



Policy and Procedure

Policy Title: Denial Review and Notification
Policy No.: UM-RPP-003
Issuing Dept.: Utilization Management
Applicable To: M-Cal Comm Medicare
Effective Date: 07/01/2020
Last Review Date: 03/09/2026

Purpose

1. To provide a mechanism to notify members, practitioners, and health plans of denial for requested services for Non-Behavioral Health, Pharmacy, and Behavioral Health (when delegated by the Health Plan).

Policy

1. The Risk Bearing Organization (RBO) Utilization Management (UM) decision making is based only on appropriateness of care and service and existence of coverage. It does not provide compensation for practitioners or other individuals conducting utilization review for issuing denials for coverage or service or delay care.
2. All Non-Behavioral Health or Behavioral Health medical necessity denials of a requested health care service, in whole or in part, must be reviewed by a California licensed physician or a California licensed health care professional (e.g. pharmacist) who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider and may make an adverse determination to deny or modify requests for services by using clinical reasons for the decisions regarding medical necessity referencing description of criteria or clinical guidelines.
 - 2.1. A qualified unrestricted applicable California license for appropriate fields of practice (e.g. physician, pharmacist) reviews 100% of denials.
 - 2.2. The licensed reviewer (e.g. physician, pharmacist) must have knowledge of, but not limited to:
 - 2.2.1. Medicare coverage criteria
 - 2.2.2. Medi-Cal coverage criteria
 - 2.2.3. Health Plan-specific policies and guidelines
 - 2.2.4. Evidence-based review criteria
 - 2.3. 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.
 - 2.3.1. The information can be provided as a separate roster, upon request
3. Coverage decisions notifications to members will be tailored should the member have communication barriers. (Refer to UM-RPP-002).



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

4. The RBO does not deny for failure to obtain a prior approval when approval would be impossible or where a prior approval process could seriously jeopardize the life or health of the member.

Procedure

1. All denials or modifications based on non-Behavioral Health and Behavioral Health denials (when delegated by the Health Plan) will be reviewed based on medical necessity, non-covered benefit, carve-out services, termination of services or investigational/experimental services or device are reviewed as follows:
 - 1.1. Referral request is received through the standard UM referral process (UM-RPP-002 Prior Authorization and Approval Process).
 - 1.2. The request(s) for services that do not meet medical necessity criteria as per the utilization review criteria, carve-out services, termination of services, or non-covered benefits, or if the nurse reviewer requires further medical review, are forwarded to the licensed reviewer (e.g. physician, pharmacist) via the authorization system routing mechanism.
 - 1.2.1. The licensed reviewer (e.g. physician, pharmacist) assess the relevant clinical information used to support UM decisions. Such as:
 - 1.2.1.1. Office and hospital records such as evaluations, treatment plans or progress notes from PCPs or specialists, which outline the member's presenting problem
 - 1.2.1.2. Results of diagnostic testing, operative and pathology reports
 - 1.2.1.3. Patient psychosocial history
 - 1.2.1.4. Photographs
 - 1.2.1.5. A printed copy of criteria related to the request
 - 1.2.1.6. Information regarding benefits for services or procedures
 - 1.2.1.7. Information regarding the local delivery system
 - 1.2.1.8. Information from responsible family members
 - 1.2.1.9. If CCS-eligible child/youth – the Service Authorization Request (SAR)



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

2. The licensed reviewer (e.g. physician, pharmacist) will review all available information for medical necessity, carve-out services, termination of services, or benefit coverage. The licensed reviewer (e.g. physician, pharmacist) can make an initial determination to:
 - 2.1. Approve, modify, or deny the services;
 - 2.2. Carve-out services or terminate services; or
 - 2.3. Request for an extension for additional information.
3. If the services are approved, the licensed reviewer (e.g. physician, pharmacist) will document his determination in the authorization adjudication system listing the criteria used to make his/her determination change the status to approve and the authorization adjudication system will auto-close the authorization generating an approval notice to the member and provider (UM-RPP-002 Prior Authorization and Approval Process).
4. If the services are extended (when in the best interest for the member) for more information the licensed reviewer (e.g. physician, pharmacist) will document:
 - 4.1. The specific reason(s) for the extension, in easily understandable language
 - 4.2. When appropriate a reference of the benefit provision, criteria/guideline, protocol, or other similar criterion on which the determination was based
 - 4.2.1. When applicable the citation of the specific regulation or plan authorization procedure supporting the action
 - 4.3. When the member can expect the determination
5. If an extension is requested by the licensed reviewer (e.g. physician, pharmacist), he/she will route the case back to the nurse reviewer or UM coordinator assigned to the case who will ensure that the information needed to determine medical necessity will be collected based on federal, state, and Health Plan timeliness standards.
6. When making a determination based on medical necessity, only information reasonably necessary to make a decision will be requested. [CA Health & Safety Code §1367.01 (g)]
 - 6.1. No determination by a licensed reviewer (e.g. physician, pharmacist) will be issued orally. All adverse decisions will have a documented review, including the clinical criteria used to make the final determination as specified in section 7 of this policy.



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

7. Upon the licensed reviewer (e.g. physician, pharmacist) determining the member does not meet medical necessity, services are carved-out, services need to be terminated, or benefit criteria they will document:
 - 7.1. The criteria utilized to make the determination based on hierarchy
 - 7.2. What elements within the criteria/guideline, protocol or other similar criterion were not met
 - 7.3. The specific reason for the denial/carve-out/termination, in easily understandable language
 - 7.3.1. When applicable the citation of the specific regulation or plan authorization procedure supporting the action
 - 7.4. Their full name and credentials within the note
8. The licensed reviewer (e.g. physician, pharmacist) will forward the request via the routing configuration within the authorization system to the denials team to proceed with the letter generation for member and provider notification based on federal, state, and Health Plan timeliness standards for each product line.
 - 8.1. For members with a terminal illness, the notification shall be provided within five business days, or as required by regulatory standards, to include the reason for denying coverage, as applicable.
 - 8.2. For Medi-Cal and EAE Medicare members, notification must be sent 10 days prior to the termination, suspension, or reduction of a previously approved service(s) or item(s).
9. The Denial Coordinator will send a copy of the written behavioral/non-behavioral healthcare denial/carve-out/termination notification to the member (or member's authorized representative), providers, and health plan, as applicable.
 - 9.1. The applicable templates, as indicated by the regulators and/or health plan (i.e., the DHCS-developed, standardized Notice of Action (NOA) template and subsequent attachments, CMS Applicable Integrated Plan Coverage Decision Letter, etc.) are configured within the UM Referral system for auto-selection based on defining factors, that may include but is not limited to, member's health plan, line of business, health plan CMS contract code, health plan option code, etc.
 - 9.2. The configured templates include all applicable inserts as indicated based on defining



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

factors (i.e., State Fair Hearing form, IMR form, Your Rights, Language Assistance, etc.)

9.3. The notification will include:

9.3.1. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.

9.3.1.1. Expedited external review can occur concurrently with the internal appeals process for urgent care.

9.3.2. A reference to the benefit provision, guideline, protocol, or other similar criteria on which the denial/carve-out/termination is based.

9.3.3. List the name and telephone number of the health care professional responsible for the denial, delay, carve-out, termination, or modification.

9.3.3.1. The telephone number provided shall be a direct number or an extension.

10. The letters are computer-generated and are sent to the member as per federal, state, and Health Plan timeliness standards for each product line.

11. Denial, Carve-out, termination, or modification letters will contain the following:

11.1. Clear rationale and specific reasons for the denial in easily understandable language.

11.1.1. 8th Grade Level language for Medicare.

11.1.2. 6th Grade Level language for Medi-Cal.

11.1.3. Common reasons for denial may include the following (as applicable):

11.1.3.1. The referred to provider is not contracted with the RBO

11.1.3.2. The service does not meet utilization review criteria or benefits package.

11.1.3.3. The member was determined to be ineligible at the time the service and/or treatment were requested.



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

- 11.1.3.4. The service is not a covered benefit (this includes “Carve-Out” plans).
 - 11.1.3.4.1. Include an explanation why the service is considered a ‘carve-out.’
- 11.1.3.5. The member’s benefits for that service have been exhausted.
- 11.1.3.6. The primary care physician may provide the service(s) requested.
- 11.2. The appropriate identity of the experts included in the decision-making resulting in an adverse determination.
 - 11.2.1. Including a method for contacting the reviewer.
 - 11.2.1.1. The method expressing how the RBO affords providers the opportunity to request a peer-to-peer discussion.
 - 11.2.2. The availability of appropriate practitioner reviewers in instances of medical necessity denials to ensure that practitioners and members receive information sufficient to understand and decide about appealing an adverse determination.
- 11.3. A reference to the benefit provision, guideline, protocol, or other similar criteria on which the denial is based.
- 11.4. A statement indicating translation assistance is available if necessary.
- 11.5. The Department of Managed Health Care (DMHC) Statutory Required Paragraph with DMHC, the state and health plan toll-free telephone numbers for obtaining information on legal service organizations representation.
 - 11.5.1. To include the telephone number for the local Legal Aid Society.
 - 11.5.2. The TDD line & DMHC website address all printed in a 12-font bold face type.
- 11.6. The reviewer’s unique electronic signature or identifier on the denial letter or on the notation of denial in the file.
- 12. Appeal language will include the following:



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

- 12.1. An explanation regarding the appeals process both with the RBO and the member's appropriate health plan including the right to member representation and time frames for appeal decisions.
- 12.2. Required appeal language.
- 12.3. Description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.
 - 12.3.1. Grievance procedure and member's right to call the department for assistance when a grievance involves an emergency, was satisfactorily resolved, or has remained settled for more than 30 days.
- 12.4. The 1557 Notices are attached to all member communication
 - 12.4.1. Language Assistance Taglines
 - 12.4.2. Nondiscrimination Notice
- 12.5. Notice of the member's right to bring a civil action under ERISA Section 502(a)(1)(B) and in accordance with Title XXII, Fair Hearing rights as related to Denial, Termination or Reduction in Service.
13. Upon request, the member, practitioner, and the public may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criteria on which the denial was based free of charge.
 - 13.1. A disclosure of the specific utilization review criteria/guideline or benefit provision used as a basis for the denial will be sent to the member and the provider.
 - 13.2. The disclosure that the member can obtain a copy of the actual benefit provision, guideline, or protocol, or other similar criterion on which the denial was based shall be accompanied by the following notice:
 - 13.2.1. *"The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."*
 - 13.3. A tracking log will be maintained to identify the number of requests each year.



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

14. The denial, carve-out, termination or modification notification may include the following based on line of business: (may be oral and/or written/electronic)
 - 14.1. Includes a statement that members may be represented by anyone they choose, including an attorney.
 - 14.2. Provides contact information for the state Office of Health Insurance Consumer Assistance or ombudsman, if applicable.
 - 14.3. States the timeframe for filing an appeal.
 - 14.4. States the organization's timeframe for deciding the appeal.
 - 14.5. The notification to the practitioner is not required to include the member's right to representation if the practitioner is not acting as an authorized representative.
 - 14.6. Includes a statement of non-discrimination.
 - 14.7. Where applicable, voicemail messages are not an acceptable form of oral notification or refer to UM-RPP-002 Prior Authorization and Approval Process, Notification Standards section 28.2.

15. For Medi-Cal members:
 - 15.1. Member's right to call the State Medi-Cal Managed care Ombudsman Office for answering questions or help in appealing the decision.
 - 15.2. Member's right to, and method of obtaining, a fair hearing to contest the denial, deferral, or modification action and the decision the IPA has made.
 - 15.3. Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, attorney friend, or other spokesperson.
 - 15.4. Name and address of the RBO and State toll-free telephone number for obtaining information on legal service organization for representation.
 - 15.5. Member's right to appeal within at least 90 days to appeal the decision through the health plan's grievance/appeal process.
 - 15.6. Member's right to appeal to the Department of Managed Health Care (DMHC) if not



Policy and Procedure

Policy Title: Denial Review and Notification
Policy No.: UM-RPP-003
Issuing Dept.: Utilization Management
Applicable To: M-Cal Comm Medicare
Effective Date: 07/01/2020
Last Review Date: 03/09/2026

satisfied with the appeal decision at the Plan Level

16. Member, provider, practitioner, and the public can obtain, upon request, a written statement describing the availability of diagnosis and treatment codes and their corresponding meaning. Source Documentation: [29 CFR 2590.715-2719(b)(2)(ii)(E)(1); 45 CFR 147.136(b)(2)(ii)(E)(1)]

16.1. Consumer Resources

- 16.2. A statement of additional consumer resources may include Source Documentation: [29 CFR 2590.715-2719 (b)(2)(ii)(E)(4); 45 CFR 147.136(b)(2)(ii)(E)(4)]

- 16.3. Other resources to help you: Do you have questions about your appeal rights or this notice? Need help with an appeal? You can get help from the Consumer Assistance Program (CAP) in California.

California Department of Managed Health Care Help Center

Toll Free: 1-888-466-2219 TDD/TTY 1-877-688-9891

<http://www.healthhelp.ca.gov>

17. Non-Medical Necessity Denials/Administrative Denials

- 17.1. The RBO classifies all non-medical necessity decisions as either categorical (non-covered benefit) or numerical (benefit exhaustion) and will include any supporting materials (e.g., EOC, Summary of Benefits, or State and Federal regulations).

17.2. Decisions about the following do not require medical necessity review:

17.2.1. Services that are limited by number, duration, or frequency, based on the member's specific benefit plan

17.2.2. Extension of treatment beyond the specific limitations and restrictions as set forth by the member's specific benefit plan

17.2.3. Care or services whose coverage does not depend on any circumstances

17.2.4. Requests for personal care services or assistance with other activities of daily living (ADL)



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

17.2.5. Experimental or investigational requests that are always excluded and never deemed medically necessary under any circumstance

17.2.5.1. The RBO will identify the specific service or procedure excluded from the member's benefit plan; or

17.2.5.2. The RBO will utilize the Health Plan's materials to provide the member with additional information related to exclusions or will proceed as deemed by the Health Plan

17.3. All letters will include the appropriate attachments regarding the need and right for assistance with interpretation of documents.

18. Appeals:

18.1. Appeals are a non-delegated function by the Health Plans to the RBO. The RBO ensures that identified member reconsiderations are referred to the plan within 24 hours of receipt (Refer to Policy UM-APP-003 UM Handling of Grievances and Appeals).

18.2. Should the RBO receive additional clinical information regarding a denial already provided to a Medicare beneficiary within 65 days of the denial notice, the RBO will forward that information to the Health Plan within 24 hours of receipt for the Health Plan to render a reconsideration. This includes clinical information received in writing or from a Peer-to-Peer.

19. Reopening Organizational Determinations:

19.1. The RBO may receive requests to reopen organizational determinations for Medicare Advantage beneficiaries.

19.2. Reopens may be initiated by one of the following:

19.2.1. Health Plan revises the initial determination or level 1 appeal decision (as delegated by the health plan)

19.2.2. Independent Review Entity (IRE) revises the reconsidered determination

19.2.3. Administrative Law Judge (ALJ) or attorney adjudicator revises his or her decision



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

19.2.4. The Council revises the ALJ or attorney adjudicator decision or its review decision

19.3. A determination will be reopened if the following are met:

19.3.1. There is no appeal in process.

19.3.1.1. Refer to QM-PRO-003. UM will receive all Appeal information from the Member Services - Grievance & Appeals Department. Upon UM verification and confirmation, the request is not under an appeal UM can proceed with the reopening process.

19.3.2. The request is received verbally or in writing.

19.3.2.1. Peer to peer call can be considered a reopening if verbal or written request is received.

19.3.3. The request for reopening must be clearly stated.

19.3.4. The request must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening and should not be submitted).

19.3.5. The request should be made within the timeframes permitted for reopening:

19.3.5.1. Within 1 year from the date of the organization determination or reconsideration for any reason (if the case is not under appeal).

19.3.5.2. Within 4 years from the date of the organization determination or reconsideration for good cause such as new evidence that was not available or known at the time of the original decision or the evidence used in making the original decision was in error (ex. clerical errors or omissions such as mathematical or computational mistakes, inaccurate data entry or coding, computer errors, or denial of claims as duplicates).

19.3.5.3. If the request does not meet these requirements, then the requester will be directed to contact the health plan and follow the appeal process.



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

- 19.3.6. The request for reopening is for good cause or there is reliable evidence of fraud or similar theft.
- 19.3.7. Services may not be denied for medical necessity if they were previously approved through prior authorization or a pre-service determination.
- 19.4. Timeframes for making reopening decisions:
 - 19.4.1. Standard: 30 calendar days from the date of the written request for reopening.
 - 19.4.2. Expedited: No later than 72 hours from the receipt of the request.
 - 19.4.3. At any time if there exists reliable evidence (e.g., relevant, credible, and material) that the initial determination or level 1 appeal was procured by fraud or similar fault.
 - 19.4.4. At any time for the purpose of correcting a clerical error on which the determination was based.
 - 19.4.5. At any time to effectuate a decision issued under the coverage National Coverage Determination (NCD) appeals process
 - 19.4.6. Or as specified in the Full-Service Health Plan's policies and procedures.
- 19.5. Notification of Reopening Decisions
 - 19.5.1. A written notice to the parties of the updated decision will be issued
 - 19.5.1.1. The written notice will:
 - 19.5.1.1.1. State the rationale and basis for the reopening and revision
 - 19.5.1.1.2. State the specific reason for the revision or change in rationale, written in a manner that is understandable to the member
 - 19.5.1.1.3. Provide information on any appeal rights
 - 19.5.2. If a reopening results in issuance of payment to a provider, a revised remittance



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

advice notice must be issued.

19.6. If the request is dismissed/denied the requester and/or provider is sent written notification with the appeal information.

19.6.1. A dismissed reconsideration can occur under the following circumstances:

19.6.1.1. An individual requests a reconsideration on behalf of the member, but a properly executed appointment of representative form has not been filed and there is no other documentation to show that the individual is legally authorized to act on the member's behalf. This does not relieve the RBO of its obligation to make attempts to secure the missing documentation.

19.6.1.2. The member or the party fails to file the reconsideration with the established timeframes and good cause for late filing has not been established.

19.6.1.3. The RBO becomes aware that the member has obtained the service before the RBO completes its pre-service reconsideration.

19.6.1.4. It is determined by the Plan that the individual or entity making the request failed to make a valid request for an organization determination or coverage determination.

19.6.1.5. The beneficiary/member expires while the request is pending, and the member's spouse or estate has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the organization determination or coverage determination.

19.6.1.6. Any other circumstance where the RBO lacks jurisdiction to review the case.

19.6.2. Notice of Dismissal will contain:

19.6.2.1. The reason for dismissal

19.6.2.2. The right to request that the RBO vacate the dismissal action.

19.6.2.3. The right to request reconsideration of the dismissal.



Policy and Procedure

Policy Title: Denial Review and Notification
Policy No.: UM-RPP-003
Issuing Dept.: Utilization Management
Applicable To: M-Cal Comm Medicare
Effective Date: 07/01/2020
Last Review Date: 03/09/2026

19.6.3. Vacating a dismissal

19.6.3.1. If good cause is established, the RBO may vacate its dismissal of a request for an organization determination within six (6) months from the date of the notice of dismissal. The RBO will perform an initial determination consistent with the applicable adjudication timeframe. The good cause resulting in the dismissal will be clearly documented in the UM referral system.

19.6.3.1.1. If the RBO is unable to establish good cause to vacate the dismissal, the dismissal will remain. The RBO will issue the Refusal to Vacate Dismissal Notice indicating that good cause has not been established and the dismissal cannot be vacated. The notice will be written in clear and concise language that explains why the information submitted with the request to vacate the dismissal does not establish good cause to vacate the dismissal action.

20. Appropriately qualified licensed health professionals supervise all medical necessity decisions.
21. California licensed reviewers (e.g. physician, pharmacist) will review any behavioral/non-behavioral health denial of care based on medical necessity.
 - 21.1. Practitioners will be given the opportunity to discuss any behavioral/non-behavioral health utilization management denial decision with a physician or health care professional reviewer or obtain a copy of the criteria used to make the decision, or to call the RBO at (855) 848-5252.
22. The member is to be notified in writing of the expert/specialty practitioner whose advice was obtained in connection with an adverse determination upon member's request. This must be done without regard to whether the advice was relied upon to make determination.
23. The UM Chairperson or designee will be available to the requesting practitioner to discuss by telephone any determinations based on medical appropriateness.
24. All expedited appeals will be processed in compliance with time frame required by Centers for Medicare and Medicaid Services (CMS) and in accordance with health plans process.
25. Reason for the denial takes into account the members presenting medical conditions, disabilities, and any special language requirements.



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

26. The RBO UM process does not allow processing staff to change the denial criteria cited by the licensed reviewer (e.g. physician, pharmacist) in the case notes as it is transferred to the member denial notice.
27. Processing staff is instructed not to alter the denial reason cited by the licensed reviewer (e.g. physician, pharmacist), with the exception of punctuation or grammar. There must be documented evidence that the licensed reviewer (e.g. physician, pharmacist) has reviewed and approved the change.
28. Speech Therapy
 - 28.1. Speech therapy is included as basic health care services under the Knox-Keene Act. Therefore, any denial must be based upon lack of medical necessity. Denials cannot be based on absence of coverage for such services or based upon lack of physical impairment, or absence of a physical cause for the member's condition, or on the basis that a member does not have a sufficient physical ailment to trigger coverage under clinical guidelines.
 - 28.2. All decisions are based upon medical necessity utilizing guidelines consistent with DMHC requirements, the Knox-Keene Act, and any other California and federal law.

Forms & Resources

1. Not Applicable

References and Citations

1. California Health and Safety Code Section 1367.01 (e) and (g), 1371.8 and AB 1455
2. Code of Federal Regulations (CFR) 2590.715 – Documentation of Plan or Policy Terms
3. CFR 147.136 – Internal claims and appeals, external review process
4. National Committee on Quality Assurance (NCQA) Standards and Guidelines – Appropriate Professionals, Denial Notices
5. HICE Timeliness Standards- Commercial, Medi-Cal, and Medicare Timeliness Standards
6. Code of Federal Regulation (CFR) 29 Section 2560.503-1(b)(3)
7. Parts C&D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance;



Policy and Procedure

Policy Title: Denial Review and Notification
Policy No.: UM-RPP-003
Issuing Dept.: Utilization Management
Applicable To: M-Cal Comm Medicare
Effective Date: 07/01/2020
Last Review Date: 03/09/2026

Section 80 Reopening and Revising Determinations and Decisions

Definitions

Term	Definition
Medically Necessary Services	<p>Medical, dental, behavioral, rehabilitative, or other health care services which:</p> <ol style="list-style-type: none"> 1. Are reasonable and necessary to prevent illness or medical conditions, or provide early screening, interventions, and/or treatment for conditions that cause suffering or pain, cause physical deformity or limitation in function, cause illness or infirmity, endanger life, or worsen a disability; and 2. Are provided at appropriate facilities and at the appropriate levels of care for the treatment of a member’s medical conditions; and 3. Are consistent with the diagnoses of the conditions; and 4. Are no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, efficiency and independence and; 5. Will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual, and those functional capacities that are appropriate for individuals of the same age. 6. Are procedures, supplies, equipment, or services that are determined to be: <ol style="list-style-type: none"> 6.1. Appropriate for the symptoms, diagnosis, or treatment of the medical condition, and 6.2. Provided for the diagnosis or direct care and treatment of the medical condition, and 6.3. Within the standards of good medical practice within the organized medical community, and not primarily for the convenience of the patient’s physician or another provider. 7. Additionally, the most appropriate procedure, supply, equipment, or service must satisfy the following requirements: <ol style="list-style-type: none"> 7.1. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment or service are clinically significant and produce a greater likelihood of benefit for the patient with the particular medical condition being treated than other possible alternatives; and 7.2. For hospital stays, acute care as an inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that it is not possible to provide safe and adequate as an outpatient or in a less intensified medical setting.
Reopening	<p>A remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.</p>



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

Record Retention	Records including Notice of Action (NOA), will meet the retention requirements. Please refer to policy HS-HIP-014 Record Retention, Archival and Destruction).
------------------	--

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
11/07/2023	AltaMed Health Services	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
11/07/2023	Omnicare Medical Group	Dr. Thomas Kim, Vice President, Assoc. Chief Value Officer
11/09/2023	LaSalle Medical Associates	Dr. Felix Lin, Medical Director
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
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



Policy and Procedure

Policy Title: Denial Review and Notification

Policy No.: UM-RPP-003

Issuing Dept.: Utilization Management

Applicable To: M-Cal Comm Medicare

Effective Date: 07/01/2020

Last Review Date: 03/09/2026

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