TREATMENT AUTHORIZATION REQUEST: AUTHORIZATION PROCESS AND TIMELINE STANDARDS

Purpose

To provide a consistent process for reviewing Treatment Authorization Requests (TAR) which refer to requests for service.

Scope

The review of requests for service applies to all requests received by the Utilization Management (UM) department. The UM staff works within their scope of practice, in conjunction with the Medical Director and with the oversight of the UM Committee, to review requests appropriately. Appropriately licensed health professionals supervise all review decisions. VCHCP expects delegated entities to have similar standardized programs and processes and routinely audit delegated entities for compliance.

Definitions

Pre-service request/decision: A request/review for coverage of medical care or service that the Plan must approve, in whole or in part, in advance of the member obtaining medical care or services. Preauthorization and precertification are pre-service decisions.

Post service request/decision: A request/review for coverage of medical care or services that have been received (e.g., retrospective review). A request for coverage of care that was provided by an out-of-network (OON) practitioner and for which the required prior authorization was not obtained is a post service decision. Although the Plan requires prior authorization of OON care, post service decisions include any requests for coverage of care or services that a member has already received.

Concurrent request/decision: A request/review for coverage of medical care or services made while a member is in the process of receiving the requested medical care of services, even if the organization did not previously approve the earlier care. Any review for an extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Concurrent reviews are typically associated with inpatient care or ongoing ambulatory care.

Urgent request/decision: A request/decision for medical care, treatment or services where application of the time frame for making non-urgent/routine or non-life-threatening care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a person who reasonably believed that an emergency medical condition existed ***or***
- Could seriously jeopardize the life, health or safety of the member or others, due to member's psychological state, ***or***
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request, ***or***
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Note: For urgent care decisions, a health care practitioner with knowledge of the member's medical condition may act as the member's authorized representative.

Nonurgent request/decision: A request/review for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Reclassification of requests that do not meet the definition of "urgent". All types of requests received while the member is receiving care may be reclassified as preservice or post service if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or post service)

Policy

VCHCP has a process for reviewing and authorizing, modifying, or denying Treatment Authorization Requests (TARs) for services.

Determinations, when based on medical necessity, reflect appropriate application of VCHCP's approved medical policy and practice guideline criteria. Determinations may also be based on eligibility and benefit coverage. All reviews consider individual needs and an assessment of the local delivery system.

A Registered Nurse (RN) or licensed physician may review and sign a denial based on benefit coverage. A licensed physician reviews and signs every denial that is based on medical necessity.

Determinations on behavioral health treatment authorization requests are delegated to OptumHealth Behavioral Solutions of California (OHBS-CA). Such delegation accepts that a licensed psychiatrist renders all denial decisions related to medical necessity determinations. A licensed psychologist may render denial decisions for outpatient services provided by non-physician practitioners.

Information, and relevant clinical decisions and rationale are clearly documented and appropriately available for review by members.

The member has a right to representation at any time during the referral process. The appointment of an authorized representative must be in writing. Members can obtain an Authorized Representative form by calling Member Services or visiting the VCHCP business office in person. The following persons may be submitted and considered as an authorized representative:

- A friend, relative or legal representative
- A parent of a child under 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control the release of relevant information.
- A court- appointed guardian, except the ward, must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of relevant information.
- A court-appointed conservator

Biomarker Testing (SB496)

VCHCP covers biomarker testing as mandated by SB496. SB496 bill would require a health care service plan on or after July 1, 2024, to provide coverage for medically necessary biomarker testing, as prescribed, including whole genome sequencing, for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition to guide treatment decisions. Prior authorization is required for biomarker testing unless it meets Section 1367.665(b) (i.e. biomarker testing for an enrollee with advanced or metastatic stage 3 or 4, or for cancer progression or recurrence in the enrollee with advanced or metastatic stage 3 or 4 cancer). Any biomarker testing requested for diseases not related to cancer including, but not limited to, other disease areas such as rheumatoid arthritis, other autoimmune conditions, organ and tissue transplant, rare diseases, pre-eclampsia, will require prior authorization to which the prior authorization process (specified under the procedure section of the Treatment Authorization Request Auth Process and Timeline Standards UM policy) will apply. Prior authorization timeframe standards such as urgent and non-urgent review timeframes, timeframe extensions for additional information, notification timeframes, denial dispute, as stated in the Procedure Section of Treatment Authorization Request Auth Process and Timeline Standards UM policy, will apply for any biomarker testing requested for diseases not related to cancer including, but not limited, to other disease areas such as rheumatoid arthritis, other autoimmune conditions, organ and tissue transplant, rare diseases, preeclampsia.

- Under Section 1367.667(d) of SB496, restricted or denied use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to grievance and appeal processes under state and federal law.

AB 2105 Coverage for Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)

If the plan requires authorization for PANDAS/PANS prophylaxis, diagnosis, or treatment, the plan will authorize PANDAS/PANS prophylaxis, diagnosis, or treatment to be provided in a timely manner that is appropriate for the severity of the enrollee's condition pursuant to Section 1367.03.The plan will not deny or delay coverage for PANDAS/PANS therapies because the enrollee previously received treatment, including the same or similar treatment, for PANDAS or PANS, or because the enrollee was diagnosed with or received treatment for their condition under a different diagnostic name, including but not limited to autoimmune encephalopathy and autoimmune encephalitis. This includes: (a) treatment received that was initially prior authorized by the Plan, (b) treatment received from a service that did not require prior authorization, and (c) treatment received from another health plan.

Diagnosis Codes:

ICD 10 D89.89 CDC PANDAS (Other specified disorders involving the immune mechanism, not elsewhere classified)

ICD 10 D89.9 CDC PANS (Disorder involving the immune mechanism, unspecified)

ICD 10 G04.90 autoimmune encephalitis

ICD 10 G93.40-G93.49 Encephalopathy codes

AB 2843 Health Care Coverage: Rape and Sexual Assault

All services related to rape and sexual assault diagnosis do not require prior authorization. This is to comply with AB 2843. This includes, but is not limited to, nine-month coverage period and the prohibition of any conditions on coverage related to the filing of a police report, criminal charges against an assailant, or the conviction of an offense. The no prior authorization information and list of rape and assault diagnosis codes will be posted on the Plan's website to inform providers. See California Penal Code Sections 261, 261.6, 263, 263.1, 286, 287, and 288.7.

Procedure

1. Referral requests and requests for authorization of services or medications are sent by providers to the VCHCP UM Department by mail, fax, and telephone or via electronic referral. After normal business hours requests for urgent or emergent preservice and urgent concurrent services are to be received by telephone only by the Plan's administrative on call physicians. This procedural information is made available to all practitioners in the Provider's Manual and is available on the provider website.

- For medication requests, please refer to Pharmacy Policies: Prior Authorization of Medication Program Policy Procedure & Pain Management for Terminally Ill Patients.

2. The date and time of the receipt of request is automatically stamped by the system whether or not all necessary information is available at that time. The request is the date that the Plan receives the request from the member or the member's authorized representative/provider, even if not received by the UM department.
    a. Date of Receipt: The date/time of receipt of an authorization request is defined as the date/time that the request is received, in accordance with the state requirements and NCQA standards. The following describes the date/time used to note the date/time a request was made for a request for authorization:
        i. If received by U.S. mail, the date/time the document is physically received is stamped at the VCHCP office by Member Services.
        ii. If received by fax, the date/time is automatically assigned by the system and indicated by the fax transmission report. The labeled fax with date/time stamped by the system is updated to add the name of the member to ensure appropriate identification.
        iii. If received by electronic health record (CERNER), the transmission date/time on the Treatment Authorization Request (TAR) in the CERNER authorization pool, is copied and pasted in the QNXT medical management system.
        iv. If received by the Healthx provider portal, the date/time is automatically stamped on the treatment authorization request (TAR) form.
        v. If received verbally by phone, the date/time the call was made with the request is documented in the QNXT medical management system by UM intake staff.
        vi. If received verbally by voicemail, the voicemail recording goes to a shared mailbox which is date/time stamped. This date/time stamp is documented in the QNXT medical management system by UM intake staff.

3. The timeliness of the notification decision date is measured from the time/date the request is received from the member, the member's authorized representative, or the provider even if the Plan does not have all the information necessary to make a decision to the date when the notice was provided to the member and practitioner. For non-urgent requests received during non-business hours, the measurement of receipt date starts from the date the request is received in the Plan, even if after business hours.

4. The Plan has methods of documenting and tracking the written notification dates. The Plan uses the date on the member and practitioner written notice as the notification date to be compliant with NCQA. The Plan retains copies of the member and practitioner written notice which has the notification date. To comply with the Department of Managed Health Care (DMHC), the Plan saves copies of fax confirmations sent to practitioners which have the dates when the faxes are sent, and the dates are systematically tracked for compliance. In addition, the Plan uses the date

on the member written notice as well as the date stamp in the QNXT medical management system as notification date. Member notifications are mailed.

5. Member eligibility and benefits are checked.

6. If the request is for other than Emergency or Urgent Services, Step #4 is skipped, and staff is directed to proceed to Step #5.
   Requests to the Plan for authorization to provide Emergency or Urgent service are addressed according to the following:
   a. Authorization for emergency care or service is not required before the care can be provided. An emergency means an unexpected medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person who possesses an average knowledge of health and medicine could reasonably assume that the absence of immediate medical attention could be expected to result in any of the following: (1) placing the Member's health in serious jeopardy, (2) serious impairment to bodily functions, (3) serious dysfunction of any bodily organ or part.

      In accordance with current law, members presenting to an emergency room facility will be triaged by the emergency room staff if a person reasonably believed that an emergency condition existed. However, if such a request for authorization of emergency care is received, it is processed immediately, and responses to such requests are made no later than four (4) hours from their receipt, or by the end of the business day, (4:30p.m. PST), whichever is sooner. If members access a non-contracted Emergency Room and based on medical evaluation the member is admitted for stabilization of an emergent medical condition, the facility shall notify the Plan or Health Network of the admission within twenty-four (24) hours. Upon notification, clinical review will occur to determine whether the member has progressed to the post stabilization phase. If clinically appropriate, a safe transfer to a contracted facility will be initiated. Transfer will be executed following coordination between concurrent review, facility case manager and with concurrence of attending and accepting provider.
   b. Urgent requests received during regular work hours are processed as soon as possible and not more than 72 hours/three (3) calendar days from the plan's receipt of request.
   c. Requests for emergency and urgent services are presented to the regular UR reviewer for that day, or the Medical Director or designee of the Plan, in order to comply with the above standards of response time.
   d. Requests for emergency and urgent services (pre-service and concurrent), made after regular work/business hours, and on weekends and holidays, are referred to the Medical Director or Acting Medical Director or Administrator of the Day ("AOD"), one of whom is on call, at all times, and available to respond to such emergency/urgent requests.

7. Approving alternative services. If the Plan approves an alternative to the service being requested and the member or the member's member's authorized representative/practitioner does not

request or agree to the alternate service, the Plan denies care that was originally requested, therefore, this is considered a denial. However, if the member or the member's authorized representative/practitioner agrees to the alternative and the care is authorized, the member or the member's authorized representative/practitioner has essentially withdrawn the initial request; therefore, this is NOT considered a denial. The Plan's UM documents the agreement of member or practitioner in the case notes.

8. Information sources used to determine benefit coverage and medical necessity. The request is checked for complete information such as:
    a. Member Name
    b. Member's Benefit Plan.
    c. Other Insurance
    d. Member ID #
    e. Requesting Provider
    f. Referral Provider
    g. Services that are required as a result of an accident are specified as such and the location of the accident is noted such as work, home, auto, other
    h. Diagnosis (ICD-10 Code), Procedure (CPT Code)
    i. Clinical History/Findings which justify the requested procedure
    j. Attempted treatment, other consults
    k. Hospital records, if indicated
    l. Diagnostic testing if indicated or applicable
    m. Operative and pathological reports when applicable
    n. Medications
    o. Requested care, procedure, or test (CPT and/or HCPCS code)
    p. Description of service (inpatient, outpatient, office)

q. Estimated length of stay (for inpatient requests)

9. If information is incomplete, the request is held, and the necessary data is obtained from the treating physician. If a request is routine, the provider is informed by fax of the need for additional data. If a request is urgent or emergent, the UR nurse informs the provider by fax and/or by telephone, of the need for such information.

10. Information sources used to determine benefit coverage and medical necessity. Documentation supporting medical necessity is gathered from appropriate sources, including but not limited to patient medical records, both submitted information and additional information available in the electronic health record, conversations with appropriate physicians and office staff, pharmacy, and claims data as well as previous UM decisions. Documentation of information collected is thorough but not overly burdensome for any of the parties.
    a. The Plan fully documents all requests for authorizations and responses to such requests for post stabilization medically necessary care in the Plan's Medical Management System.
    b. The Plan's documentation includes:
        - Date and Time of the Provider's Request
        - Name of the healthcare provider making the request
        - Name of the Plan representative responding to the request
    c. All actions and decisions are documented in the Medical Management system.

11. Non-coded or miscoded services are corrected by or in conjunction with the requesting entity.

12. The request is submitted to the licensed personnel responsible for completing the authorization process.

13. The licensed personnel check the information and coding for accuracy. Any necessary corrections are made by or in conjunction with the requesting entity.

14. Plan practice guidelines, Plan policies and procedures, and other accepted criteria are applied by qualified personnel in making authorization determinations. This process includes the application of the guidelines and criteria based on the needs of individual patients and characteristics of the local delivery system. See Medical Policy Development and Application of Medical Criteria document for details.

15. Benefit coverage is determined through Evidence of Coverage (EOC) information and eligibility verification.

16. Appropriateness of care and service issues are directed to qualified health professionals who are involved in the utilization management decision-making process.

17. Complex cases are referred to the Medical Director. Board-certified physicians from appropriate specialty areas also assist in making determinations of medical appropriateness.

18. Case management and concurrent review cases are submitted to the appropriate staff for follow-up.

19. Only licensed physicians make determinations for the denial of requests based on medical appropriateness and/or necessity.

20. Approved requests include an authorization number for the specific services authorized.

21. All authorization requests are followed by notification of the determination to the providers and members.

22. UM staff involved in utilization-related decisions are aware of the need for special concern about the risks of under-utilization. Issues of potential under-and over-utilization are submitted to the Utilization Management Committee for follow-up. The Utilization Management Committee may refer the situation(s) to the Quality Assurance Committee as appropriate.

23. All necessary emergency services are arranged for or facilitated, including appropriate authorization related to the coverage of costs, and according to the following:
    a. Emergency services, which are necessary to screen and stabilize members, do not require prior authorization in cases where a person reasonably believed that an emergency medical condition existed.
    b. Emergency services are covered if an authorized representative of the Plan, such as an employee or contractor, including but not limited to, an advice nurse, a customer service representative, a network physician or a VCHCP Medical Director, authorized the provision of emergency services.
    c. For the purpose of retrospective claim review, reimbursement for emergency care may be denied only if, upon retrospective medical review by a Plan UR Physician and/or Plan Medical Director, it is determined that the emergency services and care were never performed, or the screening examination revealed that the member did not require emergency care beyond the Basic Screening Exam and stabilization. Post service denials take into consideration the presenting symptoms as well as discharge diagnoses. Emergency room claims may be denied based on lack of information from the member or practitioner. The member and practitioner are sent a written request for the information required and is afforded at least 45 calendar days to provide the requested information. Emergency room care is also not covered for services related to jail or other custody clearance or for drug testing. However, the plan will always hold the member harmless and not financially liable and will always reimburse the facility/provider for a Basic Screening Examination.

d. The approval of emergency services is tracked by the Plan, to assure that the above standards are achieved. Any "Emergency Service" which is denied after being provided is reviewed by a UM Physician or the Medical Director of the Plan. Regular reports of such reviews and of the actions taken afterwards are provided to the UM Committee of the Plan.

Timeline Standards/ Extending Time Frames & Pended Requests/Notifications:

VCHCP will honor all regulatory and any contracted accreditation agency standards for the amount of time allowed to process referral/authorization requests. VCHCP makes utilization decisions in a timely manner and accommodates the urgency of individual situations (refer to Utilization Management Timelines Standards below, for details). Examples of such timeliness include:

Prospective or pre-service request/review: A request for coverage of medical care or services that the Plan must approve in advance, in whole or in part. Decisions are made by the Plan prior to the time that the Plan member is hospitalized and/or receiving specific care which must be authorized.

1. The Plan does not require prior authorization for emergency services.

2. Urgent preservice decisions (all necessary clinical information received at time of request) The Plan gives electronic and/or written notification of the decision to members and practitioners within 72 hours/three (3) calendar days of requests.
    a. A decision is made within 72 hours/three (3) calendar days of the Plan's receipt of request.
    b. The practitioner may be notified verbally and/or electronically or in writing of the decision within 72 hours/three (3) calendar days of the Plan's receipt of request. Verbal notification does not replace electronic or written notifications of denial decisions, but when provided, the Plan may extend the time frame for electronic or written notification. The Plan has an additional 3 calendar days following verbal notification to provide electronic or written notification.
        - Verbal notification requires communication with a live person, the Plan may not leave a voicemail, ***and***
        - The Plan records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
        - The Plan provides verbal notification within the time frames specified for an urgent preservice request.
    c. The member is notified in writing within 72 hours/three (3) calendar days of the Plan's receipt of request.

3. Urgent preservice requests extension (additional clinical information required). The Plan may extend the urgent preservice time frame once due to lack of information, for 48 hours/two (2) calendar days, under the following conditions:
    - Within 24 hours of receipt of the urgent preservice request, the Plan asks the member or the member's representative/practitioner for the information necessary to make a decision, ***and***
    - The Plan gives the member or the member's authorized representative/practitioner at least 48 hours to provide the information, ***and***
    - The extension period, within the decision must be made by the Plan, begins on the sooner of:
        - The date when the organization receives the member's response/practitioner's response (even if not all the information is provided), or
        - The last date of the time period given to the member/practitioner to provide the information, even if no response is received from the member or member's authorized representative/practitioner.

    a. Both member and practitioner are notified via pend /extend letter within 24 hours/one (1) calendar day of receipt of request, that additional specific information is needed and provided 48 hours/two (2) calendar days from the date of the pend letter to provide/submit the requested information.
        i. If additional information is received within 48 hours/two (2) calendar days, complete or not (from the date of the pend letter), a decision must be made within 48 hours/two (2) calendar days of receipt of the additional information.
            - The practitioner may be notified orally and/or electronically or in writing of the decision within 48 hours/two calendar days of the Plan's receipt of additional information.
            - The member is notified in writing within 48 hours/two (2) days of the Plan's receipt of additional information.
        ii. If no additional information is received within 48 hours/two (2) calendar days from the last date of the 48 hours/2 calendar days (date of the pend letter), a decision must be made with available information, within 48 hours/two (2) calendar days from the last date of the 48 hours/two (2) calendar days (date of pend letter) given to the member or practitioner to provide the information.
            - The practitioner may be notified orally and/or electronically or in writing of the decision within 48 hours/two (2) calendar days from the last date of the 48 hours/two (2) calendar days (date of pend letter) given to the member or practitioner to provide the information.
            - The member is notified in writing within 48 hours/two (2) calendar days from the last date of the 48 hours/two (2) calendar days (date of pend letter) given to the member or practitioner to provide the information.

Notifying the practitioner: If information on the attending or treating practitioner was not provided with the request, the Plan attempts to identify the practitioner. The organization

documents its efforts to identify the practitioner. If the practitioner is not known, the Plan addresses the notification to the attention of the attending or treating practitioner; the practitioner's name is not required.

Failure to follow filing procedures. If the member or practitioner does not follow the Plan's reasonable filing procedures for requesting urgent preservice/concurrent and nonurgent preservice coverage, the Plan notifies the member or practitioner of the failure and informs them of the proper procedures to follow when requesting coverage:

- For urgent preservice, the organization notifies the member or practitioner within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.

The Plan does not deny an urgent concurrent request that requires medical necessity review for failure following filing procedures.

4. Preservice non-urgent referral for which all information necessary to make a decision is received:
    a. A decision is made within five (5) business days of the Plan's receipt of request.
    b. The practitioner may be notified orally and/or electronically or in writing within 24 hours of the decision.
    c. The member is notified in writing within two (2) business days of the decision.

5. Non-urgent preservice requests/referral for which additional information is required (extension needed).
    a. Member and practitioner are notified within 5 business days of the receipt of the request.
    b. A minimum of 45 calendar days is provided for submission of the requested additional information.
    c. If additional information is received, complete or not, a decision must be made within five (5) business days of receipt of the additional information.
        i. The practitioner may be notified orally and/or electronically or in writing of the determination within 24 hours of the decision.
        ii. The member is notified of the determination in writing within 2 business days of making the decision.
    d. If additional information is NOT received within 45 calendar days given to the practitioner and member to supply the information, a decision must be made with the available information, within additional five (5) business days.
        i. The practitioner may be notified orally and/or electronically or in writing of the determination within 24 hours of the decision.
        ii. The member is notified of the determination in writing within 2 business days of making the decision.

6. Non-urgent preservice requests/referral that requires consultation/evaluation by a specialist/expert review (Extension for Other Reasons).

a. Member and practitioner are notified within 5 business days of the receipt of the request. The Plan notifies the practitioner and member of the type of expert reviewer required, the need for an extension and the expected date on which a decision will be rendered which is 15 calendar days from the date of the delay (pend) notice/letter.
b. After the expert review is obtained, decision must be made within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay (pend) notice/letter to practitioner or member.

Notifying the practitioner: If information on the attending or treating practitioner was not provided with the request, the Plan attempts to identify the practitioner. The organization documents its efforts to identify the practitioner. If the practitioner is not known, the Plan addresses the notification to the attention of the attending or treating practitioner; the practitioner's name is not required.

Failure to follow filing procedures. If the member or practitioner does not follow the Plan's reasonable filing procedures for requesting urgent preservice/concurrent and nonurgent preservice coverage, the Plan notifies the member or practitioner of the failure and informs them of the proper procedures to follow when requesting coverage:

- For nonurgent preservice, the organization notifies the member or practitioner within 5 calendar days of receiving the request. Notification may be verbal unless the member or practitioner requests written notification.

The Plan does not deny an urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

Concurrent review request: A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the Plan did not previously approve the earlier care. (Hospitalized member and/or receiving ongoing/ambulatory services).

The following shall apply regarding such decisions:

1. Urgent Concurrent review requests involve an initial request for urgent care. The Plan gives electronic or written notification of the decision to members and practitioners within 24 hours/one (1) calendar day of the request.
    a. A decision must be made within 24 hours/one (1) calendar day of the Plan's receipt of the request, inclusive of weekends and holidays.
        i. The practitioner may be notified orally and/or electronically or in writing within 24 hours/one (1) calendar day of the request. Verbal notification does not replace electronic or written notifications of denial decisions, but when provided, the Plan may extend the time frame for electronic or written notification. The Plan has an additional 3 calendar days following verbal notification to provide electronic or written notification.

- Verbal notification requires communication with a live person, the Plan may not leave a voicemail, ***and***
- The Plan records the time and date of the notification and the staff member who spoke with the practitioner or member, ***and***
- The Plan provides verbal notification within the time frames specified for an urgent concurrent request.

ii. The member is notified within 24 hours/one (1) calendar day of the request.

b. A request that meets the definition of urgent will be processed as such, even if the earlier care was not previously authorized by the Plan.

Notifying the practitioner. If information on the attending or treating practitioner was not provided with the request, the organization attempts to identify the practitioner. The organization documents its efforts to identify the practitioner. For urgent concurrent review decisions, the organization may inform the hospital Utilization Review (UR) department staff without attempting to identify the treating practitioner, with the understanding that staff will inform the attending/treating practitioner.

Failure to follow filing procedures. If the member or practitioner does not follow the Plan's reasonable filing procedures for requesting urgent preservice/concurrent and nonurgent preservice coverage, the Plan notifies the member or practitioner of the failure and informs them of the proper procedures to follow when requesting coverage:

- For urgent concurrent, the organization notifies the member or practitioner within 24 hours of receiving the request. Notification may be verbal unless the member or practitioner requests written notification.

The Plan does not deny an urgent concurrent request that requires medical necessity review for failure to follow filing procedures.

2. Urgent concurrent extension (not previously approved). The Plan may extend the decision notification time frame if the request to approve additional days for urgent concurrent care is related to care not previously approved by the Plan, and the Plan documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days.
    a. A decision must be made within 72 hours/three (3) calendar days from the date of request.
        i. The practitioner may be notified orally and/or electronically or in writing within 72 hours/three (3) calendar days from the time the request was received.
        ii. The member is notified within 72 hours/three (3) calendar days from the time the request was received.

3. Urgent concurrent extension (previously approved). The Plan may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24

hours prior to the expiration of the previously approved time period or number of treatments. The organization may treat the request as urgent preservice and send a decision notification within 72 hours/three (3) calendar days (Plan member is hospitalized or receiving ongoing/ambulatory services).

a. A decision must be made within 72 hours/three (3) calendar days.
    i. The practitioner may be notified orally and/or electronically or in writing within 72 hours/three (3) calendar days from the time the request to extend was received.
    ii. The member is notified within 72 hours/three (3) calendar days from the time the request to extend was received.

For ongoing review of urgent concurrent care, if approved initially, the notification period begins on the day of the review. The Plan documents the date of the ongoing review and the decision notification in the UM denial file.

Retrospective or post service review request: A request for coverage of medical care or services that have been received (e.g., retrospective review). Decisions are those which are made by the Plan after the Plan member is hospitalized and/or receiving specific care which must be authorized.

1. A decision regarding Medical Necessity is made within 30 calendar days of receipt of request.

2. The practitioner and member are notified in writing within 30 calendar days of receipt of request.

3. If the request lacks clinical information the Plan may extend the post service time frame for up to 15 calendar days, under the following conditions:
    a. The Plan notifies/asks the member and practitioner within 30 calendar days of receipt of request for the information necessary to make the decision and
    b. The Plan gives the member and practitioner at least 45 calendar days to provide the information.
    c. The extension period (15 calendar days), within which a decision must be made by the organization, begins on the sooner of:
        i. The date when the organization receives the member's/practitioner's response (even if not all the information is provided). Decision must be made within 15 calendar days of receipt of additional information or
        ii. The last date of the time period is given to the member to supply the information, even if no response is received from the member or practitioner. If no additional information is received within 45 calendar days given to member and practitioner to supply the information, decision must be made within additional 15 calendar days.

Notifying the practitioner: If information on the attending or treating practitioner was not provided with the request, the Plan attempts to identify the practitioner. The organization documents its efforts to identify the practitioner. If the practitioner is not known, the Plan addresses the notification to the attention of the attending or treating practitioner; the practitioner's name is not required.

Post service payment disputes: Post service requests for payment initiated by a practitioner or a facility are not subject to NCQA review if the practitioner or facility has no recourse against the member for payment (i.e., the member is not a financial risk).

4. Post service requests/referral that requires consultation/evaluation by a specialist/expert review (Extension for Other Reasons).
    a. Member and practitioner are notified within 30 calendar days of the receipt of the request. The Plan notifies the practitioner and member of type of expert reviewer required, the need for an extension and the expected date on which a decision will be rendered which is 15 calendar days from the date of the delay (pend) notice/letter.
    b. After the expert review is obtained, decision must be made within 15 calendar days of obtaining expert review, not to exceed 15 calendar days from the date of the delay (pend) notice/letter to practitioner or member.
    c. Member and practitioner are notified of decision within 15 calendar days of obtaining expert review, not to exceed 15 calendar days from the date of the delay (pend) notice/letter to practitioner or member.

For discussion of the review of Appeals and Expedited Appeals, please refer to the Utilization Management Policy for Appeals document.

Authorization Period

The period of time that authorizations are valid is determined by the UM department and approved by the UM Committee, in conformance with any contracted accreditation agency requirements. This time period varies depending upon the type of request and UM template used

in creating the record in the medical management/documentation system known as QNXT. This time frame could vary from 1 calendar day to 180 calendar days from the date of approval. Even when a service is pre-approved, providers are cautioned and encouraged to always check the member's eligibility before providing the particular service.

Extending Time Frames/Pended Requests (General Information):

Referral/authorization requests may be placed in a pended status until necessary additional clinical information or benefit clarification is obtained for the Medical Director or physician designee to make an appropriate determination.

Documentation of pended requests shall include the following:

- Specific reason for pending the request and specific clinical information needed to make a determination.
- Efforts taken to obtain the necessary information.
- Judgment and name of the medically trained person making the decision.

Extension by members or Practitioners:

Members may voluntarily agree to extend the decision-making timeframe for urgent concurrent care. Members may also voluntarily agree to extend the time frame for urgent and non-urgent pre-service and post service decisions for reasons other than lack of necessary information or matters beyond the Plan's control. They may also voluntarily agree to additional extensions of urgent and non-urgent preservice or post service decisions beyond the previously mentioned extensions. Extensions by members can be accomplished by calling or writing the Utilization Review Department and the received information will be documented in QNXT.

Notifications (General Information)

1. Notification of the determination for all authorization requests are sent to the practitioners and members according to the required time frames.

2. Denial notifications for Urgent Care requests are sent to practitioners and members.

3. Denial notifications for concurrent or post service requests are sent to the practitioners and members.

4. Notifications to practitioners may be oral and/or electronic or written.

5. Notifications to members are to be written.

6. The determination notification identifies the physician or staff reviewer and the process available to the treating physician(s) to discuss by telephone those denials that are based on medical appropriateness. Physician peer to peer is completed within 1-2 business days. Plan physician

reviewers document the peer-to-peer discussion in the medical management clinical notes section. The timeliness of peer-to-peer completion will be reported in the Utilization Management Committee.

7. Written communication to a Physician or other health care provider of a denial, delay, or modification of a request includes the direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them.

8. Modifications or Denials for requested services include a clear statement on the notification letter, in easy-to-understand language, explaining the reason for the action, how the reason for the denial pertains to the member's particular case and suggestions for alternative treatment plans (when appropriate). The information also includes the specific utilization review criteria, guideline or protocol or the benefit provision used in making the determination and the procedure for how to obtain the full criteria, guideline, and protocol or benefit provision if desired. The Plan will provide copies of clinical review criteria/guidelines at no cost if desired.

9. Notification of a denied request, for all types of authorization requests which include non-urgent pre-service, urgent pre-service, urgent concurrent review and post service, includes information about initiating an expedited appeal, if appropriate. See expedited appeal process in the UM policy for Appeals document for details.

10. Notification letter of a denied or modified request includes the information on the member's right to participate in the appeal and grievance process of the Plan, including a description of the Plan's appeal and grievance process, Plan's address, and telephone numbers. Through the UM denial/modification notification letter, the member is provided the Department of Managed Healthcare's telephone number, the Department's TDD line, and the Department's internet address. The UM denial/modification notification letter includes the Independent Medical Review (IMR) information obtained through the Department of Managed Health Care (DMHC) which includes the department's toll-free telephone number and the department's internet web site to access complaint forms, IMR application forms and instructions online. The letter provides information regarding the right of a member to request an Independent Medical Review (IMR) in cases where the member believes that health care services have been improperly denied, modified, or delayed.

11. When the Plan denies services deemed experimental and the member is identified as having a terminal illness, notification of the denial includes information regarding the process for requesting a conference as a part of the appeal procedure.

12. The Plan's denial and modified letters includes information regarding the members' right to participate in the grievance process of the Plan, the Plan's telephone number, the Department's telephone number, the Department's TDD Line, and the Department's Internet address.

VCHCP UM Denial/Modification/Delay File Audit Process

The VCHCP Quality Assurance team conducts quarterly audits of denial files to assess the Plan's Utilization Management (including Pharmacy) denial, delay, and modification communications and identify areas of non-compliance with the requirements of Section 1367.01(h)(4). The denial file audit aims to provide recommendations for improving the Plan's denial, delay, and modification communications to ensure compliance with DMHC regulations and enhance the clarity and transparency of the decision-making process for members and providers.

VCHCP uses the 5% or 30 (whichever is less) case file review methodology to determine the number of files with denials and modifications to be audited. VCHCP's Health Information Analyst pulls a count of all denial and modified decision files every quarter to calculate the total number of files to be audited using the 5% or 30 (whichever is less) case file review methodology. The file pulled is forwarded to the QA team for audit. The specific files to be audited are selected randomly from the denial file universe.

The audit includes assessing the following criteria:

1. The decision was made by the appropriate licensed personnel (physician reviewers);
2. The decision was made in a timely manner.
3. the denial decision was relayed to the requesting provider and member in a timely manner
4. The clinical reason was written in clear and concise language
5. The clinical reason specifies the criteria for the denial
6. The clinical reason includes the medical policy or guideline that was utilized to make the determination.

The Plan's onsite Medical Director and the Director of Health Services have an oversight of the audit process and ensure the appropriate audit tools and measures are in place. VCHCP utilizes the DMHC file audit tool for the audit process. The Director of Health Services provided the on-boarding training for the Quality Assurance team on the audit process including the audit tool, sources of information in the medical management system, quantitative and qualitative analysis.
Under the direction of the Plan's onsite Medical Director, Director of Health Services, and the Utilization Management Manager, the QA nurse can formulate free text revisions of the denial/modified approved language to ensure that they are clear, easily understood, and remain identical to the clinical language formulated by the physician reviewer prior to the revision. This process was implemented on March 17, 2023, in compliance with Section 1367.01(h)(4), which specifically mandates the inclusion of clear and

concise explanations of the reasons for the Plan's decision and the clinical reasons regarding medical necessity, as well as the appropriate use of medical terminology in layman's terms. The physician reviewer will be notified of the revision and requested to confirm approval of the revision.

Quality Assurance nurse on-board training includes checking the denial and modified decision clinical rationales for readability using the Flesch-Kincaid Grade Level Scoring, ensuring the physician reviewers are following the clinical rationale templates, and ensuring medical terminology have equivalent layman's language. The Director of Health Services and the Utilization Management Manager oversee the clinical rationale revisions on a daily basis and provide spot feedback and education when needed. Utilization management nurses receive feedback from their UM Manager regarding the use of the clinical rationale template and the layman's terminology on a daily basis, as needed during denial /modification review completions. General reminder/education on appropriate, clear, concise clinical rational is included in the staff meeting.

Physician reviewers are educated monthly on the audit results and clinical rationale statement requirements including member-friendly, concise, and easily understood denial/modified reasons, and defined uncommon medical terms. A library of medical to layman terms and clinical rationale statement samples is made available to all physician and nurse reviewers. An up-to-date clinical rationale bank remains available for all physician reviewers to use. This is accessible via Plan's Medical Management System (QNXT) external links. The Medical Director will provide education to the physician reviewer if a trend concerning the decision making is found. Feedback and education are continuously provided to physicians and findings are discussed in the Plan's UM

Committee Meeting wherein five (5) of the physicians (including the Medical Director are active and voting members.

Utilization Management Timeline Standards

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic / Written)**	**Member Notification of All Decisions (Written Only)**
Urgent Pre-Service All necessary information received at time of initial request	*All necessary clinical information received at time of initial request* Decision must be made within 72hours/3 calendar days of receipt of request.	Practitioner: Within 24 hours of the decision, not to exceed 72 hours/3 calendar days of receipt of request. Document date and time of oral notifications. If oral/verbal notification given, has an additional 2 calendar days from verbal notice to provide electronic or written notification.	Member: Within 72 hours/3 calendar days of receipt of request.

Urgent Pre-Service Extension Needed Additional clinical information required: may extend urgent preservice time frame **once** due to lack of information.	*Additional clinical information required* On the day of receipt of request, ask the member and practitioner for information needed via pend/extend letter and provide 48 hours/2 calendar days to submit requested information from the date of the pend letter.		
	Additional information received or incomplete: If additional information is received, complete or not, within 48 hours/2 calendar days (from the date of pend/extend letter), decision must be made within 48 hours/2 calendar days of receipt of additional information.	*Additional information received or incomplete* Practitioner: Within 24 hours/1 calendar day of decision not to exceed 48 hours of receipt of additional information. Document date and time of oral notifications. If oral/verbal notification given, has an additional 2 calendar days from verbal notice to provide electronic or written notification.	*Additional information received or incomplete* Member: Within 48 hours/2 calendar days of receipt of additional information.
	Additional information not received: If no additional information is received within the 48 hours/2 calendar days (from the date of the pend/extend letter), a decision must be made with available information, on the 3rd calendar day of receipt of request.	*Additional information not received* Practitioner: On the 3rd calendar day of receipt of request. Document date and time of oral notifications. If oral/verbal notification given, has an additional 2 calendar days from verbal notice to provide electronic or written notification.	*Additional information not received* Member: On the 3rd calendar day of receipt of request.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic / Written)**	**Member Notification of All Decisions (Written Only)**
Urgent Concurrent - Initial request (i.e., inpatient, ongoing/ambulatory services such as home health, PT, OT, SNF etc.)	Within 24 hours/1 calendar day of receipt of request, inclusive of weekends and holidays.	Practitioner: Within 24 hours/1 calendar day of receipt of request. Document date and time of oral notifications. If oral/verbal notification given, has an additional 3 calendar days from verbal notice to provide electronic or written notification.	Member: Within 24 hours/1 calendar day of receipt of request.
Urgent concurrent – Extension request (*not previously approved)* - (i.e., extension of inpatient, extension of ongoing/ambulatory services such as home health, PT, OT SNF etc.) Plan may extend the decision notification time frame if the request to approve additional days for urgent concurrent is related to care not previously approved by the Plan, and the Plan documents that it made at least one attempt and was unable to obtain the needed clinical information within 24 hours after the request for coverage of additional days/visits.	Within 72 hours/3 calendar days of receipt of request to extend.	Practitioner: Within 24 hours/1 calendar day of decision, not to exceed 72 hours/3 calendar days from the time the request was received. Document date and time of oral notifications. If oral/verbal notification given, has an additional 3 calendar days from verbal notice to provide electronic or written notification.	Member: Within 72 hours/3 calendar days from the time the request was received.
Urgent concurrent – Extension request (*previously approved)* - (i.e., extension of inpatient, extension of ongoing/ambulatory services such as home health, PT, OT SNF etc.) Plan may extend the decision notification time frame if the request to extend urgent concurrent care was made less than 24 hours prior to the expiration of the previously approved time period or number of treatments. The Plan may treat the request as urgent preservice.	Within 72 hours/3 calendar days of receipt of request to extend.	Practitioner: Within 24 hour/1 calendar day of decision, not to exceed 72 hours/3 calendar days from the time the request was received. Document date and time of oral notifications. If oral/verbal notification given, has an additional 3 calendar days from verbal notice to provide electronic or written notification.	Member: Within 72 hours/3 calendar days from the time the request was received.

	Notification Timeframe

Type of Request	Decision Timeframes & Delay Notice Requirements	Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic / Written)	Member Notification of All Decisions (Written Only)
Standing Referrals to Specialists / Specialty Care Centers All information necessary to make a determination is received	**All information necessary to make a determination is received** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. **NOTE:** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes. Document date and time of oral notifications for urgent requests.	Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.
Standing Referrals to Specialists / Specialty Care Centers Additional clinical information required	**Additional clinical information required:** Notify member and practitioner within 3 business days of receipt of request & provide at least 5 business days for submission of requested information. *Additional information received or incomplete:* If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 3 business days of receipt of information. *Additional information not received* If no additional information is received within the 5 business days given to the practitioner and member to supply the information, decision must be made with the information that is available by the end of that 5th business day.	Practitioner: Within 24 hours of the decision. Document date and time of oral notifications for urgent requests.	Member: Within 2 business days of the decision.
Require consultation/evaluation by a Specialist/ Expert Review	**Require consultation by an Expert Reviewer:** Within 3 business days of receipt of request or as soon as you become aware that you will not meet the 3-business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered which is 15 calendar days from the date of the delay (pend) notice/letter.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 3 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay (pend) notice to the practitioner and member.	*Require consultation by an Expert Reviewer:* Practitioner: Within 24 hours of the decision not to exceed 15 calendar days from the date of delay notice/pend letter to practitioner and member.	*Require consultation by an Expert Reviewer:* Member: Within 2 business days of the decision, not to exceed 15 calendar days from the date of delay notice/pend letter to practitioner and member.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic / Written)**	**Member Notification of All Decisions (Written Only)**

Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	Practitioner: Within 24 hours of the decision.	Member: Within 2 business days of the decision.
Non-urgent Pre-Service - Extension Needed Additional clinical information required	**Additional clinical information required:** Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of additional information.	Practitioner: Within 24 hours of the decision.	Member: Within 2 business days of the decision
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.	Practitioner: Within 24 hours of the decision.	Member: Within 2 business days of the decision.
Require consultation/evaluation by a Specialist/ Expert Review	**Require consultation by an Expert Reviewer:** Within 5 business days or as soon as you become aware that you will not meet the 5-business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered which is 15 calendar days from the date of the delay (pend) notice/letter.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay (pend) notice to the practitioner and member.	*Require consultation by an Expert Reviewer:* Practitioner: Within 24 hours of the decision not to exceed 15 calendar days from the date of delay notice/pend letter to practitioner and member.	*Require consultation by an Expert Reviewer:* Member: Within 2 business days of the decision not to exceed 15 calendar days from the date of delay notice/pend letter to practitioner and member.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic / Written)**	**Member Notification of All Decisions (Written Only)**

Retrospective or Post Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request.	Member: Within 30 calendar days of receipt of request.
	Additional clinical information required: Notify member and practitioner via pend letter within 30 calendar days of receipt of request & provide 45 calendar days for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition within 15 calendar days of receipt of additional information.	Practitioner: Within 15 calendar days of receipt of information not to exceed 45 calendar days from receipt of request.	Member: Within 15 calendar days of receipt of information not to exceed 45 calendar days from receipt of request.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition within an additional 15 calendar days, not to exceed 60 calendar days from receipt of request.	Practitioner: Within an additional 15 calendar days of the delay (pend) notice/letter not to exceed 60 calendar days from the receipt of request.	Member: Within an additional 15 calendar days of the delay (pend) notice/letter not to exceed 60 calendar days from the receipt of request.
Require consultation/evaluation by a Specialist/ Expert Review	**Require consultation by an Expert Reviewer:** Notify member and practitioner within 30 calendar days of receipt of request or as soon as you become aware that you will not meet the 30-calendar day timeframe, whichever occurs first, of the type of expert reviewer required and the anticipated date on which a decision will be rendered which is 15 calendar days from the date of the delay (pend) notice/letter.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 15 calendar days of obtaining expert review, not to exceed 15 calendar days from the date of the delay (pend) notice to the practitioner and member.	*Require consultation by an Expert Reviewer:* Practitioner: Within 15 calendar days of obtaining expert review, not to exceed 15 calendar days from the date of the delay (pend) notice/letter to practitioner and member.	*Require consultation by an Expert Reviewer:* Member: Within 15 calendar days of obtaining expert review, not to exceed 15 calendar days from the date of the delay (pend) notice/letter to practitioner and member.

		Notifica	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic**	**Member Notification of All Decisions (Written Only)**

Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity) 2. Non-Urgent (e.g., post-service pend	*LAP Services Not Delegated:* All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request 2. Request forwarded within two (2) business days of member's request		*LAP Services Delegated/Health Plan:* All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.

Supporting Documents: Health Services Job Aid: Electronic Referrals via Cerner; See Drug Policy: Pain Management for Terminally Ill Patients; See Drug Policy: Prior Authorization of Medications; TAR Timeframe Workflow Grid

A. References: None

B. History:

Reviewers: UM Committee; Medical Director; QA Manager; Health Services Director
Reviewed/Revised: Lita Catapang, RN & Albert Reeves, MD
Committee Review: UM: August 2009; QAC: August 2009 Reviewed/No
Reviewed/Updated: Faustine Dela Cruz, RN & Albert Reeves, MD
Committee Review: UM: August 11, 2011; QAC: August 23, 2011
Reviewed/No Changes by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD
Committee Review: UM: February 9, 2012; QAC: February 28, 2012
Reviewed/No Updates by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD
Committee Review: UM: February 14, 2013; QAC: February 26, 2013
Reviewed/Updated by: Ramona Truwe, RN; Faustine Dela Cruz, RN; Catherine Sanders, MD
Committee Review: UM: August 8, 2013; QAC: August 27, 2013
Reviewed/No Changes by: Faustine Dela Cruz; Catherine Sanders, MD
Committee Review: UM: February 13, 2014; QAC: February 25, 2014
Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD
Committee Review: UM: November 13, 2014; QAC: November 25, 2014
Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD
Committee Review: UM: February 12, 2015; QAC: February 24, 2015
Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD
Committee Review: UM: August 13, 2015; QAC: August 25, 2015
Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD
Committee Review: UM: February 11, 2016; QAC: February 23, 2016
Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: May 12, 2016; QAC: May 24, 2016
Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: February 9, 2017; QAC: February 28, 2017
Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: November 9, 2017; QAC: November 28, 2017
Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: February 8, 2018; QAC: February 27, 2018
Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: November 8, 2018; QAC: November 27, 2018
Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD
Committee Review: UM: February 14, 2019; QAC: February 26, 2019

Reviewed/No Updates by: Faustine Dela Cruz; Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 13, 2020; QAC: February 25, 2020
Reviewed/Updated by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 11, 2021; QAC: February 23, 2021
Reviewed/Updated by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 17, 2022; QAC: February 22, 2022
Reviewed/Updated by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 2, 2023; QAC: February 7, 2023
Reviewed/Updated by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 8, 2024; QAC: February 27, 2024
Reviewed/Updated by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: August 8, 2024; QAC: August 27, 2024
Reviewed/Updated by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: November 14, 2024; QAC: November 26, 2024
Reviewed/Updated by: Faustine Dela Cruz, RN, Howard Taekman, MD & Robert Sterling, MD
Committee Review: UM: February 20, 2025; QAC: February 25, 2025

Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/9/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review; updated timeframes to remove NCQA timelines and replace with DMHC timelines
9/29/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Updated to remove language that member is provided an information packet that includes the IMR application instructions, application form and an envelope addressed to the Department of Managed Health Care (DMHC) in Sacramento. DMHC provided clarification that the Plan does not need to include the IMR application and addressed envelope on initial UM denials.
11/29/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Changed “prudent layperson” to “reasonable person” language as required by DMHC.
9/12/18	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Written communication to a Physician or other health care provider of a denial, delay, or modification of a request includes the direct telephone number or an extension of the healthcare professional responsible for

			the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them. Physician peer to peer is completed within 1-2 business days. Plan physician reviewers document the peer-to-peer discussion in the medical management clinical notes section. Timeliness of peer-to-peer completion will be reported in the Utilization Management Committee.
2/14/19	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	DMHC requirements: For medication requests, please refer to Drug Policy: Pain Management for Terminally Ill Patients; See Drug Policy: Prior Authorization of Medications Added MED EXIGENT to TAR Timeframe Workflow Grid
2/13/20	No	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN	Annual review
2/11/21	Yes	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN Meriza Ducay, RN	Updated with DMHC requirements on documentation.
2/17/22	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN	Updated to comply with DMHC requirements: The Plan will provide copies of clinical review criteria/guidelines at no cost if desired. Updated with DMHC's definition of Reasonable Person
8/11/22	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN Meriza Ducay, RN	Updated with DMHC's language regarding Emergency services where a person reasonably believed that an emergency medical condition existed.
2/2/23	No	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN	Annual review
2/8/24	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN; Meriza Ducay, RN	Updated to meet NCQA requirements

6/7/2024	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN	Updated UM Timelines Chart with NCQA requirements.
6/18/2024	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN	Updated to demonstrate compliance with the requirements of SB 496 per DMHC's requirement.
8/8/2024	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN; Gia Zabala, RN	Updated to add UM Denial/Modification/Delay File Audit Process per DMHC requirement.
10/2/2024	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN; Gia Zabala, RN	Updated to comply with SB496 with clarification regarding using the prior authorization process (specified under procedure section of the Treatment Authorization Request Auth Process and Timeline Standards UM policy) will apply. Prior authorization timeline standards such as urgent and non-urgent timeframes, timeframe extensions, pend, and notifications, stated in this UM policy, will apply for biomarker testing requested for non-cancer diagnosis.
10/31/2024	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN; Gia Zabala, RN	Updated to elaborate on the process for the various methods of receiving the treatment authorization requests such as via fax, mail, electronic health records, provider portal, phone calls and verbal receipt of requests.
11/21/24	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN; Gia Zabala, RN	Updated to provide clarification on the Biomarker testing language for medical conditions requiring prior authorization per DMHC requirement.
12/23/24	Yes	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN; Gia Zabala, RN	Updated with the UM requirements of AB 2105 Coverage for Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)
1/2/25	No	Howard Taekman, MD; Faustine Dela Cruz, RN; Gia Zabala, RN	Highlighted language - Prior authorization is required for biomarker testing unless it meets Section 1367.665(b) (i.e. biomarker testing for an enrollee with advanced or metastatic

			stage 3 or 4, or for cancer progression or recurrence in the enrollee with advanced or metastatic stage 3 or 4 cancer) in response to DMHC comment letter/ table received 12/30/24; Comment # 6 under H.SB 496 – Exhibit J-9: Treatment Authorization Request: Authorization Process and Timeline Standards.
2/17/25	Yes	Howard Taekman, MD; Faustine Dela Cruz, RN; Gia Zabala, RN	Updated to comply with AB 2843 Health Care Coverage: Rape and Sexual Assault
5/28/2026	Yes	Gia Zabala, RN; Kristin Eichenberg RN	DMHC approved policy on 1/23/2026.