CENCAL HEALTH POLICY AND PROCEDURE	
Title: Pre-Service Review	**Policy No. :** HS-UM07
Department: Health Services	
Effective Date: 7/1/2015	**Revised Date:** 7/9/19
Cross Reference:	**Annual Review Date:**
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I. Purpose:

The purpose of this policy is to describe the process by which CenCal Health performs pre-service (prospective) authorization review activities, and to outline Utilization Management (UM) determination and notification timeframe requirements for conducting pre-service reviews.

II. Policy:

CenCal Health's UM staff evaluates medical necessity for pre-service requests, using qualified and licensed clinical professionals and in accordance with California law, requirements set forth by the Department of Health Care Services Medi-Cal Managed Care Division, and other applicable regulatory agencies. The basis of UM decisions are on the appropriateness of care and service, and existence of coverage. The UM staff are not compensated for denying services or encouraged to make decisions that result in underutilization.

Pre-service authorization requirements are not applicable for emergency services; minor consent services (see **IV. Definitions** for details); preventive services; basic prenatal care; sensitive services, including but not limited to family planning services, sexually transmitted disease services, and HIV testing and counseling services.

III. Procedure:

Review Requirements- During the decision-making process for services that require pre-service (prospective) authorization review, the UM staff adheres to these minimum requirements:

1. Qualified health care professionals supervise review decisions, including service reductions. Qualified CCH Medical Directors review and make determinations for service requests that are modified or denied based on medical necessity. For purposes of this provision, qualified CCH Medical Directors or Pharmacists with a PharmD licensure may review and deny an authorization request for medications.
2. The UM staff applies clinical criteria and guidelines in the decision-making process. Please refer to policy *HS-UM22, Clinical Criteria for Utilization Management Decisions* for detailed information.
3. The UM staff uses the most up-to-date versions of criteria and guidelines for decision-making.
4. There are clear documentation of the reason(s) for decisions.
5. Members are notified regarding service requests denied, delayed terminated, modified or carved-out. Appeal rights are on the Notice of Action (NOA) for both Providers and Members.
6. Decisions are made in a timely manner and are not unduly delayed for medical conditions requiring time sensitive services.
7. Records, including any NOAs, shall meet the retention requirements described contractually.
8. Requesting providers are notified of any decision to approve, delay, modify, terminate, carve-out or deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Depending on the decision type, the notice to the provider may be orally or in writing.

Review Function- CCH performs pre-service review to determine medical necessity prior to scheduled/elective admissions, rendering services, or starting a course of treatment that requires authorization for payment. The Utilization Management department can request additional clinical information during the pre-service review process when the submitted documents are insufficient to make a determination. In addition to determining medical necessity of requested services, CCH performs pre-service review to:

1. Pre-approve a scheduled/elective inpatient admissions;
2. Prior authorize services or procedures;
3. Validate billing codes and identify potential unbundling activities;
4. Determine initial and continuous level of care and length of stay needs;
5. Determine if a lower level of care, a less costly, or another type of service can meet the needs of the Member
6. Determine if the requested service is within the PCP's scope of practice;

7. Determine if an in network specialist can provide the medically necessary service that is requested for or from a non-contracted provider;
8. Determine if initial or ongoing specialty or tertiary care is needed or if the care can be directed to an in-network provider or PCP;
9. Refer to a tertiary care center when there is supporting documentation that the Member has an unusual medical need that cannot be addressed by local contracted and preferred Health Plan providers;
10. Identify service duplication, benefit limitations, or exclusions and benefit carve-outs;
11. Identify potential quality of care issues by using specified quality indicators and nursing judgment and submitting information to the appropriate Quality Management (QM) personnel;
12. Identify and refer Member who may benefit from CCH case management services, other CCH programs, State programs, or community resources;
13. Identify and refer potential fraudulent or abusive practices to CenCal Health's Compliance Unit.

Review Timeframes- The pre-service review timeframe, which is the time it takes to review an authorization request from the receipt date of the request to the notification date to the provider and/or Member are noted below for pre-service reviews.

Emergency Care Requests: No pre-authorization required. Follow the reasonable person standard to determine that the presenting complaint might be an emergency.

Routine Pre-Service Authorization or Reauthorization Requests: CenCal shall attempt to make decisions within 5 working days from the receipt of reasonably necessary information to render a decision but shall take no longer than 14 calendar days from the receipt of the request. This timeframe may be extended and the decision delayed for an additional 14 calendar days only when the Member or the Member's provider or authorized representative requests an extension, or when CCH justifies the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be processed as such.

Expedited/Urgent Pre-Service Authorization Requests: Requests in which the requesting provider indicates, or CenCal Health determines, that following the routine authorization request timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, CCH will make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires. The timeframe for expedited/urgent requests is no later than 72 hours from the receipt of the request for services. If the Member requests or if CCH justifies an extension to the 72 hours timeframe is in the best interest of the Member, CCH may extend the 72 hours timeframe up to 14 calendar days.

Decision Delays- If a Member requests an extension or if CCH determines an extension of the decision-making timeframe is needed and in the best interests of the Member, CCH will issue a Delay NOA to the Member no later than 72 hours for urgent request or 14 calendar days for routine request from the receipt of the original request. The Delay NOA will indicate when a decision is anticipated and what information is requested or needed. If the final decision is to deny, modify, or terminate the request or the service is carved-out, CCH will issue another NOA to the Member no later than 17 calendar days for urgent requests or 28 calendar days for routine request from the receipt date of the request.

If the decision regarding a pre-service authorization request is not made within 17 calendar days for urgent requests or 28 calendar days for routine requests, the requested service is considered denied and a NOA issued to the Member.

Decision Notification- CCH notifies requesting providers of approved service requests via Provider Portal or fax notice. In turn, the provider notifies the Member.

CCH notifies both the provider and Member of decisions to deny, delay, terminate, modify, or carve-out service requests by issuing a written notification known as a Notice of Action (NOA). These NOAs are available in threshold language and sent to the Member and/or their authorized representative, and to the requesting provider. The NOA to the Member and provider shall include: (1) a statement of the action (2) a clear and concise explanation of the reason/rationale for the decision, (3) a description of the criteria or guidelines used, and (4) the clinical reasons for the decisions regarding medical necessity.

For provider notifications, the name and contact number of the decision maker. Refer to Attachment A for turnaround and communication timeframe specifications.

These DHCS approved NOAs also inform the Member of the following:

1. Their right to request an appeal of the decision made by CCH regarding the denial, delay or modification of a service request.
2. Their right to request free copies of all supporting documents, records and criteria/guidelines used in decision-making
3. Their right to, and when and how the Member can request a Fair Hearing to contest the denial, delay, or modification decision and/or the appeal outcome
    a. Their right to represent himself/herself at the Fair Hearing or to be represented by legal counsel, a friend or other authorized representative
4. The name and address of CCH Member Services Department, local Ombudsman, and the Department of Social Services (DSS) toll-free telephone numbers for obtaining information on legal service organizations for representation.

CenCal Health provides required notification to its Members and their authorized representatives within the timeframes and as specified in Title 22 CCR Sections 51014.1,

51014.2, 53894 and Health and Safety Code Section 1367.01. NOAs are sent to Members no later than the third working day after the decision is made.

Verification of Notice of Action- To ensure that non-templated section of NOAs contain accurate, clear and concise reason(s) for the decision and includes the proper citation or reference source, CCH conducts the following verification procedure:

1. The clinical reviewer drafts the NOA verbiage, which includes the clear and concise reason/rationale and citation or reference source.
2. The clinical reviewer sends the draft NOA along with submitted documents, citations, and references to the Medical Director for reviews and determination.
3. The Medical Director reviews the draft NOA and submitted documents. The Medical Director makes necessary changes to the draft NOA and returns the NOA to the clinical reviewer for final processing.
4. The clinical reviewer forwards the finalized NOA to a clerical support team member (aka "Clinical Support Associate" (CSA)) to complete the NOA issuance process, which includes, validating and completing the demographic information on the NOA, sending a copy of the NOA to requesting provider, and printing and sending a hardcopy NOA to the member.

For NOAs to members whose preferred language is Spanish, the CSA will forward the NOA to Member Services for translation of the rationale section of the Spanish NOA version before sending the NOA to the member. If translating the clinical rationale will jeopardize CCH's ability to comply with the mailing timeframes, the NOA may be issued to the member with the rationale in English.

IV. Definitions:

Medically Necessary or **Medical Necessity-** Medically necessary services are reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. When determining the Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" expands to include the standards set forth in Title 22, CCR, Section 51340 and 51340.1.

Minor Consent Services- Members under eighteen (18) years old may get certain services, considered sensitive services, without parental approval. These services include:

- HIV testing and counseling;
- Pregnancy testing and other pregnancy-related services;
- Family planning services;
- Treatment for sexual assault, including rape and sexually transmitted diseases; and
- Outpatient mental health for 12 y/o or older who are mature enough to participate intelligently and either (1) there is danger of serious physical or mental harm, or (2) alleged victim of incest or child abuse

Utilization Management – The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan, sometimes called 'utilization review".

V. References:

California Health and Safety Code, Division 2, Chapter 2.2, Article 5- Standards, section 1367.01(4)

CenCal Health policy, HS-UM22, Clinical Criteria for Utilization Management Decisions

DHCS/Santa Barbara San Luis Obispo Regional Health Authority's Contract 08-85212:

- Exhibit A, Attachment 5 Utilization Management, Section 2: Pre-Authorizations and Review Procedures, Section 3: Timeframes for Medical Authorization
- Exhibit A, Attachment 13 Member Services, Section 8: Denial, Deferral, or Modification of Prior Authorization Requests

DHCS, All Plan Letter 17-006, Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments

Title 22 California Code of Regulations:

- Section 51014.1- Fair Hearing Related to Denial, Termination or Reduction in Medical Services
- Section 51014.2- Medical Assistance Pending Fair Hearing Decision
- Section 53894- Notice to Members of Plan Action to Deny, Defer or Modify a Request for Medical Services
- Section 51340- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services
- Section 51340.1 Requirements Applicable to EPSDT Supplemental Services

VI. Attachments:

Attachment A- UM Decision Turnaround and Communication Timelines for Prior Authorization and Retrospective Requests

UM DECISION TURNAROUND TIME and COMMUNICATION TIMELINES FOR PRIOR AUTHORIZATION AND RETROSPECTIVE REQUESTS

Request and Decision Type	Turnaround Time (TAT) for Processing Authorization Request (Calculated from the date of receipt to the date of decision notification)	Communication Timeline In accordance to Title 22 CCR §53894 and DHCS/SB-SLO Contract 08-85212
Request- Routine (includes reauthorization) Decision-Approve	• 14 calendar days • May extend up to 14 calendar days upon issuance of a Delay NOA • Total TAT not exceed 28 calendar days	1 working day of decision to the provider, not to exceed a total TAT of 14 days (without Delay) or 28 days (with Delay)
Request- Expedited Decision- Approve	• 72 hours • May extend up to 14 calendar days upon issuance of a Delay NOA • Total TAT not to exceed 17 calendar days	1 working day of the decision to the provider, not to exceed a total TAT of 72 hours (without Delay) or 17 days (with Delay NOA)
Request- Retrospective Decision- Approve	• 30 calendar days • Delays are not permitted	1 working days of the decision to the provider, not to exceed a total TAT of 30 days
Request- Routine Decision- • Deny • Modify • Terminate • Carve-Out	• 14 calendar days • May extend up to 14 calendar days upon issuance of a Delay NOA. • Total TAT not exceed 28 days • If "Terminate" (includes suspension and reduction) is for the continuation of or for previously authorized services, NOA should be issued at least 10 days before the effective termination date if the request was received 10 days in advance.	• Verbally within 1 working days to the provider. • Follow by a written NOA within 3 working days of decision to the member **and** provider, not to exceed a total TAT of 14 days (without Delay) or 28 days (with a Delay NOA)
Request- Expedited Decision- • Deny • Modify • Terminate • Carve-Out	• 72 hours • May extend up to 14 calendar days upon issuance of a Delay NOA. • Total TAT not exceed 28 days • If "Terminate" (includes suspension and reduction) is for the continuation of or for previously authorized services, NOA should be issued at least 10 days before the effective termination date if the request was received 10 days in advance.	• Verbally within 1 working days to the provider. • Follow by a written NOA within 3 working days of decision to the member **and** provider, not to exceed a total TAT of 72 days (without Delay) or 17 days (with a Delay NOA)
Request- Routine, Urgent, Retrospective Decision- Delay/Deferral	• For Routine- Issue a Delay NOA to the member and provider within 14 days of the request receipt date • For Urgent- Issue of a Delay NOA to the member and provider within 72 hours of the request receipt date • For Retrospective- Delay is NOT ALLOWED	
Request- Concurrent Decision- All Categories	• Review completed within 24 hours from receipt of supporting documents • For all decision types, communicate decision to the provider within 24 hours • For deny, modify, terminate (see above for "terminate" timeline), or carve-out decisions, issue NOA to member and provider within 2 working days	