POLICIES AND PROCEDURES	**Title**: UM-060 UM Decisions and Timely Access to Care
	Procedure #: UM-060
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Department / Function: Medical Management	**Effective Date**: 05/24/2022
Region: Fresno, Kings, and Madera Counties	**Last Review and/or Revision Dates**: 11/6/2024
	LOB: Medi-Cal Managed Care

I. Purpose

To ensure CalViva Health is in compliance with all Federal and State rules and guidance regarding Timeliness of Authorization and to accommodate the clinical urgency of the situation and minimize any disruption in the provision of health care. The policy outlines procedures that ensure compliance with timeliness standards as well as communications to practitioners/providers within established guidelines for timely access. The decisions and notifications are conducted in accordance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d) and 42 CFR 438.900 et seq., CalViva Health and California Health and Wellness conducts all utilization management activities in accordance with CA Health and Safety Code 1363.5 and 1367.01.

II. Policy

A. CalViva has an Administrative Services Agreement ("ASA") with Health Net Community Solutions ("Health Net") to provide certain administrative services on CalViva's behalf. CalViva also has a Capitated Provider Services Agreement with Health Net for the provision of health care services to CalViva members through Health Net's network of contracted providers. Precertification and prior authorization functions are provided through these arrangements with Health Net. Unless otherwise specified, for purposes of this policy the terms "CalViva" or "Plan" will also include delegates such as Health Net or other entities that have been delegated responsibility for activities affected by this policy.

1. Delegated Health Net Departments/Positions referenced in this policy include:
   1.1. Utilization/Care Management Department
   1.2. Utilization/Care Management RNs
   1.3. Medical Director

2. CalViva will retain discretionary decision making for Utilization/Care Management program matters and actions (e.g. criteria approval, timeliness standards, etc.) requiring approval by CalViva.

2.1 Health Net or other delegated entities are required to comply with CalViva's Quality Improvement ("QI") and Utilization Management ("UM") Programs and related policies and procedures.

2.2 Delegated entities performance and compliance with standards will be monitored and evaluated on an ongoing basis by CalViva's Chief Medical Officer ("CMO"), the Chief Compliance Officer ("CCO"), and CalViva's Quality Improvement/Utilization Management ("QI/UM") Committee.

B. The Plan follows the applicable state and federal regulations inclusive of California Department of Health Care Services (DHCS), MCP State Contract standards, and NCQA accreditation requirements with regard to Utilization Management (UM) practices. CalViva Health will provide timely notification to the provider in order for the member to be offered an appointment within the access timelines established by state regulatory guidelines.

1. The Plan uses standard software, such as "Readability Studio", for determination of readability at the applicable grade level.

2. Correspondence will be offered to the members in an appropriate cultural and linguistic manner.

3. The NOA is comprised of two components. MCPs are required to send these documents together any time an Adverse Determination NOA is issued:

3.1 The appropriate DHCS standardized NOA template and

3.2 The DHCS standardized NOA "Your Rights" template.

4. CalViva Health complies with Assembly Bill 1184 in regard to communication of Sensitive Services and will not disclose medical information related to sensitive health care services provided to a protected individual to the primary subscriber or any plan enrollees other than the protected individual receiving care, absent an express authorization of the protected individual.

C. The Plan will provide members and providers with written notice of an adverse benefit determination using the appropriate DHCS-developed, standardized Notice of Action (NOA) template and Members are provided with the NOA "Your Rights" template. The following five distinct NOA templates accommodate actions that Plans may commonly take:

1. Denial of a treatment or service;
2. Delay of a treatment or service;
3. Modification of a treatment or service;
4. Termination, suspension, or reduction of the level of treatment or service currently underway; and
5. Carve-out of a treatment or service.

D. The Plan will not make any changes to the NOA templates or NOA "Your Rights" templates without prior review and approval from DHCS, except to insert information specific to the member as required. Content requirements of the NOA are delineated in federal and state law. The written NOA must meet all language and accessibility standards, including translation, font, and format requirements, , Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, federal and state law, and all requirements in the DHCS contract.

Effective 01/28/2022 the Plan complied with the updated English NOA templates including the "Your Rights" statements, and partial translation.

E. Members may request, free of charge, copies of all documents and records the Plan relied on to make its decision, including any clinical criteria or guidelines used. For decisions based in whole or in part on medical necessity, the written NOA must contain all of the following:
   1. A statement of the action the Plan intends to take.
   2. A clear and concise explanation of the reasons for the decision.
   3. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline.
   4. The clinical reasons for the decision. The Plan must explicitly state how the member's condition does not meet the criteria or guidelines.
   5. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions must be communicated to the member in writing. In addition, with the exception of decisions rendered retrospectively, decisions must be communicated to the provider initially by telephone or facsimile and also in writing.
   6. Plans must include the most current version of the state hearing form. Knox-Keene licensed Plans must also include the IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.

F. The Plan's Medi-Cal program utilizes recognized guideline and criteria sets for utilization decision making, such as: Title 22, Title 17, DHCS Policy Letters and All Plan Letters, and, when no DHCS policy or guideline exist, The MCP's Medical Policies. Should conflicting criteria exist, the Health Plan is required by the state to consider Title 22 to be definitive.

G. The Plan will validate the member's benefit plan in accordance with Member's Handbook, California Code of Regulations and Medi-Cal Provider Manual, Part 2 to determine benefit coverage.

H. A case may be referred to a Physician Consultant for review and/or a second opinion. (UM-010 Second Opinions)

I. Timing of decisions will be consistent with the urgency of the clinical situation and regulatory timeframes in accordance with federal, state, and regulatory guidelines.

J. Practitioners with questions about the UM process can call the Plans toll free number during regular business hours Monday-Friday 8:00AM to 5:00PM.

K. Utilization Management Staff are not available 24/7, however fax or web access submission are available.

III. Definitions

A. **Adverse Benefit Determination:** Any of the following actions taken by an Plan:
   1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   2. The reduction, suspension, or termination of a previously authorized service.
   3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 CFR section 447.45(b) is not an adverse benefit determination.
   4. The failure to provide services in a timely manner.
   5. The failure to act within the required timeframes for standard resolution of grievances and appeals.

B. **Concurrent Review:** Concurrent review is a member-centric process that includes 3 essential components:
   1. Medical Necessity Review,
   2. Discharge and Transitional Care Planning, and
   3. Coordination of Care.

   The focus during the acute hospital event is to support a smooth transition across the care continuum. A primary goal of CCR is to support the member and member's healthcare team to optimize health outcomes during the acute event when the member experiences a health status change. This is done through our work and advocacy with the PPG (as applicable), member, and the hospital interdisciplinary care team to:
   - Validate acute care plan and continued stay appropriateness.
   - Ensure services are accessed timely to minimize delay in services or discharges.
   - Collaboratively develop the post hospital discharge plan.
   - Educate the member's healthcare team on the member's benefit structure and available resources.
   - Facilitate expeditious authorizations for services to support timely access to post-acute services (e.g., home health, DME, post-acute physician, pharmaceutical, and ancillary service access).
   - Facilitate referrals to member resources, where appropriate, such as Community Supports, Enhanced Case Management, Complex Case Management, Case Management, etc.

C. **Expedited Authorizations** Requests where provider or Plan indicates that the standard time frames could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. The Plan provides a decision as expeditiously as the Member's health condition requires.
   1. Timely Decision: The decision is made within 72 hours of receipt of the request (Medi-Cal Contract, Health & Safety Code 1367.01 and 42 CFR section 438.2109d)

D. **Medical Necessity (Medi-Cal Definition):** "Medically Necessary" will include all Covered Services that are reasonable and necessary to protect life, prevent illness or disability, alleviate severe pain through the diagnosis or treatment of disease, illness or injury, achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity per Title 22 CCR Section 51303(a) and 42 CFR 438.210(a)(5).When determining the

Medical Necessity of Covered Services for a Medi-Cal beneficiary under the age of 21, "Medical Necessity" is expanded to include the standards set forth in 42 USC Section 1396d(r), and W & I Codec Section 14132 (v).

For individuals under 21 years of age, the EPSDT/Medi-Cal for Kids and Teens service is considered medically necessary or a medical necessity when it is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services. A service need not cure a condition to be covered under EPSDT/Medi-Cal for Kids and Teens. Services that maintain or improve the child's current health condition are also covered under EPSDT/Medi-Cal for Kids and Teens because they "ameliorate" a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of "ameliorate" is to "make more tolerable." Additional services must be provided if determined to be medically necessary for an individual child.

E. **Notice of Action:** A written notice that gives Medi-Cal beneficiaries an explanation of decisions regarding their eligibility for Plan Medi-Cal coverage or benefits. When required, the NOA includes information about fair hearing rights and how to appeal the decision if the member disagrees with the determination.
F. **Participating Physician Group (PPG):** A group of physicians organized as a legal entity with an agreement in effect with the Plan to furnish medical services to the Plan's members.
G. **Pre-Service Request:** The process of reviewing proposed services that are medically appropriate for a particular Medi-Cal patient to determine benefit eligibility and medical appropriateness under the Managed Care Plan.
H. **Protected Individual:** means any adult, insured or covered under a health insurance policy, who fears that the disclosure of his or her medical information could subject the insured or covered individual under a health insurance policy, to harassment or abuse. Also, could include a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code.
I. **Post Service/Retrospective Request:** The process of reviewing the medical necessity of services that were rendered without prior authorization.
J. **Sensitive Services:** All health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6929 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.
K. **Time Frame:** The date the request for utilization management determination is made, including all necessary medical information.
L. **Urgent Care:** Means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (e.g., sore throat, fever, minor lacerations, and some broken bones).
M. **Working day(s):** Means State Calendar (State Appointment Calendar, Standard 101) working day(s).

N. **World Professional Association for Transgender Health (WPATH)**: WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association, Standards of Care for Gender Identity Disorders.
Note: CalViva Health will provide, at no cost, the clinical review criteria and any training material or resources to providers and health care service plan enrollees. For access to training materials members and providers can be directed to: https://www.wpath.org/resources/SB855WPATHMaterialsFor access to the WPATH training for member or providers who want to take by choice, (Plan will not cover the cost): www.wpath.org/gei For access to the WPATH clinical criteria: https://www.wpath.org/publications/soc.

IV. Procedure

A. Timeliness Review Procedure. All timeframes are maximum timeframes; UM decisions should be made as expeditiously as the member's health condition requires. The postmark on the Plan's notice to the member will be used to confirm compliance with all prior authorization request timeframes and notice requirements set forth below. Any decision delayed beyond stated timeframes shall be considered a denial and must be processed as such (Contract Exhibit A Attachment 5(3)(G); 42CFR 438.404(c)(5)). In this situation, the member has the right to request an appeal with the Plan and the Plan will send the member written notice of all appeal rights.
NOTE: For all Prior Authorizations: For terminations, suspensions, or reductions of previously authorized services, the Plan will notify members at least ten days prior to the date of the action pursuant to Title 42 CFR section 431.211 to ensure there is adequate time for members to timely file for Aid Paid Pending, with the exception of circumstances permitted under Title 42 CFR sections 431.213 and 431.214.

B. Constitutional due process requires that a member's benefits must not be reduced or terminated without timely and adequate notice explaining the reasons for the proposed action and the opportunity for a hearing. (Goldberg v. Kelly (1970) 397 U.S. 254, 267–268). In the case of a member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, DHCS has determined that adequate notice means notice in the member's selected alternative format or notice that is otherwise in compliance with the ADA, Section 504 of the Rehabilitation Act of 1973, and Government Code Section 11135. Plans may not deny, reduce, suspend, or terminate services or treatments without providing adequate notice within applicable legal timeframes. Plans must calculate the deadline for a member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, to take action from the date of adequate notice, including all deadlines for appeals and aid paid pending.

1. Review and Notification of Plan Determination to Member/Provider

1.1 Written Notification of approvals, modification, and denials are sent to the Members and Providers using the appropriate NOA Template within the appropriate timeframe required or as expeditiously as the Member's condition requires.

1.2 Written Notice for denials, modifications, and deferrals are provided in the required timeframe to allow the Member sufficient time to request Aid Paid Pending (continuation of benefits), if applicable . (Health & Safety Code 1367.01 (h)(3)).

1.3 Timeframes for Initial and Written Notification to Providers and Members:

1.3.1 Initial Notification of approvals, modification, and denials are made to the requesting provider within 24 hours of the decision via phone or fax. There is no requirement for Initial Notification to the Member.

1.3.2 Written Notification of Routine approvals, modifications, and denials to the Member are made within two (2) business days of the decision using the appropriate NOA template.

1.3.3 Written Notification of Deferral for Routine Pre-Service requests are sent to the Member and requesting provider within the initial five (5) working days from receipt of the original request, or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first. The Plan will inform the provider and the member of the anticipated date on which a decision will be rendered.

1.3.4 Written Notification of Deferral for Expedited Pre-Service requests are sent to the Member and requesting provider within 72 hours from receipt of the original request, or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first.

1.4 All written notification timeframe requirements are the same for all types of authorization requests unless specified otherwise (Please refer to Post Service Section). Applicable initial notification requirements are specifically outlined under Concurrent Review Section.

2. Routine (Non-Urgent) Pre-Service

2.1 Timeline Decision: The decision is made as expeditiously as the member's condition requires but within 5 working days of receipt of all information reasonably necessary to render a decision and using the appropriate NOA Template.

3. Routine Authorization (Pre-Service) – Additional Information Needed

3.1 The Plan may need additional time when one or more of the following circumstances occur:

3.1.1. Additional clinical information is required

3.1.2. Consultation by an Expert Reviewer is required

3.1.3. Additional examination or tests to be performed

3.1.4 The Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest.

3.2 The Plan will inform the provider and the member of the anticipated date on which a decision may be rendered using the DHCS approved NOA Delay Letter Template. Upon receipt of the information, the Plan's decision will be made within the required timeframe.

3.3 **Written Notification, Notice of Action – Deferral** must be sent to enrollee and requesting provider within the initial five (5) working days from receipt of the original request, or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, and:

3.3.1 Specify the additional information requested but did not receive; requesting only that information that is reasonably necessary to make a decision

3.3.2 Provide the anticipated date of decision which will not exceed 14 calendar days from the original request.

3.3.3 Advise the Member that they have a right to file a grievance to dispute the delay.

3.3.4 Advise the requesting provider that in accordance with Section 1367.03(a)(5)(H):

3.3.4.1 If this delay to obtain additional information and resulting delay will have a detrimental impact on the health of the member, you must contact the Plan.

3.3.4.2 If this delay will not have a detrimental impact on the health of the member, you must document this in the member record.

3.3.5 Advise the Member that they have a right to file a grievance to dispute the delay.

3.4 **Determination Timeline for a Decision following a Deferral**

3.4.1 When additional information is received: If requested information is received, decision must be made within 5 working days of the receipt of complete information.

3.4.2 Decision when additional information received is incomplete or not received:

If provider has not complied with the request for additional information, by the anticipated decision date, the Plan shall review the request with the information available and make a determination by the 14th calendar day from receipt of the original request.

4. Expedited Authorization (Pre-Service): Requests where provider or the Plan indicates that the standard time frames could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. The Plan will provide a decision as expeditiously as the Member's health condition requires.

4.1 Timeline Decision: The decision will be made within 72 hours of receipt of the request.

5. Expedited Authorization (Pre-Service) – Deferral Needed:

5.1 Deferral Decision Timeframe The Plan may need additional time when one or more of the following circumstances occur:

5.1.1 Additional clinical information is required or

5.1.2 The case requires consultation by an Expert Reviewer or

5.1.3 Additional examinations or tests need to be performed.

5.1.4 The Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest.

If provider has not complied with the request for additional information by the anticipated decision date, the Plan shall review the request with the information available and make a determination by the 14th calendar day from receipt of the original request.

5.2 Written Notification, Notice of Action – Deferral: Written Notification must be sent to the Member and requesting provider within the initial 72 hours from receipt of the original request, or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, and:

5.2.1 Specify the additional information requested; requesting only that information that is reasonably necessary to make a decision.

5.2.2 Provide the anticipated date of decision.

5.2.3 Advise the requesting provider that: "In accordance with Section 1367.03(a)(5)(H):

5.2.3.1. If this delay to obtain additional information will have a detrimental impact on the health of the member, you must contact the Plan.

5.2.3.2.If this delay will not have a detrimental impact on the health of the member, you must document this in the member record."

5.2.4. Advise the Member of their rights including how to appeal the decision.

5.3 Determination Timeline for a Decision following an expedited deferral: The Plan must make a determination within 72 hours following either:

5.3.1 The Plan's receipt of the specified information, or

5.3.2 The end of the anticipated decision date which is no later than the 14th calendar day from receipt of the original request.

5.3.3 to provide the specified additional information.

6. **Urgent Concurrent Requests**

6.1 Decision Timelines:

6.1.1 Determination will be made within 24 hours of receipt of review request, provided that the request is made at least 24 hours prior to the expiration of previously approved period of time or number of treatments.

6.1.2 In the case of Concurrent Review, care will not be discontinued until the treating provider has agreed to a care plan appropriate for the medical needs of the enrollee.

6.2 Notification Requirements

6.2.1 Initial Notification:

6.2.1.1 Initial notification to the treating provider is made within 24 hours of receipt of request

6.2.1.2 For Inpatient determinations

6.2.1.2.1 The Facility Utilization Review department may be informed of the determination and rely on them to inform the attending/treating practitioner.

6.2.1.3 For Inpatient determinations

6.2.1.3.1 Denial notices to the treating provider may be mailed to the street address of the hospital but are directed to the attention of the treating/attending physician.

6.2.1.3.2 Denial letters to the Member are mailed to the Member's listed mailing address

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6.3 Correspondence Content

6.3.1 Approval letters will specify the health care services approved.

6.3.2 Denial or modification letters will include:

6.3.2.1 Clear and concise explanation of the reasons for the decision.

6.3.2.2 A reference to the benefit provision, guideline, protocol, or criteria on which the denial decision is based.

6.3.2.3 If the denial was based on lack of clinical information, the denial must include a reference to the clinical criteria that has not been met.

6.3.2.4 If the denial is related to a member who has a terminal illness, a description of alternative treatment, drug, services or supplies covered by the plan, if any.

6.3.2.5 Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol, or criteria which the denial decision was based.

6.3.2.6 Notification to members that if a medical or vocational expert's advice was obtained related to their case, they may be provided the identity of these experts, upon request.

6.3.2.7 Information to the practitioner in the denial letter that a physician or appropriate reviewer is available to discuss the determination.

6.3.2.8 Include the name and direct phone number or an extension of the health care professional responsible for the denial.

6.3.2.9 Information on how the member may file a grievance or appeal and request an External Independent Review as applicable. Information provided regarding appeal rights includes:

- The right to submit written comments, documents, or other relevant information.
- An explanation of the appeal process, including the right to member representation and time frames for deciding appeals.
- A description of the expedited appeal process for urgent and urgent concurrent denials.
- Availability of, and contact information for, the applicable office of health insurance consumer assistance or ombudsman to assist the member with internal appeals and external review processes.
- In addition, will include additional requirements as required by state and or federal regulations.

6.4 Urgent Concurrent Requests Requiring Additional Time

6.4.1 Extensions are allowed only for the following conditions:

6.4.1.1 Outpatient Requests for Extension of Services

6.4.1.2 If the review request for extension of services was not made at least 24 hours prior to the expiration of the previously approved prescribed period or number of treatments, the review request may be treated as an Urgent Pre-Service review request determination and make the decision within the regulatory timelines of within 72 hours of receipt of request.

- This does not require written notification as an extension, the review request will be reviewed as an Urgent Pre-

Service request as noted above for timeliness, communication, and notification for Urgent Pre-Service review requests.

- Initial notification to the provider of approvals and denials within the lesser of 24 hours of decision or 72 hours from receipt of the request by either fax, phone or electronic notice.

  If additional information is required, follow the "Additional Information" process for Expedited Authorization (Pre-Service) – Deferral Needed .

6.5 Timelines

6.5.1 An additional 48 hours are afforded to the facility to provide the additional information. However, the Plan's determination must be made within 24 hours of receipt of information but not to exceed 72 hours from receipt of request.

6.6 Communication of Determination

6.6.1 The Utilization Review Department, of the facility, may be informed of the determination and the expectation that the department will inform the attending/treating practitioner.

6.6.2 This information must be detailed and documented in Medical Management records.

7. Post-Service

(Request for authorization for covered services already completed, prior to claim submission).

7.1 Timeline Decision

7.1.1 The decision is made within 30 calendar days of the receipt of the request .

7.1.2 The Plan is also required to communicate the decision to the provider in a manner that is consistent with current law.

7.2 Notification Requirements:

7.2.1 Initial Notification is *not* required for post-service review requests.

7.2.2 Written notification of approvals, denials, and modification to the Member and providers using the appropriate NOA Template are made within 30 days of the receipt of information that is reasonably necessary to make this determination per HSC 1367.01(h)(1)

IV. Authority

1. Ca Health and Safety Code 1367.01(e)(g)(h)(1-3), 1363.5 and(5),1371.8
2. Patient Protection and Affordable Care Act: 42 CFR 438.400(b), 438.404, 438.210(d), and 438.410.
3. DHCS Managed Care Contracts (Two Plan and Geographic Model), Exhibit A, Exhibit A, Attachment 5, Utilization Management, Attachment 13, Member Services, Denial, Deferral or Modification of Prior Authorization Requests.

4. Title 22 CCR 51340 and 51340.1
5. Title 42 USC Section 1396.d (r)(5)
6. Assembly Bill 1184
7. APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination
8. Requirements, and Language Assistance Services (Supersedes APL 17-011 and Policy Letters 99-003 and 99-004)
9. APL 21-011 Grievance and Appeal Requirements, Notice and Your Rights Templates
10. APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative
11. APL 20-022 Alternate Format Selection for Members with Visual Impact
12. . APL 23-005 Requirements For Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (Supersedes APL 19-010)
13. CCR 1300.70(b)(2)(H) &(c) and 1300.70(a)(3) and c)
14. W&I Code section 10951.5, and as outlined in APL 21-001.

V. References

1. CalViva Health UM-002 Pre-Certification and Prior Authorization
2. CalViva Health UM-010 Second Opinion
3. CalViva Health UM-113 Criteria for UM Care Decisions
4. CalViva Health UM-050 Communications and Accessibility to UM

VII. ATTACHMENTS

A. None

APPROVAL:

Officer/Committee Chairperson  **Date:**

Name: Patrick C. Marabella, M.D., M.S.
Title: Chief Medical Officer/Committee Chairperson

Policy History			
Date	**Department**	**Policy or Section #**	**Comment(s)**
05/24/2022	Utilization Management		New Policy
7/12/2022	Utilization Management		Added APL 21-011 language regarding denied authorization and deferral timeframe.
11/17/2022	Utilization Management		Committee approved.
06/19/2023	Utilization Management		Updated Definitions and Concurrent Review Sections. Added APL 23-005.
11/07/2023	Utilization Management		Annual review. Updated Definitions section. Added NOA statement.
11/16/2023	Utilization Management		Committee approval
06/11/2024	Utilization Management		Minor edits.
09/20/2024	Utilization Management		DMHC comment letter compliance updates; Updated to include modified and denial concurrent review correspondence content. Duplicate CCR Correspondent criteria removed. Updated “MCP” language to “Plan”.
11/01/2024	Utilization Management		DMHC comment letter changes to clarify decision timeliness procedures. Removed in-text APL citations.
11/6/2024	Utilization Management		Annual review. Updated DHCS NOA template letter title to include “delay”.
11/21/2024	Utilization Management		Committee approval.