Plan provides documented evidence that all generated reports are periodically reviewed for the purpose of identifying trends and conducting gap analysis (e.g., UM and/or Access committee minutes validate review of generated reports with documented discussion and follow-up action taken as necessary). -The Plan provides documented evidence that providers are aware of referral processes and tracking procedures (e.g., Provider Manual, provider newsletters, fax blasts, etc.).. |

| 1.4 APPEAL PROCEDURES | | | |
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| <p><u>Exhibit A, Attachment 5 – UTILIZATION MANAGEMENT</u> 2. Pre-Authorizations and Review Procedures Contractor shall ensure that its pre-authorization, concurrent review and retrospective review procedures meet the following minimum requirements: E. Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 13, Member Services. There shall be a well-publicized appeals procedure for both providers and patients.</p> <p>(Please see Subcategory 1.2, Prior Authorization Review on pages 13-15 for reference to the requirements pertaining to member notification.)</p> | <ul style="list-style-type: none"> -Policies and procedures (member and provider appeals) -UM Program Description -Provider Manual - Member Handbook/EOC | | <p>-Both the Provider Manual and Member Handbook/EOC include a well-publicized appeals procedure for both providers and members.</p> |
| <p><u>Exhibit A, Attachment 14 – MEMBER GRIEVANCE SYSTEM</u> 5. Member Appeal Process Contractor shall implement and maintain an appeal process as described below to resolve Member appeals. A. Member, or a provider acting on behalf of a Member and with the Member’s written consent, may file an appeal.</p> | <ul style="list-style-type: none"> -Policies and procedures (member appeals) -UM Program Description -Provider Manual - Member Handbook/EOC | | <p>-The Member Handbook/EOC clearly displays the member appeals process including language that indicates a member or provider on behalf of a member and with the member’s written consent may file an appeal. -Policies and procedures are aligned with the contractual language and similarly include language indicating that a member or provider on behalf of a member and with the member’s written consent may file an appeal.</p> |
| <p>B. Contractor must provide a Member notice, as expeditiously as the Member’s health condition requires, within 45 days from the day Contractor receives the appeal. A Member notice, at a minimum, must include the result and date of the appeal resolution. For decisions not wholly in the Member’s favor, Contractor, at a minimum’ must include: 1) Member’s right to request a State Fair Hearing; 2) How to request a State Fair Hearing; 3) Right to continue to receive benefits pending a State Fair Hearing; and 4) How to request the continuation of benefits.</p> | <ul style="list-style-type: none"> -Policies and procedures (member appeals) -UM Program Description -Provider Manual - Member Handbook/EOC -Committee meeting minutes (UM and G&A) | <p>-An onsite verification study of appeals files may be conducted to confirm timeliness of decision-making.</p> | <p>-The Plan’s policies and procedures and the Member Handbook/EOC indicate appeals processing timeframes that are aligned with the contract requirement to provide member notice within 45 days from receipt of the appeal. (Note: For Knox-Keene licensed plans, Section 1368 does not distinguish grievances from appeals. Therefore, resolution must be within 30 calendar days for all grievances, including appeals.) -Plan staff who process appeals receive initial and ongoing training that address timeliness of processing. The Plan is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.).</p> |

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| | | | -The Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement. Auditing tools specifically measure whether decisions are made timely and audit results can be produced at the frequencies indicated per the Plan's policies and procedures. When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, increased staffing, discussion in UM or G&A Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. |
| C. Contractor may extend the timeframe to resolve an appeal by up to 14 calendar days if the Contractor shows that there is a need for additional information and how the delay is in the Member's interest. | -Policies and procedures (member appeals) -UM Program Description -Provider Manual - Member Handbook/EOC -Committee meeting minutes (UM and G&A) | -An onsite verification study of appeals files may be conducted to confirm timeliness of decision-making, including documented extensions up to 14 calendar days as needed. The Plan further documents that a need for further information has been requested and how the delay is in the member's best interest. | -The Plan's policies and procedures and the Member Handbook/EOC indicate that the timeframe to resolve an appeal may be extended up to 14 calendar days if the Plan shows there is a need for additional information and how the delay is in the member's best interest. -Plan staff who process appeals receive initial and ongoing training that address timeliness of processing. There is a focus on documenting <i>both</i> the need for additional information and how the delay is in the member's interest when appeals are extended for up to 14 calendar days. The Plan is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). -The Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement. Auditing tools specifically measure whether the Plan clearly documents both the need for additional information and how the delay is in the member's interest when the timeframe to resolve an appeal is extended up to 14 calendar days. When audit results demonstrate instances of non-compliance, the Plan takes follow-up |

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| | | | action as necessary and can substantiate this through documentation (e.g., re-training, discussion in UM or G&A Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. |
| D. Contractor must authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires if the services are not furnished while the appeal is pending and Contractor reverses a decision to deny, limit, or delay services. | <ul style="list-style-type: none"> -Policies and procedures (member appeals) -UM Program Description -Provider Manual -EOC/Member Handbook -Committee meeting minutes (UM and G&A) | -An onsite verification study of appeals files may be conducted to confirm that the Plan provides the disputed services as expeditiously as the member's health condition requires if the Plan reverses its initial determination. | <ul style="list-style-type: none"> -The Plan's policies and procedures and the Member Handbook/EOC indicate that the Plan will authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires if the services are not furnished while the appeal is pending and the Plan reverses a decision to deny, limit, or delay services. -Plan staff who process appeals receive initial and ongoing training on the Plan's requirement to authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires if the services are not furnished while the appeal is pending and the Plan reverses a decision to deny, limit, or delay services. The Plan is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). -The Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement. Auditing tools specifically measure whether the Plan authorizes or provides the disputed services promptly, and as expeditiously as the member's health condition requires if the services are not furnished while the appeal is pending and the Plan reverses a decision to deny, limit, or delay services. When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, discussion in UM or G&A Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. |

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| E. Contractor must pay for disputed services if the Member received the disputed services while the appeal was pending. | <ul style="list-style-type: none"> -Policies and procedures (member appeals) -UM Program Description -Provider Manual -EOC/Member Handbook -Committee meeting minutes (UM and G&A) | -An onsite verification study of appeals files may be conducted to confirm that the Plan pays for disputed services if the member received the disputed services while the appeal was pending. | <ul style="list-style-type: none"> -The Plan’s policies and procedures and the Member Handbook/EOC indicate that the Plan will pay for disputed services if the member received the disputed services while the appeal was pending. -Plan staff who process appeals receive initial and ongoing training on the Plan’s requirement to pay for disputed services if the member received the disputed services while the appeal was pending. The Plan is able to provide documented evidence of training (e.g., sign-in sheets, dates of training, training schedule, etc.) as well as training materials (e.g., desktop procedures, PowerPoint slides, etc.). -The Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement. Auditing tools specifically measure whether the Plan pays for disputed services if the member received the disputed services while the appeal was pending. When audit results demonstrate instances of non-compliance, the Plan takes follow-up action as necessary and can substantiate this through documentation (e.g., re-training, discussion in UM or G&A Committee meeting minutes, etc.). The Plan conducts re-measurement activities as necessary to monitor progress. |

| 1.5 | | DELEGATION OF UTILIZATION MANAGEMENT | | |
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| <p><u>Exhibit A, Attachment 5 – UTILIZATION MANAGEMENT</u> 5. Delegating UM Activities Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities.</p> <p><u>Exhibit A, Attachment 4 – QUALITY IMPROVEMENT SYSTEM</u> 6. Delegation of Quality Improvement Activities A. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their Subcontract, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.</p> | -Delegation agreements | | -The Plan’s delegation agreements clearly specify all delegated functions and the responsibilities of both the Plan and the delegated entity. | |
| 2) Contractor’s oversight, monitoring, and evaluation processes and subcontractor’s agreement to such processes. | -Delegation agreements | | -The Plan’s delegation agreements clearly specify oversight and monitoring activities including reporting requirements by the delegate at set frequencies (e.g. monthly, quarterly, and annual, etc.). -The Plan’s delegation agreements include the requirement to perform audits at a set frequency to ensure continual monitoring and oversight of delegated responsibilities. -The Plan’s oversight methodology, as described in its policies and procedures, does not rely solely on a desk-level review, but also includes a review of actual practices (e.g., audits at a set frequency to confirm processes, etc.). | |
| 3) Contractor’s reporting requirements and approval processes. The agreement shall include | -Delegation agreements | | -The Plan’s delegation agreements require the delegate to report findings and actions taken as a result of quality improvement activities at least quarterly. | |

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| subcontractor’s responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. | | | |
| 4) Contractor’s actions/remedies if subcontractor’s obligations are not met. | -Delegation agreements | | -The Plan’s delegation agreements clearly specify actions the Plan will take if the delegate does not fulfill its obligations (e.g., implementation of CAPs, de-delegation, increased reporting/auditing, etc.). |
| <p>B. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:</p> <p>1) Evaluates subcontractor’s ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.</p> <p>2) Ensures subcontractor meets standards set forth by the Contractor and DHCS.</p> <p>3) Includes the continuous monitoring, evaluation and approval of the delegated functions.</p> | <ul style="list-style-type: none"> -Delegation agreements -Delegation reports -Delegation audits -Delegation Oversight Committee meeting minutes -Implemented CAPs | | <ul style="list-style-type: none"> -The Plan provides evidence that a pre-delegation assessment of the delegate’s ability to perform all delegated responsibilities was conducted prior to delegation. Documentation supports that all outstanding concerns/questions have been resolved prior to delegation. -The Plan provides evidence that the delegate submits all reports at the specified frequencies indicated in the delegation agreement. The Plan is readily able to produce all reports. -The Plan is able to provide documentation through Delegation Oversight Committee meeting minutes that reports submitted by the delegate are regularly reviewed, analyzed, and discussed. -The Plan conducts audits of the delegate at set intervals as indicated by the delegation agreement and there is documented discussion of audit results in the Delegation Oversight Committee meeting minutes. When audit results demonstrate non-compliance, the Plan takes effective action and these efforts are clearly documented. The Plan conducts re-measurement activities as necessary to monitor progress. |