| | Utilization Management | UM-001 |
|---|---|---|
| **Department** | Health Services | |
| **Functional Area** | Utilization Management | |
| **Line of Business** | ☒ Medi-Cal ☒ D-SNP | |

| DELEGATION OF FUNCTION | | |
|---|---|---|
| ☒ Health Net | ☒ Community Care IPA | ☐ Not Delegated |
| ☒ Community Health Group | ☒ Primary Healthcare Medical Group | |
| ☒ Imperial County Physicians MG | ☒ Premier Patient Care | |

| DATES | | | |
|---|---|---|---|
| **Policy Effective Date** | 6/12/2023 | **Reviewed/Revised Date** | 12/11/2025 |
| **Next Annual Review Due** | 12/11/2026 | **Regulator Approval** | 12/15/2023 |

| APPROVALS | | | |
|---|---|---|---|
| **Internal** | | **Regulator** | |
| **Name** | Gordon Arakawa, MD | ☐ DHCS | ☐ NA |
| **Title** | Chief Medical Officer | ☒ DMHC | |

| ATTACHMENTS |
|---|
| NA |

## AUTHORITIES/REFERENCES

- **Internal**
  - CHPIV, Delegation Oversight Policy and Procedure, CMP-002
- **Federal**
  - Code of Federal Regulation (CFR): 42 CFR 438.206, 438.915, 438.900, 438.210.
  - CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F)
- **State**
  - California Health and Safety Code Sections ("H&S Code") 1262.8(i), 1317.1, 1317.4, 1363.5, 1367(d), 1367.01, 1368.1, 1371.4, 1374.16, 1374.30(i), 1383.1(a), 1383.15
  - California Welfare and Institutions Code ("W&I Code") 14103.6
  - California Business and Professions Code Section (B&P Code) 805
  - Title 28 California Code of Regulations Rules (CCR) Rules 1300.67.2(c), 1300.70, 1300.71.4, 1300.74.16
  - Title 22 California Code of Regulations Rules 53855(a), 51003
  - DMHC: Technical Assistance Guide (TAG) "Utilization Management"
  - DHCS Closed-Loop Referral Implementation Guidance
  - DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III: 2.3, 2.2, 4.4.6, 4.5.6. Exhibit E: 1.22
  - Knox-Keene Health Care Service Act and Regulations, Section 1367.01, 1374.721
- **Accreditation**
  - NCQA: Utilization Management (UM) 1, 4, 8, Elements A-B.

| HISTORY | |
|---|---|
| **Revision Date** | **Description of Revision** |
| 6/12/2023 | Policy creation |
| 10/01/2024 | Policy revision - annual review; minor non-substantive changes |
| 12/11/2025 | Mid-Year Review - Updates for APLs and/or applicable regulations. Revisions to P&P formatting. |

## I. OVERVIEW

A. This policy addresses Community Health Plan of Imperial Valley's ("CHPIV" or the "Plan") UTILIZATION MANAGEMENT ("UM") requirements, policy, and procedures.

## II. POLICY

A. CHPIV ensures it has developed, implemented, updated at least annually, and improved its UTILIZATION MANAGEMENT (UM) program to ensure appropriate processes are used to review and approve the provision of MEDICALLY NECESSARY Covered Services for its MEMBERS. At a minimum, CHPIV's UM program:

1. Includes a designated medical director or clinical director responsible for the UTILIZATION REVIEW process, and qualified staff responsible for the UM program.
2. Prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue MEDICALLY NECESSARY services.
3. Allows for a second opinion from a qualified health professional within the Network, if available. If a qualified health professional within the Network is not available, Contractor must authorize an Out-of-Network Provider to provide the second opinion at no cost to the MEMBER.
4. Makes available to NETWORK PROVIDERS and MEMBERS all relevant UM policies and procedures and clinical criteria upon request.
5. Provides training to NETWORK PROVIDERS on the procedures and services that require Prior Authorization for MEDICALLY NECESSARY services and ensures that all NETWORK PROVIDERS are aware of the procedures and timeframes necessary to obtain Prior Authorization for MEDICALLY NECESSARY services.
6. Has a Standing Referral process providing a determination within three Working Days from the date the request is made by the MEMBER or the MEMBER's Primary Care Providers (PCP) and all appropriate medical records and other items of information necessary to make the determination are provided.
7. Has a specialty referral system to track and monitor referrals requiring Prior Authorization. When Prior Authorization is delegated to SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS, CHPIV ensures that SUBCONTRACTORS and DOWNSTREAM SUBCONTRACTORS have systems in place to track and monitor referrals requiring Prior Authorization and must furnish documentation of SUBCONTRACTOR's and DOWNSTREAM SUBCONTRACTOR's referrals to DHCS upon request.

8. CHPIV ensures it integrates UM activities into the Quality Improvement System (QIS), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or their designee.
9. CHPIV ensures it has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services, in accordance with the parity in mental health and substance use disorder requirements.

B. CHPIV maintains procedures that address the following:
1. Authorization decisions are based on the Medical Necessity of a requested health care service and are consistent with criteria or guidelines supported by sound clinical principles and evidence based. CHPIV ensures all denial notices will include a specific reason(s).
2. Policies, processes, strategies, evidentiary standards, and other factors used for UM or UTILIZATION REVIEW are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits.
3. NETWORK PROVIDERS, as well as MEMBERS and Potential MEMBERS are informed of CHPIV's process for and timeframes of all services that require Prior Authorization, concurrent authorization, or retrospective authorizations.
4. Process for consulting with PROVIDERS as needed for Prior Authorization requests for the purposes of determining Medical Necessity for medical services unless doing so would lead to undue delay in care.
5. Decision-making process to deny or to authorize an amount, duration, or scope that is less than requested must be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition and disease or Long-Term Services and Supports (LTSS) needs.
6. Qualified health care professionals must supervise the review of decisions, including service reductions, and must review all denials that are made, in whole or in part, based on Medical Necessity.
7. Written criteria or guidelines for UTILIZATION REVIEW that are developed with practicing health care PROVIDERS. The written criteria or guidelines must be based on sound clinical practices and processes which are evaluated and updated when necessary, and at least annually.
8. Process for providing clear and concise written explanation of the reasons for denying, deferring, or modifying a service; a description of the criteria or guidelines used; and the clinical reasons for the decision based on Medical Necessity.
1. CHPIV will ensure to maintain payment policies and procedures that allow for individual medical necessity determinations, outlining the process for considering individual circumstances when making payment decisions based on medical necessity. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business*.
2. CHPIV will ensure to establish that a reduction or premature discontinuation of a previously authorized ongoing course of treatment constitutes an organization determination. *This*

*requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*

9. Process for notifying MEMBERS regarding denied, deferred or modified referrals.
10. The appeals process for both PROVIDERS and MEMBERS and how it is published on CHPIV's website.
11. The timelines for decisions and appeals that are made in a timely manner ensure they are not unduly delayed when MEMBER's medical condition requires time sensitive services.
12. Prior Authorization requirements and the services they are and are not applied to. For example, Prior Authorization requirements must not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, or initial mental health and substance use disorder (SUD) assessments.
13. Records relating to Prior Authorization requests, including any Notices of Action (NOA), must meet the retention requirements.
14. Process for notifying the requesting Provider of any decision to deny, approve, modify, or delay a Service Authorization Request, or when authorizing a service in an amount, duration, or scope that is less than requested.
15. Ensure that authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits.

C. CHPIV maintains procedures that address timeliness for medical authorization that include:

3. Emergency Care: CHPIV must not require Prior Authorization for emergency care for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.
4. Post-Stabilization: CHPIV must respond to a Provider's request for authorization for post-stabilization services within 30 minutes or the service is deemed approved.
5. Non-Urgent Care Following an Exam in the Emergency Room: CHPIV must respond to a Provider's request for post-stabilization services within 30 minutes or the service is deemed approved.
6. CHPIV will ensure to provide coverage of post-stabilization care services related to an emergency medical condition, provided after stabilization, to maintain the stabilized condition or to improve or resolve the MEMBERS condition. Post-stabilization care is a covered service when related to the emergency medical condition for which the MEMBER presented. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*
7. CHPIV will ensure to provide coverage for post-stabilization care services, regardless of pre-approval, if administered to maintain the MEMBERS stabilized condition within one hour of a pre-approval request. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*
8. CHPIV will ensure to provide financial responsibility for post-stabilization care services when it fails to respond to a pre-approval request within one hour, cannot be contacted,

or a plan physician is unavailable to resolve a care disagreement. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*

9. CHPIV will ensure to allow physician(s) the opportunity to consult with a plan physician for post-stabilization care services. This consultation opportunity will be documented in the member's medical record.
   a. The Plans' financial responsibility ends for post-stabilization care that has not been preapproved when:
      1) A plan physician with privileges at the treating hospital assumes responsibility for the MEMBERS care.
      2) A plan physician assumes responsibility for the MEMBERS care through transfer;
      3) A plan representative and the treating physician reach an agreement concerning the MEMBERS care; or
      4) The MEMBER is discharged.

   *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*

10. Concurrent Review of Authorization for a Treatment Regimen Already in Place: CHPIV must respond to a concurrent authorization request within five Working Days or less, consistent with the urgency of the MEMBER's medical condition.
11. Retrospective Authorization Request for Treatment Received: CHPIV must accept requests for retrospective authorization requests within a reasonably established time limit, not to exceed 365 calendar days from the date of service.
12. Routine Authorizations: CHPIV must respond to routine requests as expeditiously as the MEMBER's condition requires, but no longer than five Working Days from receipt of the information reasonably necessary and requested by Contractor to render a decision, and no longer than 7 calendar days from the receipt of the request. These timeframes begin upon the receipt of the request, even if additional information is pending. CHPIV may extend this deadline up to an additional 14 calendar days only if the MEMBER or the MEMBER's provider requests an extension or if CHPIV justifies, to DHCS upon request, a need for additional information and how the extension is in the MEMBER's interest.
13. Expedited Authorizations: CHPIV must make expedited authorization decisions for service requests where a MEMBER's provider indicates, or CHPIV, SUBCONTRACTOR, DOWNSTREAM SUBCONTRACTOR, or NETWORK PROVIDER determines that, following the standard timeframe for Prior Authorizations could seriously jeopardize the MEMBER's life; health; or ability to attain, maintain, or regain maximum function. CHPIV must provide its authorization decision as expeditiously as the MEMBER's health condition requires, but no longer than 72 hours after receipt of the request for services. These timeframes begin upon the receipt of the request, even if additional information is pending. CHPIV may extend this deadline up to an additional 14 calendar days only if the MEMBER or the MEMBER's provider requests an extension or if CHPIV justifies, to DHCS

upon request, a need for additional information and how the extension is in the MEMBER's interest.

14. Hospice Services: CHPIV may only require Prior Authorization for inpatient hospice care and must respond to inpatient hospice care authorization requests.
15. Therapeutic Enteral Formula: CHPIV must comply with all timeframes for medical authorization of MEDICALLY NECESSARY therapeutic enteral formula billed on a medical or institutional claim and the equipment and supplies necessary for delivery of enteral formula billed on a medical or institutional claim.
16. Physician Administered Drugs: For medical authorization of MEDICALLY NECESSARY Physician administered drugs billed on a medical or institutional claim, CHPIV must comply with the same timeframes as other medical services, as set out in this subsection.

D. CHPIV ensures it includes in its UM program mechanisms to detect both under- and over-utilization of health care services including Behavioral Health Services.
E. CHPIV ensures it has processes in place to monitor utilization data to appropriately identify MEMBERS eligible for ECM and applicable Community Supports.
F. CHPIV ensures it has processes in place to monitor and track Non-specialty Mental Health Services utilization data for both adult and pediatric MEMBERS.
G. CHPIV will ensure to implement and maintain adherence to Closed-Loop Referral requirements through the following:
    1. Tracking MEMBER referrals:
        a. Minimum data element for every referral, including MEMBER information, referral details (date, service type, referring provider information. Authorization and processing information (dates, status, decisions).
        a. Data Timeliness for referral status updates collected monthly from service providers. CHPIV will ensure to maintain systems capable of real-time data updates.
        b. Tracking system compliance to data sharing laws such as HIPAA and CMS interoperability rules.
        c. CHPIV will ensure to track referral statuses and document reasons for referral loop closure.
    2. Supporting MEMBER referrals
        a. CHPIV will ensure to notify members and referring service providers about referral progress, such as authorization decisions, referral loop closure updates within two business days of receiving them.
        b. CHPIV will ensure to support pending referrals by following up with service providers for outreach and additional information and re-referring MEMBERS to alternative services in the case that the initial referral is not satisfied.
    3. CHPIV will ensure to monitor and regularly review data to identify trends and barriers.
    4. CHPIV will ensure to provide technical assistance to providers.
    5. CHPIV will ensure the adoption of CLR requirements in Enhance Care Management (ECM) and Community Supports (CS) beginning on July 1, 2025.
    6. CHPIV will ensure to track and store all referral data elements and align with DHCS data sharing protocols specific to ECM and CS.
    7. CHPIV will ensure to track Correctional Facility referrals for pre-release services. CHPIV will ensure services are available on the day of the MEMBER's release.

*This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*

H. Integrated organization determination or integrated reconsideration.
   1. CHPIV will ensure any failure to adhere to the mandated notice and timing requirements for an integrated organization determination or integrated reconsideration will constitute an adverse determination for the MEMBERS. The Plan will proceed as required for an adverse determination.
   2. CHPIV will ensure any delay in providing timely notice of an adverse organization determination that adversely affects a MEMBERS health will be treated as an adverse determination.
   3. CHPIV will ensure any expedited integrated organization determination requests that are denied will automatically be transferred to the standard timeframe, and a determination will be made within the standard timeframe.
   4. CHPIV will ensure to maintain a procedure for making timely organization determinations regarding the benefits a MEMBER is entitled to receive, including basic, mandatory, and optional supplemental benefits, and the amount, if any, that the MEMBER is required to pay for a health service.
   5. CHPIV will ensure timeframe and notice requirements are met, regardless of whether information is requested from non-contracted providers, specifically regarding all aspects of Utilization Management.
   6. CHPIV will ensure to establish and maintain a process allowing MEMBERS to request an integrated organization determination. CHPIV ensures to clearly communicate to MEMBERS through appropriate channels.
   7. CHPIV ensures to establish and maintain process for requesting an integrated organization determination is the same for all covered benefits.
   8. CHPIV will ensure to not extend deadlines for integrated organization determination.
   9. CHPIV will ensure to establish and maintain documented, integrated processes for MEMBERS which address integrated grievances, integrated organization determinations, and integrated reconsiderations. CHPIV ensures these integrated processes will be readily accessible to MEMBERS.
   10. CHPIV will ensure to not rescind or modify an integrated organization authorization after the provider renders the health care service in good faith.
   11. CHPIV will ensure to issue standard Integrated Organization Determinations as expeditiously as the member's health condition requires, but no later than 14 calendar days from receipt of the request. This timeframe applies to services or items not subject to prior authorization.
   12. CHPIV will ensure to issue notices of integrated organization determinations made following an extension as expeditiously as the MEMBERS health condition requires, but no later than the extension's expiration date.
   13. CHPIV will ensure to provide prompt oral notification of denial and a written denial letter within 3 calendar days for expedited integrated organization determination requests, including information on standard processing timeframes, grievance rights and processes, and resubmission options. The written denial must inform the MEMBER of the right to file an expedited integrated grievance and the right to resubmit the request with physician support, including instructions about the integrated grievance process and its timeframes.

14. CHPIV will ensure to establish expedited integrated organization determinations requiring information from non-contract providers, the plan must request necessary medical information from the non-contract provider within 24 hours of the initial request. The plan must make expedited integrated organization determinations as expeditiously as the MEMBERS health condition requires, and no later than 72 hours from receipt of the request.
15. CHPIV will ensure to provide written notice of integrated organization determinations at least 10 calendar days prior to terminating, suspending, or reducing a previously approved service, this appeal will be an integrated coverage decision letter.
16. CHPIV will ensure UM decision notices describe all applicable Medicare and Medicaid appeal rights. The description shall include the process for initiating an appeal and any relevant deadlines.
17. CHPIV will ensure to mail or otherwise transmit a written notice of the dismissal of the integrated organization determination request to the parties.
    1. The reason for the dismissal.
    2. The right to request that the applicable integrated plan vacate the dismissal action.
    3. The right to request reconsideration of the dismissal.
18. CHPIV will ensure to provide written notice to MEMBERS of their appeal rights and State Hearing rights for all fully or partially denied Integrated Organization Determinations. Such notice must be included with any communication regarding a fully or partially denied Integrated Organization Determination.
19. CHPIV will ensure to provide for Integrated Organization Determinations denials, in whole or in part, a Medi-Cal service or benefit (including overlap cases), the Plan must include the most current State Hearing form with the Integrated Organization Determination notice. This requirement applies when the denial is not for a Medicare-only service or benefit.
20. CHPIV will ensure to provide the Member with IMR information and application materials, including verbatim language, the most recent IMR form, application instructions, the DMHC's toll-free telephone number, and an envelope addressed to DMHC when an Integrated Organization Determination for a Medi-Cal service is denied as experimental/investigational, or is a denial of urgent care or an emergency service. CHPIV shall inform MEMBERS of their rights to an IMR.
21. CHPIV will ensure to provide integrated organization determination notices must be written in plain language, available in accessible formats and languages, and include the determination made, the determination date, its effective date, the reasons for the determination, reconsideration rights and procedures (including representation, expedited resolution, and continuation of benefits), and instructions for exercising these rights. CHPIV shall ensure notices meet readability and accessibility standards for all MEMBERS.
22. CHPIV will ensure to provide Integrated organization determination notices written in plain language, be available in a language and format that is accessible to the MEMBER, and explain the following:
    a. a. The applicable integrated plan's determination.
    b. The date the determination was made.
    c. The date the determination will take effect.
    d. The reasons for the determination.

e. The MEMBERS right to file an integrated reconsideration and the ability for someone else to file an appeal on the MEMBERS behalf.
f. Procedures for exercising MEMBERS rights to an integrated reconsideration.
g. Circumstances under which expedited resolution is available and how to request it.
h. If applicable, the MEMBERS rights to have benefits continue pending the resolution of the integrated appeal process.

23. CHPIV will ensure to provide the MEMBER a written notification of the reasons for the delay and their right to file an expedited integrated grievance if they disagree with the extension, as expeditiously as the MEMBERS health condition requires, but no later than upon expiration of the extension when the UM decision timeframe is extended,
24. CHPIV will ensure to issue a denial notice to the MEMBER and notify the relevant physician or provider on the date the timeframe expires when an integrated organization determination is not reached within the specified timeframe, resulting in a denial.

*This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*

I. CHPIV will ensure to conduct an annual analysis of prior authorization data from the prior contract year, excluding data on drugs, calculating metrics for MEMBERS with and without specified social risk factors including approval rates, denial rates, appeal approval rates, extended timeframe approval rates, expedited approval and denial rates, and average and median processing times for standard and expedited requests. This analysis will inform utilization management practices and ensure equitable access to covered items and services. *This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*

J. Utilization Management Committee.

1. The Plan shall establish a Utilization Management (UM) committee led by the Plan's medical director.

2. The UM committee will oversee and guide all utilization management activities and policies.

3. All UM policies and procedures must be reviewed and approved by the designated UM Committee prior to implementation and annually thereafter.

4. Beginning in 2025, the UM Committee will conduct an annual health equity analysis of prior authorization utilization.

5. The UM Committee shall document processes including objective determination of financial conflicts of interest and recusal management. These documented processes will ensure an objective party determines if disclosed financial interests are conflicts of interest.

6. Document in writing the reasons for its decisions regarding the development of UM policies. This documentation will be made available to CMS upon request.

7. The Utilization Management (UM) committee shall be comprised of a majority of practicing physicians. Documentation of physician credentials and current practice status will be maintained for all UM committee members.

8. The UM committee must include at least one practicing physician who is independent and free of conflict relative to the MA organization and MA plan.

9. The UM Committee shall be established and include at least one practicing physician with expertise in the care of elderly or disabled individuals.

10. The UM committee shall include members representing diverse clinical specialties, such as primary care and behavioral health. This multidisciplinary representation ensures comprehensive consideration of varied conditions in the development of utilization management policies.

11. The UM Committee must include at least one member with expertise in health equity, defined as holding relevant educational degrees or credentials, experience conducting disparity studies, leading equity-focused initiatives, or leading health equity advocacy. The Plan will maintain documentation verifying the health equity expertise of the designated UM Committee member.

12. The UM Committee must approve all utilization management policies and procedures. This includes, but is not limited to, coverage criteria, prior authorization policies, access to services standards, and application of medical necessity criteria.

*This requirement applies specifically to the Dual Eligible Special Needs Plan (D-SNP) line of business.*

## III. PROCEDURE

A. Delegation of Functions
   1. Delegated functions covered under this policy are described in the applicable delegate's own policies and procedures governing the performance of those functions. Delegates are required to maintain compliant and current policies consistent with applicable regulatory and contractual requirements. CHPIV's oversight activities verify adherence to those standards.

B. Delegation Oversight
   1. CHPIV maintains full accountability for all delegated activities and provides oversight to ensure compliance with federal, state, and contractual requirements.
   2. Oversight activities are conducted in accordance with CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure, and include:
      a. Ongoing monitoring
      b. Performance reviews
      c. Data analysis
      d. Utilization of benchmarks, if available
      e. Annual desktop and on-site audits

## IV. DEFINITIONS

Whenever a word or term appears capitalized in this policy and procedure, the reader should refer to the "Definitions" below.

| TERM | DEFINITION |
|---|---|
| **Downstream Subcontractor** | Means an individual or an entity that has a Downstream Subcontractor Agreement with a Subcontractor or a Downstream Subcontractor. |
| **Medically Necessary or Medically Necessity** | Means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury as required under W&I Code section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. |
| **Member** | A beneficiary enrolled in a CHPIV program. |
| **Network Provider** | Provider or entity that has a Network Provider Agreement with Contractor, Contractor's Subcontractor, or Contractor's Downstream Subcontractor, and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services under this Contract. A Network Provider is not a Subcontractor or Downstream Subcontractor by virtue of the Network Provider Agreement. |
| **Provider** | Individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. |
| **Subcontractor** | Means an individual or entity that has a Subcontractor Agreement with Contractor that relates directly or indirectly to the performance of Contractor's obligations under this Contract. A Network Provider is not a Subcontractor solely because it enters into a Network Provider Agreement. |
| **Utilization Management (UM) or Utilization Review** | Means Evaluation of the Medical Necessity appropriateness, and efficiency of the use of health care services, procedures, and facilities. |