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| Text  Description automatically generated with low confidence | **Utilization Management** | UM-001 |
| **Department** | Health Services  |
| **Functional Area** | Utilization Management  |
| **Impacted Delegate** | [x]  Subcontractor [ ]  NA |

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| **DATES** |
| Policy Effective Date | 6/12/2023 | Reviewed/Revised Date |  |
| Next Annual Review Due | 6/12/2024 | Regulator Approval |  |

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| **APPROVALS** |
| **Internal** | **Regulator** |
| Name | Gordon Arakawa, MD | [ ]  DHCS[x]  DMHC | [ ]  NA |
| Title | Chief Medical Officer |

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| **ATTACHMENTS** |
| NA |

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| **AUTHORITIES/REFERENCES** |
| * **Internal**
	+ CHPIV, Delegation Oversight Policy and Procedure, CMP-002
* **Federal**
	+ Code of Federal Regulation (CFR): 42 CFR 438.206 and 438.915.
* **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 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
	+ DMHC: Technical Assistance Guide (“TAG”) “Utilization Management” (last published 08/09/2015)
	+ DHCS: DHCS 2024 Medi-Cal Managed Care Agreement, Exhibit A, Attachment III, Section 2.3; TAG Utilization Management
	+ Knox-Keen Health Care Service Act and Regulations, Section 1367.01, 1374.721
* **Accreditation**
	+ NCQA: Utilization Management (UM) 1, Elements A-B
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| **HISTORY** |
| Revision Date | Description of Revision |
| 6/12/2023 | Policy creation |
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1. OVERVIEW
2. This policy addresses Community Health Plan of Imperial Valley’s (“CHPIV” or the “Plan”) UTILIZATION MANAGEMENT (“UM”) requirements, policy, and procedures.
3. POLICY
4. 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:
5. Includes a designated medical director or clinical director responsible for the UTILIZATION REVIEW process in accordance with H&S Code section 1367.01, and qualified staff responsible for the UM program.
6. 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.
7. 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, in accordance with 42 CFR section 438.206.
8. Makes available to NETWORK PROVIDERS and MEMBERS all relevant UM policies and procedures and clinical criteria upon request.
9. 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.
10. 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.
11. 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.
12. CHPIV ensures it integrates UM activities into the Quality Improvement System (QIS) specified in Exhibit A, Attachment III, Section 2.2 (Quality Improvement and Health Equity Transformation Program), 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.
13. 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 in 42 CFR section 438.900, et seq.
14. CHPIV maintains procedures that address the following:
15. 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.
16. 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.
17. 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.
18. 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.
19. 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.
20. 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.
21. 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, in accordance with H&S Code section 1363.5.
22. 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.
23. Process for notifying MEMBERS regarding denied, deferred or modified referrals.
24. The appeals process for both PROVIDERS and MEMBERS and how it is published on CHPIV’s website.
25. 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.
26. 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.
27. Records relating to Prior Authorization requests, including any Notices of Action (NOA), must meet the retention requirements described in Exhibit E, Section 1.22 (Inspection and Audit of Records and Facilities).
28. 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.
29. Ensure that authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR section 438.900, et seq.
30. CHPIV maintains procedures that address timeliness for medical authorization that include:
31. 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.
32. Post-Stabilization: CHIPIV must respond to a Provider’s request for authorization for post-stabilization services within 30 minutes or the service is deemed approved in accordance with 22 CCR section 53855(a).
33. 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.
34. Concurrent Review of Authorization for a Treatment Regimen Already in Place: CHIPIV must respond to a concurrent authorization request within five Working Days or less, consistent with the urgency of the MEMBER’s medical condition and in accordance with H&S Code section 1367.01(h)(1).
35. 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.
36. 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 14 calendar days from the receipt of the request, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. 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, in accordance with 42 CFR section 438.210.
37. 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, in accordance with 42 CFR section 438.210 and H&S Code section 1367.01. 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. 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, in accordance with 42 CFR section 438.210.
38. Hospice Services: CHPIC may only require Prior Authorization for inpatient hospice care and must respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and all applicable DHCS APLs.
39. 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, as set forth in all applicable DHCS PLs and APLs, W&I Code section 14103.6, and H&S Code section 1367.01.
40. 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, at set out in this subsection.
41. CHPIV ensures it includes in its UM program mechanisms to detect both under- and over-utilization of health care services including Behavioral Health Services.
42. CHPIV ensures it has processes in place to monitor utilization data to appropriately identify MEMBERS eligible for ECM and applicable Community Supports as specified in Exhibit A, Attachment III, Subsection 4.4.6 (MEMBER Identification for ECM) and Subsection 4.5.6 (Identifying MEMBERS for Community Supports).
43. CHPIV ensures it has processes in place to monitor and track Non-specialty Mental Health Services utilization data for both adult and pediatric MEMBERS.
44. **PROCEDURE**
45. CHPIV delegates the Utilization Management process to its Subcontractor, Health Net.
46. Delegation Oversight
	* 1. CHPIV shall provide oversight and continually assess the delegated functions, responsibilities, processes, and performance of Health Net. CHPIV ensures Health Net’s compliance with regulatory and contractual requirements through the following activities which are detailed in *CHPIV Policy CMP-002: Delegation Oversight Policy and Procedure*:
			1. Ongoing monitoring
			2. Performance reviews
			3. Data analysis
			4. Utilization of benchmarks, if available
			5. Annual desktop and on-site audits
47. DEFINITIONS

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

| **TERM** | **DEFINITION** |
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| **Member** | A beneficiary enrolled in a CHPIV program. |
| **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. |
| **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. |
| **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. |
| **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. |