



Policy and Procedure

Policy Title: Prior Authorization and Approval Process
Policy No.: UM-RPP-002
Issuing Dept.: Utilization Management
Applicable To: M-Cal Comm Medicare
Effective Date: 07/01/2020
Last Review Date: 03/09/2026

Purpose

1. To describe the prior authorization and approval process, which includes timeliness and member/provider notification.

Policy

1. The Risk Bearing Organization (RBO) performs medical necessity and benefit coverage determinations for Medical, Pharmacy, and Behavioral Health (when delegated) referral requests. Certain services require a referral for prior authorization (e.g., Pharmacy/Pharmaceutical Step Therapy, DME, Home Health, Specialty providers).
 - 1.1 The RBO adheres to all coverage mandates established by the Full-Service Health Plan and applicable regulatory entities. The Full-Service Health Plan retains sole responsibility for defining covered benefits, while the RBO implements utilization management activities in accordance with plan-issued policies and procedures. The RBO operationalizes the plan’s requirements by applying the plan-defined benefit provisions and ensuring that all utilization management decisions comply with mandated coverage standards and nondiscrimination requirements.
2. The RBO Utilization Management (UM) department accepts referrals submitted by the member’s Primary Care Physician (PCP), Specialty, or Ancillary providers and by the member when applicable.
 - 2.1 For Medicare, members, a member’s representative, or a provider on behalf of the member, has the right to voluntarily request plan approval (either prior or concurrent to receiving services) in circumstances where there is a question whether the plan will cover a service, item, or Part B drug. A member’s right to voluntarily receive plan approval extends to any service, item, or Part B drug which the member believes is or should be covered by the plan (this includes non-covered services, items and Part B drugs services and those for which the plan does not require prior authorization (PA) as a condition for coverage in its annual Evidence of Coverage).
3. The RBO adheres to federal, state, and Health Plan timeliness standards.
 - 3.1 If the Health Plan timeliness standards are more stringent than industry standards, the RBO will adhere to the Health Plan policies and procedures.
 - 3.2 Please refer to UM-RPP-002 Prior Authorization and Approval Process_TAT Grid
4. The RBO requires no prior authorization for specific services. (Refer to policy UM-RPP-044 Self-Referral Services)



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5. All UM processes will be conducted with confidentiality.
6. Only qualified and appropriately licensed health care professionals supervise review decisions (e.g., MD, DO, Chiropractor, Psychologist, Pharmacist, Speech-Language Pathologist), including service reductions, and a qualified physician will review all denials that are made, whole or in part, based on medical necessity.
7. The RBO complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, religion, disability, or sex (sex discrimination includes sex characteristics, orientation, stereotypes, pregnancy or gender identity). The RBO does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender (including gender identity or gender expression).
8. The RBO shall not rescind or modify authorization after the provider renders the health care service in good faith and pursuant to the authorization. This section shall not be construed to expand or alter the benefits available to the enrollee under a plan.
9. The RBO will authorize care that is consistent with the Whole Child Model (WCM) program standards and provided by CCS-paneled providers, approved Special Care Centers (SCCs), and approved pediatric acute care hospitals.
10. Every month UM receives a Preclusion report from the IPA Operations department listing providers within the network, both contracted and non-contracted, if under LOA. Any providers identified on the report will be cross walked to open/unused authorizations to identify any potential member impact. A report will be developed and forwarded to the corresponding member Health Plan, or an Attestation will be provided if there are none to report. Please refer to policy IP-CON-001 Precluded Providers.
 - 10.1 The RBO c/o Altura MSO Will not authorize requests for any ordering/servicing provider listed on the exclusion lists or any servicing provider who have opted out of Medicare. The only exception made is for emergent or urgent services. A written denial notice will be issued.
11. The RBO understands that under UM, the potential for economic profiling may exist; however, the RBO does not engage in economic profiling.

Procedure

1. Only a qualified and appropriately licensed health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, based on medical necessity.



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- 1.1. Staff members who are not qualified healthcare professionals may collect data for preauthorization and concurrent review under the supervision of appropriately licensed health care professionals. They may have the authority to approve services for which there are explicit criteria, and no clinical judgement is required.
2. The RBO shall ensure that all contracted network providers and non-contracting specialty providers are informed of the prior authorization/referral process.
3. Network Providers (Primary Care Physician (PCP) or Specialty Providers) are required to submit a referral request (Refer to Specialty Referral Tracking policy UM-APP-001).
 - 3.1. The network provider can submit the referral via the RBO provider portal, e-fax, telephone, or by mail.
 - 3.2. For After-hours, the on-call UM staff will review the e-fax line for evidence of urgent or expedited referral request after business hours, weekends, and holidays. The RBO's 24/7 referral number shall connect the member or the member's representative to the on-call medical management team who will:
 - 3.2.1. Have the ability to approve covered services
 - 3.2.2. Have the capability to coordinate continuous care and follow-up covered services, including referrals to specialist physicians, for all members who have received an MSE or Emergency Services and have been stabilized.
 - 3.2.3. Log the call listing the time, date and any pertinent information related to persons involved, resolution, and follow-up instructions.
 - 3.2.4. Gather relevant clinical information to support non-behavioral (e.g., Medical and Pharmacy) and behavioral (if applicable) healthcare UM decision making.
4. Referral System
 - 4.1. The referral system has the capability to track, compile, and evaluate referrals to include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.
 - 4.2. Upon entry into the system, one of the following referral statuses will be selected:
 - 4.2.1. Urgent Concurrent



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4.2.2. Urgent/Expedited

4.2.3. Routine/Standard

4.2.4. Retrospective

4.2.5. All requests (e.g., standard, expedited, urgent concurrent) are deemed "received" on the date and time:

4.2.5.1. The RBO or the Full-Service Health Plan initially stamps a document received by regular mail (i.e., U.S. Postal Service);

4.2.5.2. A faxed document is successfully transmitted to the RBO or the Full-Service Health Plan, as indicated on the fax transmission report;

4.2.5.3. A verbal request is made by telephone with a member/provider service representative;

4.2.5.4. The RBO does not utilize a voicemail system. However, if the Full-Service Health Plan utilizes a voicemail system to accept requests or supporting statements after normal business hours, the RBO will honor the receipt date as the date left on the voicemail system.

4.2.5.5. A request is received through the RBO or the Full-Service Health Plan's website, provided the website and/or portal meets all regulatory requirements.

4.3. The single authorization request form will be completed to include the following (if applicable):

4.3.1. A request for an initial specialty consultation

4.3.2. Treatment(s) request based upon reasonable and appropriate medical standards

4.4. A member, provider or the health plan may directly submit an oral or written request for an expedited organization determination

4.5. The referral specialist must document a note indicating all oral request for determination



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5. Auto-logic

5.1. The referral system has built-in auto-logic to auto-approve services based on established UM business rules based on practice patterns. Additionally, the system simultaneously will screen referrals submitted for potential eligibility for California Children Services (CCS).

6. CCS

6.1. The California Children Service (CCS) Program provides medically necessary services and case management for Medi-Cal beneficiaries with CCS eligible conditions or diagnoses who meet program eligibility requirements in accordance with California Code of Regulations (CCR) Title 22, Section 41510 and 51013, and California Health and Safety Code Section 123800.

6.1.1. For members under the Whole Child Model (WCM), the RBO will provide medically necessary services by CCS paneled providers, which may require the member to be seen out of network. The RBO will allow CCS-eligible members access to out-of-network providers to obtain medically necessary services if the RBO has no specialist that treats the CCS-eligible condition within the RBO's provider network, or if in-network providers are unable to meet timely access standards. The RBO will not deny out-of-network services based on cost or location.

6.2. These referrals will be placed into a CCS queue for the RBO Case Manager to perform the CCS screening. The Case Manager serves as the link between the Primary Care Physician (PCP) and CCS, the Specialty Providers, and contracted Health Plan.

6.3. Potential CCS patients will be identified as early as is feasible. As part of their case management, all financial and medical elements involved in the care of these members will be referred and tracked for the CCS referral decision.

7. Genetically Handicapped Persons Program (GHPP)

7.1. The Genetically Handicapped Persons Program (GHPP) covers specific genetic diseases for adults over the age of 21 as specified by Title 17 section 2931-2932, Title 22 section 41670, Civil Code section 1798.17, HSC 12125 – 125191, and HSC 123800.

7.1.1. For members under the GHPP, the RBO will provide medically necessary services by a GHPP paneled providers, which may require the member to be seen out of



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network. The RBO will allow GHPP-eligible members access to out-of-network providers to obtain medically necessary services if the RBO has no specialist that treats the GHPP-eligible condition within the RBO's provider network, or if in-network providers are unable to meet timely access standards. The RBO will not deny out-of-network services based on cost or location.

- 7.2. These referrals will be placed into a CCS queue for the RBO Case Manager to perform the CCS and GHPP screening. The Case Manager serves as the link between the Primary Care Physician (PCP) and CCS/GHPP, the Specialty Providers, and contracted Health Plan.
 - 7.3. Potential GHPP patients will be identified as early as is feasible. As part of their case management, all financial and medical elements involved in the care of these members will be referred and tracked for the GHPP referral decision.
8. UM Coordinator
- 8.1. Authorizations who do not meet the auto-logic rules are placed in the UM coordinators queue for review and processing. The UM Coordinator is a non-clinical staff member who may collect data for preauthorization and concurrent review under the supervision of appropriately licensed healthcare professionals. The UM coordinator is responsible for screening all incoming authorization requests, verifying eligibility and benefits, and completing the data entry of the authorization process. The UM Coordinator is not involved in any decision making that requires clinical judgment and have no authority to deny any services. Licensed staff members supervise all review decisions. Additional UM Coordinator responsibilities include:
 - 8.1.1. Supporting licensed UM personnel
 - 8.1.2. Acting as a resource to practitioners, providers, or members for benefit/practitioner/provider/health plan information
 - 8.1.3. Providing the first line of telephonic response for incoming UM department calls
 - 8.1.4. Collecting data for UM reports pertaining to the pre-authorization and concurrent review processes.
 - 8.1.5. Maintaining logs, databases, and a filing system for authorizations.
 - 8.1.6. Coordinating electronic and mailed communication of authorization information to the providers and members. Preparing denial letters and letters of agreement



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- 8.2. The UM coordinator can approve referrals based on the UM Matrix. The UM Matrix is a tool developed to delineate the authority (non-clinical, clinical) for approval of specific services based only on appropriateness of care and on utilization practice patterns.
 - 8.3. The UM coordinator adheres to the UM Matrix and will process the referral based on the level of approval or will forward the referral to the UM nurse for medical necessity or benefit review.
 - 8.4. Referrals received in error (misdirected) will be forwarded to the Full-Service Health Plan or carve out vendor (e.g., Denti-Cal, Behavioral Health (when not delegated), VSP) within 24 hours of receipt of the request or as soon as the RBO determines the referral was received in error.
9. UM Nurse Role
- 9.1. The UM Nurse holds an unrestricted license from the Board of Registered Nursing or Vocational Nursing in California. Responsibilities include overseeing the authorization process by processing precertification referral requests according to medical necessity guidelines and benefit coverage based on the UM Matrix. Any referrals that do not meet clinical criteria or benefit coverage will be sent to the Physician Reviewer/Medical Director (PR/MD) for final determination.
10. Physician Reviewers/Medical Directors
- 10.1. The PR/MD's have the education, training, or professional experience in medical or clinical practice and hold a current license to practice in California as applicable, without restriction. Responsibilities include reviewing prior authorization request for medical necessity, review referral requests for continuity of care, direct staff as to appropriate and on guideline usage, and determine appropriate criteria and/or benefit is utilized. Additionally, only a physician or other health care professional, as appropriate, reviews any denial of care based on medical necessity.
 - 10.2. Upon review, the PR/MD may Approve, Deny, Defer/Delay/Pend/Extend, or Modify the request. For Denial Review, refer to policy UM-RPP-003 Denial Review and Notification. For Defer/Delay/Pend/Extend review refer to policy UM-RPP-004 Extending Referral Requests.
 - 10.3. Referrals must be evaluated and authorized by a person with a defined level of responsibility based on the level of skill required to evaluate the necessary information.



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- 10.3.1. Specifically, the PR/MD or health care professionals reviewing partial or fully adverse organizational determinations must have both of the following:
 - 10.3.1.1. Expertise in the field of medicine or health care that is appropriate for the services at issue. However, the reviewer does not need to be of the same specialty or sub-specialty.
 - 10.3.1.2. Knowledge of the applicable criteria based on the line of business (e.g. Medicare coverage criteria)
- 10.3.2. The RBO will provide information about the licensed reviewer (e.g. physician, pharmacist) making organizational determinations such as name, specialty, board certification, relevant training, experience, or similar, as applicable.
- 10.3.3. If multiple services are requested on a single TAR, that are interrelated, it may be appropriate for organizations to use the same reviewer. However, if they are not interrelated, decisions to deny each item/service must be made by a reviewer with appropriate expertise.
- 10.4. When applicable, board certified physicians from appropriate specialty areas will assist in making determinations of medical necessity. In the event the PR/MD determines the referral requires an expert review, the referral will be forwarded to the Board-Certified provider when the PR/MD determines that a case requires specialized expertise beyond their scope. The UM department maintains a roster of board-certified reviewers across various specialties via internal contracted specialty network and externally through contracted board-certified vendor.
 - 10.4.1. In the event the PR/MD is unable to make a determination due to the complexity of the case or the need for a specialty-specific opinion, the case must be referred to a board-certified physician reviewer who possesses the appropriate clinical background. This ensures that:
 - 10.4.1.1. The decision is informed by a reviewer with the relevant specialty knowledge and board certification, which enhances the quality and appropriateness of care decisions.
 - 10.4.1.2. Standards such as those from NCQA require that denial decisions be made by a clinical professional and that appeals involve a reviewer with the same or similar specialty



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10.4.1.3. Utilizing a board-certified reviewer allows for a more individualized assessment that considers the member's unique medical history, comorbidities, and treatment progress

10.4.1.4. Documenting the use of board-certified reviewers in complex cases supports transparency in the UM process and provides a defensible rationale for decisions made.

11. Medical Necessity Review

11.1. As previously mentioned, the referral undergoes various levels of review, as delineated based on the UM Authorization Matrix. However, when the review is for medical necessity or benefits, the following must be considered:

11.1.1. Coverage and benefit criteria

11.1.2. Whether the service or item is reasonable and necessary

11.1.3. The member's medical history, condition(s), diagnosis(s), and clinical notes

11.2. In addition to the above, the UM nurse and PR/MD will utilize the UM Criteria Hierarchy.

11.3. The UM criteria hierarchy, in reviewing authorizations, can be, but is not limited to:

11.3.1. UM Authorization Matrix

11.3.2. Medicare or Medi-Cal Criteria - refer to Medi-Cal or Medicare website

11.3.3. Health Plan Criteria – refer to the specific health plan

11.3.4. The RBO approved UM Criteria (e.g., Milliman Care Guideline, UpToDate)

11.4. Verification of Benefits does not require a licensed health care professional. Refer to policy UM-RPP-007 Application of Clinical Criteria.

11.5. After reviewing medical records submitted with the request and/or available historic documentation, the PR/ MD may determine there is insufficient information available to render an appropriate medical necessity determination. Additional information may be necessary when, but is not limited to:

11.5.1. Clinical information received is outdated



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- 11.5.2. Clinical information received is not pertinent to the request
- 11.5.3. Specific information is needed to render a decision (lab results, images, etc.)
- 11.5.4. The member's presenting problem is not specified
- 11.6. When additional information is required, the UM nurse and PR/MD will direct the UM coordinator to request for additional information. Refer to policy UM-RPP-004 Extending Referral Requests.
 - 11.6.1. The received date is utilized as the starting date to calculate turnaround times for decision timeliness, regardless of the need for additional information.
- 11.7. If additional information is required, the UM coordinator will contact the Primary Care Physician and/or Specialist by fax or telephone to request specific information (e.g., patient records, conversations with appropriate physicians) reasonably necessary and appropriate to make a determination.
 - 11.7.1. There will be a minimum of three documented attempts to contact the provider during normal office hours. One attempt via phone, and 2 requests via fax or email depending on the provider's ability to receive information.
 - 11.7.1.1. During the outreach attempts, a direct fax number will be given to the provider or office staff to submit the additional information to ensure the process is not overly burdensome
 - 11.7.2. If, after all attempts are exhausted, the PR/MD should attempt to communicate with the requesting provider before issuing a decision to deny in writing.
 - 11.7.3. Within 2 days of receipt of standard requests
 - 11.7.4. At the time of receipt of expedited/urgent requests but no later than 24 hours
 - 11.7.5. There will be a specific description of the required information
 - 11.7.6. The name, phone number, fax number, e-mail, and/or mailing address, as applicable, for the point of contact, will be documented
 - 11.7.7. The date and time of each request, documented by date and time stamps on copies of a written request, call record, facsimile transmission, e-mail, and/or



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overnight mail with certified return receipt.

11.7.8. Call records should include specific information about who was contacted, what was discussed/requested, and what information was obtained by the plan.

11.8. The PR/MD may determine outreach for additional information is not needed when the documentation on record indicates, but is not limited to, the following:

11.8.1. There is no more information available to support the request

11.8.2. The PR/MD considers the records available and historical records permit making a clinical decision

11.8.3. Receipt of additional information would not change the outcome of the determination

12. Extension

12.1. Notice to implement extension process for an authorization request because additional information is required to render a decision will be given to the requesting practitioner and member in adherence with federal, state, and Health Plan timeliness standards. (Refer to UM-RPP-004 Extending Referral Request).

12.1.1. Urgent concurrent requests must have a decision made to approve or deny within the urgent concurrent timeframe; however, a timeframe extension may be taken for the following reason:

12.1.1.1. The request to extend urgent concurrent care was made at least 24 hours prior to the expiration of the prescribed period of time or treatment. A decision will be made within 72 hours.

12.1.1.2. The request to approve additional days for urgent concurrent is related to care not previously approved and the RBO documents that it made at least one attempt to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. A decision will be made within 72 hours.

12.1.1.3. The Member voluntarily agrees to extend the decision-making time frame.



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- 12.2. Benefit or contractual clarifications are not reasons to extend.
- 12.3. The notice shall include specific information regarding what is needed to complete the review as well as the anticipated decision date.
- 12.4. The notification will contain a description of the criteria or guidelines used, including a citation of the specific regulations or plan authorization procedures supporting the action and the clinical reasons for the decision regarding medical necessity and when the enrollee can expect a decision.
- 12.5. The authorization request awaiting additional medical information will be pended in accordance with specific health plan agreements and/or the ICE timeliness standards per LOB.
- 12.6. If the RBO does not receive the additional information within the ICE timeliness standards per LOB, a determination will be issued based on the information on hand.
- 12.7. Concurrent Review: The RBO may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions:
 - 12.7.1. Within 24 hours of receipt of the urgent preservice request, the organization asks the member (or the member's representative) for the specific information necessary to make the decision.
 - 12.7.2. The RBO gives the member at least 48 hours to provide the information.
- 12.8. The extension period, within which a decision must be made by the organization, begins:
 - 12.8.1. On the date when the organization receives the member's response (even if not all the information is provided)
- 12.9. At the end of the period given to the member to provide the information if no response is received from the member or the member's authorized representative.

Additional screening is performed during the review process parallel to performing medical necessity and benefit coverage review. Some of these screenings are as follows but are not limited to the following sections.

13. Continuity of Care



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- 13.1. Continuity of care is made available to newly enrolled members that are transitioning into the RBO, and existing members that are undergoing care with a terminated provider. These members have the right to request continuity of care in accordance with California law and managed care plan (MCP) contracts with some exceptions. The RBO members with pre-existing provider relationships who make a continuity of care request must be given the opportunity to continue treatment as defined by California law and managed care plan (MCP) contracts. Refer to policy UM-RPP-015 Continuity of Care.
- 13.2. Should coordinated care plans be offered, the RBO will:
 - 13.2.1. Have a 90-day minimum continuity and coordination of care process that is valid for the duration or course of treatment based on medically necessary to avoid disruptions in care and prohibit prior authorization during any active course(s) of treatment when a Medicare recipient/member.
 - 13.2.2. Ensure members switching from one Medicare plan to another provide at a minimum a 90-day transition period without the need of prior authorization for medically necessary services during an active course of treatment or less if the duration of treatment ends prior to the 90-day period.
 - 13.2.3. Not shorten the authorization period, number of services, evaluation or other without support that such review or change were consistent with the relevant coverage criteria and supported by the evidence in the member's medical record, and by treatment guidelines or clinical literature that is widely available.
 - 13.2.4. Arrange for and cover any medically necessary covered benefit outside of the plan provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet an enrollee's medical needs.
 - 13.2.5. New members cannot have an active course of treatment disrupted for the first 90 days, even if services are rendered by an out-of-network provider
14. Letter of Agreement
 - 14.1. The RBO assures members receive specialized services and/or treatment as appropriate when the RBO is unable to provide requested, medically necessary treatment and/or services by contracted providers.



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- 14.2. In such an instance, the PR/MD will request a Memorandum of Understanding (MOU) or Letter of Agreement (LOA) be generated. The UM coordinator will proceed with the MOU/LOA by:
 - 14.2.1. Contacting the requested provider to determine if he/she will sign a MOU or LOA with the RBO, establishing a contracted rate of payment and UM processes.
 - 14.2.2. If the provider accepts the terms of the LOA/MOU, the RBO's UM staff will proceed with the Streamline Verification.
 - 14.2.3. Refer to policy UM-APP-009 Referral to Non-Participating Providers
15. Second Opinion
 - 15.1. The RBO provides members, who meet specific criteria, with a second opinion and/or third opinion (if allowed by the member's health plan benefits) consultation by an appropriately qualified health care practitioner.
 - 15.2. A second or third opinion may be requested by any member of the healthcare team. A member, parent(s) and /or guardian(s), or a social worker. Refer to policy UM-RPP-005 Second Opinion and Third Opinion.
16. Potential Quality Issue (PQI)
 - 16.1. The RBO's clinical staff will identify and report variations in the quality of care provided to members. Quality Indicators are used to evaluate the quality of clinical services and to measure performance, which is central to improving the quality of health care. Refer to policy UM-RPP-013 Potential Quality Issue (PQIs) Referral Process.
17. Care Management/Case Management
 - 17.1. The RBO evaluates its members for medical, social, and behavioral health care needs. When barriers or resource needs are identified, members will be referred to the Care Management Department as appropriate.
18. DME Rental to Purchase
 - 18.1. As part of the benefit verification process, the UM coordinator will review the service item if established for rental to purchase based on Medi-Cal and Medicare



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requirements.

19. Excluded Services

19.1. A member may self-refer to any qualified and willing in-network provider without prior authorization for the following services:

19.1.1. Emergency and Post-Stabilization Services, including behavioral health care (when delegated)

19.1.2. Urgent Care

19.1.3. Crisis Stabilization

19.1.4. Urgent Care for home and community services-based members

19.1.5. Family Planning Services

19.1.6. Basic Prenatal Care

19.1.7. Routine and Preventive Gynecological Care

19.1.8. Communicable Disease Services, STI and HIV Testing and Counseling

19.1.9. Sexual Assault Services

19.1.10. Sensitive Services for Minors, age 12 years and older

19.1.11. Preventive Services

19.1.12. Out of Area Renal Dialysis Services

19.1.13. Tobacco Cessation Services

19.2. In the event, a referral is submitted to the RBO for services mentioned above, the RBO will notify the member and provider of the no prior authorization requirement and withdraw the request. Refer to policy UM-APP-011 Cancelled or Withdrawn Referral Request.

20. Carve Out Services/Linked Services



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- 20.1. The member will be screened for carved out services (e.g., Regional Center, IHO, and WIC). Refer to policy UM-DCO-003 Carve Out Programs.
- 21. Local Delivery System
 - 21.1. Referrals will be evaluated to determine services requested are appropriate for the requested specialty or specialty care centers. Members will be referred to providers who have demonstrated expertise in managing specific conditions or diagnoses requiring consultation.
 - 21.2. For Medicare members, the following procedures must be performed at Medicare-certified facilities:
 - 21.2.1. Carotid Artery Stenting
 - 21.2.2. Certain oncologic PET scans
 - 21.2.3. Lung-volume reduction surgery
 - 21.2.4. Ventricular assist device (VAD) destination therapy
 - 21.2.5. To ensure the facility is Medicare Certified, the following website will be used: [CMS website https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html](https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/index.html)
 - 21.2.5.1. Refer to MS-CRD-001M HDO Appendix A Table and MS-CRD-006 Ancillary Provider Cred Recred and Oversight
- 22. Pharmacy
 - 22.1. Injectables/Infusions
 - 22.1.1. The RBO providers will refer all injectable medication requests to the UM Department for prospective review. The UM Department shall ensure the timely and efficient processing of authorization requests for drugs, when prescribed for members, that are covered under the terms of the plan's contract. Refer to policy UM-RPP-022 Injectable Medication.
 - 22.1.2. The RBO will respond to requests, as required based on line of business, as follows:



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- 22.1.2.1. For Commercial and Medicare, within 72 hours for non-urgent requests, and within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization request from a prescribing provider
- 22.1.2.2. For Medi-Cal, within 24 hours for both urgent and non-urgent requests, upon receipt of a completed prior authorization request from a prescribing provider

22.2. Step Therapy

22.2.1. The RBO will require prior authorization for pharmaceutical requests that require a prerequisite drug for a step therapy program as per regulatory standards

22.2.2. Exceptions

- 22.2.2.1. Providers must submit the Prescription Drug Prior Authorization or Step Therapy Exception Request Form to request an exception.
- 22.2.2.2. When delegated, the RBO will adjudicate the referral based on medical necessity or the plan's policies and procedures, as applicable.
- 22.2.2.3. Should additional information be required the UM designee will follow the standard process to obtain the additional information.
- 22.2.2.4. Referrals will be reviewed based on the UM Matrix.
- 22.2.2.5. Timely handling of exception requests as outlined in section 29 of this policy.
- 22.2.2.6. All decisions will be communicated as outlined in the notification section of this policy.

22.2.3. For SCAN Health Plan members, step therapy is required for the non-preferred drugs outlined by the plan. The RBO will refer to the health plan policies on step therapy, as applicable.



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22.3. Physician Administered Drugs (PADs)

- 22.3.1. The processing of a PAD request requires the use of a U.S. Food and Drug Administration (FDA) approved and nationally marketed drug. An exception can be made if Medical Necessity can be established requiring the use of a compounded alternative.
- 22.3.2. Compounded products may be dispensed only when an FDA-approved therapeutic equivalent does not exist in the marketplace or when the FDA-approved product does not meet the medical needs of the member and a compound alternative is indicated to be medically necessary.
- 22.3.3. Substitution for a generic medication is required when an equivalent generic product is available for members when the following criteria is not met:
 - 22.3.3.1. Authorization may be granted only for the lowest cost item or service covered by the program that meets the member's medical needs; and
 - 22.3.3.2. Utilize the FDA bioequivalent ratings when requiring generic substitution. The FDA has rated all generic drugs "A" or "B." Only "A" rated products are considered bioequivalent and interchangeable to the brand-name equivalents by the FDA.
- 22.3.4. Members who newly enroll in the WCM program will be permitted to continue use of any currently prescribed medication, including PADs, that is part of a prescribed therapy for the member's CCS eligible condition or conditions immediately prior to the date of transition of responsibility to the RBO, whether or not the drug requires a prior authorization, until the prescribing CCS Provider has completed an assessment of the child, created a treatment plan, and determines that the particular medication is no longer medically necessary, or the medication prescribed is no longer needed. The RBO will send the applicable notification to the member informing them of the decision, as well as their Appeal rights.
- 22.3.5. The prior authorization process is consistently applied to medications and supplies, medical/surgical, mental health, and substance use disorder medications and supplies:
 - 22.3.5.1. Quantity limits and UM restrictions will not be applied more



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stringently on mental health and substance abuse disorder drugs as compared to medical/surgical drugs.

22.3.5.2. Financial requirements or treatment limitations for mental health and substance abuse disorder drugs will not be more restrictive than those applied to medical/surgical drugs.

22.4. Medical and Pharmacy Combined Services

22.4.1. As applicable, in the event a referral is submitted with services that have both a medical and pharmacy component (e.g., office visit with pharmacy medication administration) the referral will be classified as a pharmacy request as applicable. Thus, pharmacy timeframes will be applied based on the referral type (e.g., Urgent or Routine).

22.4.2. For Medicare, when a request is received that contains both Part C items or services and Part B drugs, the RBO will process the request for Part C items or services under the Part C time frames. The request for Part B drugs will be processed under the Part B adjudication time frames.

22.5. Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)

22.5.1. The RBO shall provide coverage for the prophylaxis, diagnosis, and treatment of PANDAS and PANS when prescribed or ordered by the treating physician and surgeon and determined to be medically necessary in accordance with current nationally recognized clinical practice guidelines published in peer-reviewed medical literature or by organizations composed of expert treating clinicians (Refer to policy UM-RPP-007 Application of Clinical Criteria).

22.5.2. Covered services shall include, but are not limited to, antibiotics, behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medications, plasma exchange, and intravenous immunoglobulin therapy.

22.5.3. Coverage for PANDAS/PANS shall not be subject to a copayment, coinsurance, deductible, or other cost-sharing that exceeds that applied to other benefits provided by the member's health plan contract (Refer to Claims policies and procedures).

22.5.4. The RBO shall not deny or delay coverage for PANDAS/PANS therapies based on the member's prior receipt of treatment, including the same or similar



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treatment, or based on a prior diagnosis under a different name, including autoimmune encephalopathy.

22.6. COVID 19

22.6.1. The RBO will cover therapeutics for the treatment of COVID-19 without cost-sharing, utilization management, or in-network requirements.

22.6.2. Coverage of COVID-19 tests, immunizations, and therapeutics includes coverage of the provider visit necessary for the member to receive said test, immunization, or therapeutic.

23. Coordination of Benefits

23.1. Where there is an overlap between Medicare and Medicaid benefits, the RBO will apply the definition of medical necessity that is the more generous.

23.1.1. For EAE Medicare members, should a request not be covered by their Medicare benefits, Medi-Cal coverage criteria will then be evaluated to determine coverage.

23.2. Coordination of benefits when other health insurance is available will be done throughout the utilization process (e.g., Utilization Management, Pharmacy, and Behavioral Health). The RBO's goal is to ensure quality outcomes, uniformed benefit determination under correct payor, reduction of duplication of benefits, and increased efficiencies towards accessing care.

24. Behavioral Health

24.1. When delegated for Behavioral Health Authorization, the UM Department will:

24.1.1. Coordinate the Behavioral Health services financed and administered by county agencies.

24.1.2. Ensure the coordination of services includes at a minimum the following:

24.1.2.1. Seamless access, coordination, and delivery of covered services that are medically necessary to members who meet the medical necessity criteria based on the UM Program Description

24.1.2.2. The Specialty Mental Health 1915(b) waiver services described in Title



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9, CCR, Sections 1820.205, 1830.205, and 1830.210 is used to determine medical necessity.

24.1.2.3. The outpatient criteria can be summarized as the following three criteria: 1) diagnosis – one or more of the specified diagnose; 2) impairment – significant impairment or probability of deterioration of an important area of life functioning; or 3) intervention: services must address the impairment, be expected to significantly improve the condition, and the condition is not responsive to a physical healthcare-based treatment.

24.1.2.4. To determine medical necessity for Drug Medi-Cal Benefits, Health Network and counties will follow Title 22, California Code of Regulations Section 51303, and 54301.

24.1.2.4.1. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Title 22 Section 51159.

24.1.2.4.2. To determine medical necessity for the authorization of Covered Services that become Medi-Cal managed care Behavioral Health Services on January 1, 2014, pursuant to Welfare and Institutions Code Section 14132.03, the Health Network shall use prescribed medical necessity criteria.

24.2. The RBO shall assure that all Behavioral Health authorization and utilization management activities are compliant with US Code provisions for managed care. Health Network's must comply with the requirements for demonstrating parity for quantitative treatment limitations between Behavioral Health and medical/surgical inpatient, outpatient, and pharmacy benefits.

25. Dental

25.1. When dental services (e.g., oral cavity or sinuses) are covered under the member's medical benefit, the UM Department will:

25.1.1. Coordinate the Dental services with the member's primary dental insurance or provider rendering the medical-dental related services.

26. Clinical Trials



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- 26.1. Clinical trials will be covered for all routine patient care costs related to the clinical trial consistent with the law and as per the member's Evidence of Coverage.
 - 26.1.1. Only to a qualified member who has been accepted into a phase I, phase II, phase III, or phase IV.
 - 26.1.2. All Clinical Trials will be forwarded to the member's designated Health Plan for determination, unless specified otherwise.
- 26.2. A Qualified Member means an enrollee who meets both of the following conditions:
 - 26.2.1. The member is considered eligible to participate in an Approved Clinical Trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition; and
 - 26.2.2. Either of the following applies:
 - 26.2.2.1. The referring health care professional is a participating provider and has concluded that the enrollee's participation in the clinical trial would be appropriate, or
 - 26.2.2.2. The member provides medical and scientific information establishing that the member's participation in the clinical trial would be appropriate.
- 26.3. "Routine Patient Care Costs" does not include the following:
 - 26.3.1. Drugs, items, devices, and services specifically excluded from coverage in the contract, except for drugs, items, devices, and services required to be covered pursuant to this section or other applicable law.
- 26.4. For Cancer Clinical Trials, refer to UM-APP-008 Cancer Clinical Trials
27. Documentation
 - 27.1. All communications regarding decisions to approve and deny requests by all UM staff must be documented in the referral adjudication system, to include how the determination was made, and steps taken for such determination, as well as specify the specific health care service approved.
28. Decision Date and Time



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28.1. The decision date and time is represented within a designated field in the UM Referral System (Action Date and Time). This field represents the date and time in which a final determination was made by the respective UM staff as defined above.

29. Timeliness Standards

29.1. The UM Department adheres to federal, state, and Health Plan timeliness standards as outlined below. Please also refer to UM-RPP-002 Prior Authorization and Approval Process_TAT Grid.

Request Type	Line(s) of Business	Decision Timeframe
Urgent Concurrent	All	As expeditiously as possible; no later than 24 hours from receipt
Urgent / Expedited	All	As expeditiously as possible; no later than 72 hours from receipt
Routine / Standard	MCR, DSNP, MCL	As expeditiously as possible; no later than 7 calendar days from receipt
Routine / Standard	COM	As expeditiously as possible; no later than 5 business days from receipt
Post-Service / Retrospective	All	Within 30 calendar days from receipt

Request Type	Line of Business	Provider Notification	Member Notification	Additional Requirements
Urgent Concurrent	All	Member & Provider written: as expeditiously as possible; no later than 24 hours from receipt	Member & Provider written: as expeditiously as possible; no later than 24 hours from receipt	
Urgent / Expedited	MCR, DSNP, COM	Electronic or verbal within 24 hours of decision; not to exceed 72 hours from receipt	Written or verbal within 24 hours of determination; not to exceed 72 hours from receipt	If verbal provided, follow with written within 3 calendar days
Urgent / Expedited	MCL	Electronic or written within 24 hours of decision; not to exceed 72 hours from receipt	Written within 2 business days of decision; not to exceed 72 hours from receipt	
Routine / Standard	MCR, DSNP, MCL	Electronic or written within 24 hours of decision; not to exceed 7 calendar days from receipt	Written within 2 business days of decision; not to exceed 7 calendar days from receipt	Includes weekends and holidays
Routine / Standard	COM	Electronic or verbal within 24 hours of decision	Member & Provider written within 2 business days of determination	
Post-Service / Retrospective	MCR, DSNP, COM	Written within 30 calendar days from receipt	Written within 30 calendar days from receipt	
Post-Service / Retrospective	MCL	Written within 24 hours of decision; not to exceed 30 calendar days from receipt	Written within 30 calendar days from receipt	

All = Medicare, Medicare DSNP EAE, Medi-Cal, Commercial MCR = Medicare DSNP = Medicare DSNP EAE MCL = Medi-Cal COM = Commercial

29.2. In the event there is a disruption to the production of referral processing, to offset any potential issues of non-compliance, flexibility adjustments will be made to foster adherence to meeting decision and notification timeframes. This will be done in



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collaboration with Information Technology (IT) support and will maintain consideration of adherence to appropriate application of medical necessity decision-making practices without deviation.

29.2.1. In the event turnaround time will not be met, an inventory report will be exported and reviewed by the UM Physician Reviewer to determine if an automated push to approve authorization can be done based on the referral specialty, diagnosis, and service, while taking into consideration eligibility, benefit and network service area.

30. Standing Referrals

30.1. Standing referrals will be processed within 3 business days. Refer to policy UM-RPP-047 Standing Referrals.

31. Change of Review Priority

31.1. After a request is initiated as a standard or expedited review, a provider may contact the RBO to change the review priority.

31.2. If the provider indicates that the member's health requires an expedited decision, the RBO will begin the applicable expedited review period at the time they receive the physician's request to expedite the decision.

31.3. A change of priority does not allow for extra review time. If the remaining standard review period is less than the applicable expedited review period, the original standard deadline still applies.

32. Denial of a Medicare request for expedited status

32.1. The organization determination is transferred to the standard time frame, and a decision is required within 14 calendar days (the 14-day period starts when the request for an expedited determination is received by the Medicare health plan/delegate) for all requests that do not meet criteria for expedited review.

32.2. California board-certified licensed physicians, qualified behavioral health professional will review any behavioral/non-behavioral health denial of care based on medical necessity and can make the determination to downgrade the initial submitted status (e.g., Urgent) to the standard time frame that will accommodate the member's needs.

32.2.1. Status changes will be applicable based on referrals submitted as urgent that



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do not evidence the member's condition is such that they face an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function.

32.2.2. Notification of downgrades will be issued to the requesting provider and member as applicable, utilizing a designated notification template as defined by the health plan, and/or CMS. Refer to section 32 for additional timeframe standards.

32.2.2.1. The member will be notified of the decision to downgrade the expedited integrated determination orally as soon as possible and in writing, using the DSNP Fast Complaint Letter, within 3 calendar days after the decision is made to downgrade the expedited integrated determination.

33. Notification Standards

33.1. The RBO will notify the requesting provider and member of any decision to deny, approve, modify, or delay an authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notification may be done orally, or in writing.

33.1.1. For Medicare members, the requesting provider will also be afforded a peer-to-peer opportunity for any request, prior to issuing an adverse determination.

33.2. As mentioned above in Timeliness Standards, the RBO will provide member and provider notifications of determinations based on regulatory required standards in accordance with federal, state, and Health Plan timeliness requirements. Refer to UM-RPP-002 Prior Authorization and Approval Process_TAT Grid.

33.3. The RBO will provide verbal notice of its coverage decision to a member, followed by a written notice thereafter, consistent with the notice requirements described below. Regardless of whether the RBO can reasonably expect to notify the member of a decision verbally (e.g., if the RBO does not have a telephone number for the member on file), the RBO will ensure timely written notice is delivered to the member as specified in the ICE standards section above.

33.3.1. Verbal Notification to the member will be deemed "successful" or "delivered" as follows:

33.3.1.1. When the RBO representative speaks directly to or leaves a



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voicemail for a member or member's representative.

33.3.1.1.1. As mentioned above, the RBO may provide initial verbal notification to the member prior to issuing the written notification.

33.3.1.2. The RBO representative will explain any conditions of the approval or denial.

33.3.1.2.1. If approved, the duration of the approval will also be provided.

33.3.1.2.2. If denied the representative will provide the following information unless the member is left a voicemail, which in turn they will be asked to return the call to be given the information:

33.3.1.2.2.1. The detailed explanation of why the medical services/items were denied including a description of the applicable coverage rule or applicable Health Plan policy upon which the action was based, and a specific explanation about what information is needed to approve coverage, if applicable.

33.3.1.2.2.2. The member will also be informed of:

33.3.1.2.2.2.1. Their right to appeal or appoint a representative to file an appeal on their behalf.

33.3.1.2.2.2.2. Their right to submit additional evidence in writing or in person.

33.3.1.3. In the event the RBO representative is not able to successfully provide verbal notice (i.e., when the RBO member's telephone number is on file, but is unable to reach the member at the number



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provided because, for example, it is either incorrect, out-of-service, or no person (or no voicemail system) answers), written notice must be sent within the applicable timeframe.

33.3.1.4. The representative will document in the referral system:

33.3.1.4.1. The date and time of each contact, will be documented in the referral system

33.3.1.4.2. The call record(s) will include specific information on who was contacted and the notification discussion.

33.3.1.5. Written notice of the decision (when written notification is required) is sent to the member within the applicable timeframe as per federal, state, and Health Plan timeliness requirements; and

33.3.1.6. The RBO is not at fault for its inability to reach the member by phone (e.g., the RBO did not make a transcribing error when writing the telephone number).

33.3.1.7. Verbal notification will be given to the provider, as applicable, in alignment with the steps outlined for the member verbal notification

33.3.1.7.1. Verbal notification may be necessary if a provider is not enrolled on the provider portal to obtain electronic notification

33.3.2. Coverage decisions notifications to members will be tailored should the member have communication barriers.

33.3.2.1. Members with cognitive barriers:

33.3.2.1.1. Referred to community resources (e.g., Regional Center, Department of Aging, Community Advocates);
or

33.3.2.1.2. Internal referral to Care Management

33.3.2.2. Members with correspondence barriers included but not limited to:



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33.3.2.2.1. Homeless (e.g., e-mail, web portal)

33.3.2.2.2. Institutionalized (e.g., fax)

34. Duration of the authorization

34.1. For initial requests for treatment, if the requested medical treatment, services, and/or procedure are covered by the RBO and meet the established criteria, the request will be approved for a duration of ninety (90) days. The duration may be expanded during a Declared Federal or Natural Disaster. Refer to policy UM-RPP-001 UM authorization Referral Request. Except when standing. Refer to policy UM-RPP-047 Standing Referrals.

34.1.1. Additionally, the RBO will follow the requirements for disasters and emergencies outlined in 42 CFR § 422.100(m).

34.2. For requests for members undergoing an active course of treatment, the request will be approved and valid for as long as medically necessary to avoid disruptions in care, in accordance with applicable coverage criteria, the individual patient's medical history, and the treating provider's recommendation.

35. Template notifications

35.1. The RBO utilizes all approved health plan letter templates when applicable (approval/denials).

35.1.1. When notifying a Medicare Advantage enrollee that a service, item, or Part B drug is not covered—either fully or partially—the RBO will:

35.1.1.1. Issue the Initial Determination Notice (IDN) or

35.1.1.2. Include the Office of Management and Budget (OMB)–approved standardized language in the Explanation of Benefits (EOB), when applicable.

35.1.2. In the event the required OMB-approved standardized language is not provided, or there is the absence of a clear exclusion in the member's Evidence of Coverage (EOC) the member will not be financially liable for the denied services, items, or Part B drugs when provided by a contracted provider or referred by a contracted provider.

35.2. The provider and member notifications are processed according to ICE timeliness



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standards based on line of business.

- 35.3. Approval letters are date-stamped as of the decision date
- 35.4. For Medicare members, CMS notifications (including authorizations and denials) are sent to the member via mail in an envelope that has the words "Important Plan Information" in 12-point font on the front of the envelope.
- 35.5. For Health/Wellness, the words "Health or Wellness or Prevention information" shall appear in 12-point font on the front of the envelope.
- 35.6. Notice 1557 taglines and disclaimer
 - 35.6.1. All member communication notices will include the 1557 taglines and disclaimers
 - 35.6.2. Letter templates are automated in the referral system and are part of the member approval or denial packet
 - 35.6.3. Letter templates are updated by IT within 30 days of Health Plan notification of template updates.
- 36. Denial Letters
 - 36.1. Denial letters are not auto generated but are instead printed and mailed to the member, and a copy is given to the provider. Refer to policy UM-RPP-003 Denial Review and Notification.
 - 36.2. The UM Coordinator will fax/telephone the practitioner(s) a copy and send a computerized approval letter to the member via the U.S. Postal services.
 - 36.3. The UM coordinator is responsible for contacting the member via telephone offering, assistance as appropriate.
 - 36.4. Online access to view the authorization is available for participating providers
 - 36.5. The RBO will provide the member notice of modification, termination, or reduction of an authorization request.
 - 36.6. Modification of the duration of any approved therapy or the length of stay in an acute inpatient facility if the RBO provides an opportunity for the provider to request



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additional therapy or inpatient days before the end of the approved duration of therapy or length of stay. The RBO will provide the member notice of action taken to terminate or reduce a treatment regimen already in place.

- 36.7. In the case of concurrent review, care shall not be discontinued until the member's treating provider has been notified of the Health Plan's decision, and a plan of care has been agreed upon by the treating provider to meet the member's needs.
- 37. Mailing of letters
 - 37.1. Mailing of letters are sent as per policy UM-APP-004 UM Mail Room Process.
- 38. Sensitive Services
 - 38.1. Sensitive and Prevention Services include:
 - 38.1.1. Family planning services and pregnancy services, including pregnancy termination;
 - 38.1.2. Sexual assault including rape diagnosis and treatment and collection of medical evidence;
 - 38.1.3. Diagnosis and treatment of sexually transmitted diseases;
 - 38.1.4. HIV counseling, testing, and treatment;
 - 38.1.5. Drug alcohol and/or substance abuse services for children ages 12 and older, except for replacement narcotic abuse and treatment; and
 - 38.1.6. Outpatient behavioral health counseling and treatment
 - 38.2. No mailing of member information for the above services will transpire. Providers are expected to contact the member and assist with care coordination. The RBO will assist with care coordination per the RBO confidentiality requirements.
 - 38.3. Refer to policy UM-RPP-034 Ensuring Timely Access to Confidential and Sensitive Services
- 39. Advance Premium Tax Credit (APTC)



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- 39.1. For open authorizations for Advanced Premium Tax Credit (APTC) members delinquent in the payment of monthly premiums payment during the second and third months of the delinquency period referred to as grace period can have their authorizations denied or rescinded. Refer to policy UM-APP-005 APTC Delinquency.
- 39.2. The RBO shall not rescind or modify an approved authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the health plan's subsequent rescission, cancellation, or modification of the enrollee's or subscriber's contract or the subsequent determination that an accurate determination of the enrollee's or subscriber's eligibility was not made at the time of approval. The exception is the Advanced Premium Tax Credit (APTC) members delinquent in the payment of monthly premiums. Refer to policy UM-APP-005 APTC Delinquency.
40. Peer to Peer
 - 40.1. The RBO affords providers the opportunity to request a peer-to-peer discussion regarding the request or decision of the request. The UM staff can help coordinate the peer-to-peer or the requesting provider can contact the PR/MD directly per the Peer-to-Peer notification form.
41. Criteria Disclosure
 - 41.1. The RBO maintains a record of the request(s) for disclosure and copies of responses to Providers, Members, and the Public. All disclosures will be maintained in the disclosure log and presented to the UM committee meeting on an annual basis.
 - 41.2. Disclosure includes policies, procedures, and criteria used to make a determination for requests submitted by contracted and non-contracted healthcare practitioners and providers. Refer to policy UM-RPP-007 Application of Clinical Criteria.
42. Utilization Monitoring
 - 42.1. The RBO will perform various types of monitoring to include but not limited to:
 - 42.1.1. Inter-Rater Reliability: The inter-rater reliability (IRR) monitors and measures the consistency of application of review criteria and to act on opportunities to improve consistency in the application of criteria currently being utilized by the RBO. Refer to policy UM-APP-002.
 - 42.1.2. Tableau Dashboard Reports: The RBO has developed an executive wide



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reporting tool that provides real time data on referral volume, productivity, and aging. Aging reports can be filtered by status (i.e., Urgent, Routine).

43. Unused authorizations

43.1. On a quarterly basis the UM department will perform an Auth/Claims reconciliation report that will be distributed its network providers (e.g., PCP and Specialist) to assist in coordinating and tracking the care of the members

43.2. The report will be cross walked to the member's eligibility. If the member is deemed termed or inactive the authorization will be allowed to expire with a note of the reconciliation verification. Refer to policy UM-APP-016 Unused or Expired Referrals.

44. Denial internal audit review

44.1. The UM Chairperson and/or Designee will review the medical appropriateness of medical and benefit denials. Additionally, the RBO UM nurse will review any denial letters performing a quality assurance verification prior to the letter being finalized and sent to member/provider.

45. Preclusion Monitoring

45.1. Every month UM receives a Preclusion report from the IPA Operations department listing providers within the network, both contracted and non-contracted, if under LOA.

45.2. The report is forwarded to UM analytics and cross-walked to open/unused authorizations.

45.3. UM analytics will develop a report with any identified members impacted.

45.3.1. Should the UM analytics team determine there is no member impact during the reporting period, an attestation will be generated.

45.4. Any report or attestation will be sent monthly to the corresponding Health Plan.

46. American Indian Member Rights and Protections

46.1. The RBO will permit American Indian members to obtain covered services from an out-of-network Indian Health Care Provider (IHCP) without requiring prior authorization. IHCPs, in-network or out-of-network, can provide referrals directly to in-network providers without a referral or prior authorization.



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- 46.2. An American Indian member may receive services from an out-of-network IHCP even if there are in-network IHCPs available. When an American Indian member requests to receive services from an IHCP, and there is no in-network IHCP available, the RBO will assist the member in locating and connecting with an out-of-network IHCP.
- 47. Proclamation of a State of Emergency or Extenuating Circumstances
 - 47.1. In the event a state of emergency is declared, or circumstances are deemed extenuating, the RBO will enact the UM Action Plan.
 - 47.2. Please referral to Altura_UM Action Plan

Forms & Resources

- 1. Turn Around Time (TAT) Grid
- 2. Altura_UM Action Plan

References and Citations

- 1. All Plan Letter (APL) 16-014 Tobacco Cessation
- 2. California Code of Regulations (CCR) Section 51303 Health Care Services
- 3. California Health and Safety Code (CA HSC) 1371.8 Licensing Provisions
- 4. California Health and Safety Code (CA HSC) 1367.241 Licensing Provisions
- 5. Center for Medicare and Medicaid Services (CMS) Medicare Managed Care Manual Chapter 13 Organization Determinations
- 6. CMS Memorandum October 18, 2016 – Provider Outreach Requirements
- 7. CMS 4182 Final Rule
- 8. CMS 4159 Final Rule
- 9. Code of Federal Regulations (CFR) 422.568 Standard timeframes and notice requirements for organization determinations.
- 10. National Committee on Quality Assurance (NCQA) Standards and Guidelines



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11. Industry Collaboration Effort (ICE) Timeliness Standards
11. Commercial - <http://www.iceforhealth.org/library.asp?sf=&scid=702#scid702>
12. Medi-Cal - <http://www.iceforhealth.org/library.asp?sf=&scid=1389#scid1389>
13. Medicare - <http://www.iceforhealth.org/library.asp?sf=&scid=2431#scid2431>
14. 42 CFR §422.566(a)
15. 42 CFR §423.566(a)
16. 42 CFR §156.122
17. CMS Memorandum February 22, 2017 Updated Guidance on Outreach for Information to Support Coverage Decisions
18. CMS Memorandum May 22, 2020 Information Related to Coronavirus Disease 2019 - COVID-19
19. APL 20-018
20. APL 22-032
21. SB 612 Speech-Language Pathologists
22. APL 24-002
23. AB 2105 (Lowenthal, Ch. 822, Stats. 2024)—Coverage for PANDAS and PANS
24. 1557 Nondiscrimination in Health Programs and Activities Final Rule

Definitions

Term	Definition
Referral	A treatment authorization request.
Medicare Medically Necessary Services	Those services reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body part or otherwise medically necessary.



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Medi-Cal Medically Necessary Services	Those services reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Concurrent 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 organization did not previously approve the earlier care.
Urgent Request	When the member's condition is such that the member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function.

Company/Client Approval(s)

Date	Company/Client	Approve By (Full Name – Title)
07/01/2020	Altura MSO	Bonnie Orellana, VP Medical Management
02/11/2021	AltaMed Health Services	Dr. Ursula Baffigo, Senior Medical Director
02/11/2021	Omnicare Medical Group	Dr. Ursula Baffigo, Senior Medical Director
02/10/2022	AltaMed Health Services	Dr. Ursula Baffigo, Senior Medical Director
02/10/2022	Omnicare Medical Group	Dr. Ursula Baffigo, Senior Medical Director
05/26/2022	AltaMed Health Services	Dr. Patricia Auchard, Interim Senior Medical Director
05/26/2022	Omnicare Medical Group	Dr. Patricia Auchard, Interim Senior Medical Director
02/09/2023	AltaMed Health Services	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
02/09/2023	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
08/24/2023	LaSalle Medical Associates	Dr. Albert Arteaga, President
02/08/2024	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
02/15/2024	AltaMed Health Services	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
02/15/2024	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
05/07/2024	AltaMed Health Services	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
05/07/2024	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
05/09/2024	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
08/06/2024	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
08/06/2024	AltaMed Health Services	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
08/08/2024	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
11/12/2024	AltaMed Health Services	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
11/12/2024	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
11/14/2024	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
02/13/2025	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
02/18/2025	AltaMed Health Services	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
02/18/2025	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
05/06/2025	AltaMed Health Services	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
05/06/2025	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
05/08/2025	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
05/14/2025	Family Choice Medical Group	Dr. Alan Adler, Medical Director
08/05/2025	AltaMed Health Services	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer



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08/05/2025	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
08/07/2025	LaSalle Medical Associates	Dr. Jasmine Sharma, Medical Director
08/13/2025	Family Choice Medical Group	Dr. Alan Adler, Medical Director
08/27/2025	Golden Physicians Medical Group	Dr. Dat Nguyen, Medical Director
11/11/2025	AltaMed Health Services	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
11/11/2025	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
11/12/2025	LaSalle Medical Associates	Dr. Jasmine Sharma, Medical Director
11/13/2025	Family Choice Medical Group	Dr. Alan Adler, Medical Director
11/19/2025	Golden Physicians Medical Group	Dr. Dat Nguyen, Medical Director
02/10/2026	AltaMed Health Services	Dr. Thomas Kim, Vice President, Associate Chief Value Officer
02/11/2026	Family Choice Medical Group	Dr. Alan Adler, Medical Director
02/12/2026	LaSalle Medical Associates	Dr. Jasmine Sharma, Medical Director
02/25/2026	Golden Physicians Medical Group	Dr. Dat Nguyen, Medical Director
03/09/2026	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Associate Chief Value Officer

Version History

Date	Company/Client	Action Description
11/06/2020	Omnicare Medical Group	Annual Approval
08/24/2023	LaSalle Medical Associates	Initial Adoption and Approval
03/01/2025	Family Choice Medical Group	Initial Adoption and Approval
05/01/2025	Golden Physicians Medical Group	Initial Adoption and Approval