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|------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|
|  <p><b>POLICIES AND PROCEDURES</b></p> | <b>Title:</b> Prior Authorization Requests              |
|                                                                                                                        | <b>Procedure #:</b> UM-002                              |
|                                                                                                                        | <b>Page:</b> 1 of 12                                    |
| <b>Department/Functional Area:</b> Utilization Management                                                              | <b>Effective Date:</b> 3/1/2011                         |
| <b>Region:</b> Fresno, Kings, Madera Counties                                                                          | <b>Last Review and/or Revision Dates:</b><br>08/27/2025 |
|                                                                                                                        | <b>LOB:</b> Medi-Cal Managed Care                       |

## I. Purpose

- A. To establish appropriate clinical time frames and standards for Utilization/Care Management determinations to ensure timeliness of care and to minimize any disruption in the provision of health care to CalViva members.
- B. To establish guidelines for the review of potential denials of service for lack of medical necessity and including the process to notify CalViva members and providers of referral modifications, deferrals, and denial of services.
- C. Also, to outline CalViva's oversight and monitoring of Precertification and Prior Authorization processes performed by delegated entities.

## 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. CalViva Health may also delegate responsibilities described in this Policy to other organizations such as sub-contracted health plans that the Plan may contract with to provide or arrange for covered services for assigned CalViva members. All delegated organizations are required to have standards, policies and processes in place that comply with Medi-Cal requirements and applicable state and federal regulations.
  - C. This policy impacts all CalViva members, as well as contracted and non-contracted providers requesting precertification/prior authorization. CalViva Health, or its delegated entities, will review prior authorization requests for certain ambulatory, outpatient or specialty referral services and perform precertification for routine and elective inpatient services. See Attachment A for the list of services requiring prior authorization or precertification. The Plan's UM/CM Program ensures medical decisions made by Plan or medical directors are not unduly influenced by fiscal or administrative management.
  - D. Prior authorization is not required for services such as: Emergency services Family planning services, HIV counseling, Outpatient mental health services, among others (To see a completed list, please refer to the Procedure section).
    1. Prior authorization is not required for primary care. Primary care physicians (PCPs) are encouraged to practice in the full scope of their training.
    2. In an effort to remove barriers, improve timeliness of care and ensure quality of care, prior authorization is also not required for most in network specialist visits and most in network diagnostic and imaging services provided by participating providers.
    3. In addition, when indicated, coordination must occur between CalViva or its delegated entities and the state sponsored public health programs such as California Children's Services (CCS), Mental Health, and Regional Centers. Precertification or prior authorization for referrals to these programs is not required.
  - E. Information on prior authorization, referral, and precertification procedures and timeframes is distributed to providers via the Provider Operations Manual and other communications. Attachment A, a list of services requiring prior authorization or precertification, is made available to providers.
    1. Preventive care may be Medically Necessary, but coverage for Medically Necessary preventive care is governed by the terms of the applicable Plan Documents.
  - F. The Plan will notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be orally or in writing.

Members are notified in writing of any decision to deny, delay, or modify a request for services.

1. The Plan maintains well publicized appeal procedures for both providers and members. Refer to Plan policies and procedures for a description of the appeals procedures.
- G. CalViva Health follows all state and federal requirements contained in the regulations provided by the California Department of Health Services (DHCS) and other guidance inclusive of the Medi-Cal Two Plan and Geographic Managed Care Model Contracts regarding those services that are subject to prior authorization under CalViva's authorization procedures.
- H. Utilization/Care Management decisions are made in time frames established by the federal and state regulations for prior authorizations, concurrent and retrospective/post U services review decisions.
- I. Decisions to deny or to authorize an amount, duration, or scope that is less than the requested shall be made by a licensed physician with appropriate clinical expertise in treating the condition or the disease.
- J. Qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole or in part, on the basis of medical necessity. For purposes of this provision, a qualified licensed physician or CalViva Health's pharmacist may approve, defer, modify, or deny prior authorizations for pharmaceutical services, provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan medical director, in collaboration with the Plan Pharmacy and Therapeutics Committee (PTC) or its equivalent.
- K. CalViva Health provides information via CalViva Health's Provider Operations Manual to health care practitioners of the procedures and services that require prior authorizations and ensures that all the contracting Participating Physician Groups (PPGs) and contracted providers are aware of the procedures and timeframes necessary to obtain prior authorizations for these services.
- L. An online referral system is maintained to track and monitor referrals requiring prior authorization. The system contains information on internally processed authorizations, denials, deferrals, and modified referrals, and the timeliness of these referrals.
- M. CalViva Health ensures that all contracting health care practitioners, non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.
- N. The Utilization/Care Management Department will process precertification requests for all outpatient and inpatient services defined in the specific plan contract or as otherwise defined.

- O. Preventive care may be Medically Necessary, but coverage for Medically Necessary preventive care is governed by the terms of the applicable Plan Documents.

### III. Definitions

- A. **Acute** – serious and sudden condition that lasts a short time and is not chronic.
- B. **Advanced Stage Cancer** - Stage IV metastatic cancer.
- C. **Adverse Benefit Determination**- Encompasses all previously existing elements of “Action” under Federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. (The term “Action,” which was used in prior APLs and PLs, has been replaced with “Adverse Benefit Determination.”)  
An “Adverse Benefit Determination” is defined to mean any of the following actions taken by a Managed Care Plan (MCP):
  - 1. The denial or limited authorization of a requested service, including determination 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 a payment for service
  - 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
  - 6. For a resident of a rural area with only one MCP, the denial of the beneficiary’s request to obtain services outside the network
  - 7. The denial of a beneficiary’s request to dispute financial liability
- D. **California Children’s Services (CCS)** - is the public health program which assures the delivery of specialized diagnostic, treatment and therapy services to financially and medically eligible children under the age of 21 who have a CCS eligible condition.
- E. **Complex Cancer Diagnosis** - A diagnosis for which there is no standard FDA-approved treatment or for which known highly effective therapy for metastatic cancer has failed and any of the following diagnoses: hematological malignancies, acute leukemia, advanced, relapsed, refractory non-Hodgkin lymphoma and multiple myeloma, including BPDCN and T-cell leukemias and lymphomas, and advanced stage, relapsed solid tumors refractory to standard FDA-approved treatment options, advanced stage rare solid tumors for which there is no known effective standard treatment options, or any other condition for an Eligible enrollee. Eligible Enrollee means an individual enrolled with a particular Medi-Cal managed care plan who receives a complex cancer diagnosis.
- F. **Department of Health Care Services (DHCS)** - The California agency responsible for administration of the Medi-Cal program.
- G. **Department of Managed Health Care (DMHC)** – The California agency responsible for regulating health care service plans.

H. **Deferral** – also known as an "Extension Request" or a "Delay" Notice of action is issued when: additional clinical information is required to render a decision, the request requires consultation by an Expert Reviewer, and additional examination or tests need to be performed before a decision can be rendered.

I. **Emergency Medical Condition** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that **the absence of immediate medical attention could reasonably be expected to result** in the following:

1. Placing the health of the individual in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part
4. "Active Labor" means a labor at a time at which either of the following would occur:
  - 4.1: There is inadequate time to effect safe transfer to another hospital prior to delivery.
  - 4.2 A transfer may pose a threat to the health and safety of the patient or the fetus.

J. **Emergency Services and Care:** Medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

"Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

K. **Independent Medical Review (IMR):** A review of a Member grievance/appeal case by doctors who are not part of the Plan. If a Member disagrees with a Notice of Action decision, the Member can ask the Help Center at the Department of Managed Health Care (DMHC) for an Independent Medical Review (IMR). IMRs are available when the Plan denies, changes, or delays a service or treatment when it is determined the service is not medically necessary or considered eExperimental, or will not cover an Investigational treatment because the criteria isn't met, or will not pay for emergency or urgent medical services that the member may have already received. An IMR may not be requested if the Member has already requested a State Fair Hearing for that Notice of Action.

L. **Investigational Services** - Drugs, equipment, procedures, or services for which laboratory and animal studies have been completed and for which human studies are in process but:

1. Testing is not complete, and
2. The efficacy and safety of such services in human subjects are not yet established and
3. The service is not in wide usage

M. **Medical Necessity/"Medically Necessary"** – The term "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 Code Section 14132 (v). For individuals under 21 years of age, the 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 Medi-Cal for Kids and Teens. Services that maintain or improve the child's current health condition are also covered under 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.

- N. **Modification** - Authorization of a request of a service in an amount, duration, or scope that is less than requested or the termination of a previously authorized service(s).
- O. **National Cancer Institute (NCI)** - designated comprehensive cancer centers are recognized for their scientific leadership, resources, and exceptional depth and breadth of transdisciplinary research that bridges the fields of prevention, cancer control, and population science.
- P. **National Cancer Institute (NCI) Community Oncology Research Program (NCORP) Affiliated Site** - is a cancer center that has received an approved grant from NCI through NCORP that provides cancer clinical trials and care delivery studies.
- Q. **NCI Community Oncology Research Program (NCORP)** - is a national network that brings cancer clinical trials and care delivery studies to patients in their own communities and contributes to improved patient outcomes and a reduction in cancer disparities for all people.
- R. **NCI-Designated Comprehensive Cancer Center** - is a cancer center that meets ongoing standards for cancer prevention, clinical services, and research, as determined by regular reviews and evaluations by NCI.
- S. **Non-Contracted Provider** - doctor or provider that is not under contract with CalViva Health.
- T. **Pre-certification/ Prior Authorization** – The process of reviewing proposed inpatient services that are medically appropriate for a particular Medi-Cal patient to determine benefit eligibility and medical appropriateness under the MCP.
- U. **Poststabilization Care Services**- Means covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or, to improve or resolve the member's condition.

- V. **Qualifying Academic Cancer Center:** is a research and clinical cancer center that meets all the following criteria:
1. It is an institution with a medical oncology or hematology subspecialty expertise in each of the diagnoses (hematological malignancies, acute leukemia, advanced, relapsed, refractory non-Hodgkin lymphoma and multiple myeloma, including BPDCN and T-cell leukemias and lymphomas, and advanced stage, relapsed solid tumors refractory to standard FDA-approved treatment options, advanced stage rare solid tumors)
  2. It has a portfolio of phases 1, 2, and 3 clinical trials available for eligible enrollees.
  3. It provides fellowship programs in medical oncology, hematology or hematological oncology, radiation oncology, or a surgical oncology specialty.
  4. It provides inpatient and outpatient supportive care services.
  5. It covers clinical, anatomic, and molecular pathology with subspecialty expertise for each of the cancer types included in paragraph (A).
  6. It provides a program accredited by the American College of Surgeons (ACS) Commission on Cancer (CoC).
  7. It has accreditation for the main campus by the Foundation for the Accreditation of Cellular Therapy.
- W. **Urgent Care** - any service required to prevent serious decline of health following the onset of an unforeseen condition or injury.

#### IV. Procedure

- A. CalViva Health follows all state and federal requirements contained in the regulations provided by the California Department of Health Services (DHCS) and other guidance inclusive of the Medi-Cal Two Plan and Geographic Managed Care Contracts.
- B. Prior Authorization Requirements
1. Referral or Prior Authorization is not required for sensitive services, or MOA 638 Indian Health Service facilities, and the following services may be obtained from any qualified in-network or out-of-network provider:
    - 1.1 Emergency services following the reasonable standard to determine that the presenting complaint might be an emergency
    - 1.2 Family planning services
    - 1.3 Preventive services
    - 1.4 Services related to the treatment of sexually transmitted infection (STI) diagnosis and treatment (for children ages 12 and older)
    - 1.5 HIV counseling and testing services through the Plan's provider network and through the out-of-network local health department and family planning provider
    - 1.6 Therapeutic and elective pregnancy termination
    - 1.7 Basic prenatal (Obstetric "OB") care (Pregnancy)
    - 1.8 Minor consent services, those covered services of a sensitive nature that minors do not need parental consent to access or obtain. Such services are those related

to sexual assault, including rape, drug or alcohol abuse (for children ages 12 and older)

1.9 Immunizations at the Local Health Department (LHD)

1.10 Outpatient mental health services

1.11 Biomarker testing that is associated with an FDA-approved therapy for advanced or metastatic stage III or IV cancer or cancer progression or recurrence with advanced or metastatic stage III or IV cancer. The plan will not limit, prohibit, or modify a member's rights to cancer biomarker testing as part of an approved clinical trial under HSC section 1370.6 (See Attachment B Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources)

2. For services that are subject to prior authorization under CalViva's authorization procedures, the following steps are followed: (see Attachment A CalViva Prior Authorization Requirements List for list of services requiring Prior Authorization as well as limitations exclusions, prior authorization exceptions and detailed services that do not require authorization).

2.1 Utilization Management decision timeframes are made in accordance with the timeframes identified within the CalViva Health contract and the California Health and Safety Code Section 1367.01. See Attachment B Medi-Cal Timeliness for Utilization Management.

2.2 The Plan maintains an online referral authorization system to track and monitor services requiring prior authorization. The system contains information on internally processed authorizations, denials, deferrals, and modified requests, and the timeliness of these requests.

3. Pursuant to Senate Bill 987, California Cancer Equity Act and Section 14197.45 of the Welfare and Institutions Code, the Plan in good faith contracts with at least one National Cancer Institute (NCI)-designated comprehensive cancer center, site affiliated with the NCI Community Oncology Research Program (NCORP), or qualifying academic cancer center, within its contracted provider network and its subcontracted provider network, if applicable, within each county in which the Plan operates, for provision of services to any eligible enrollee diagnosed with a complex cancer diagnosis.

3.1 The Plan allows any eligible enrollee diagnosed with a complex cancer diagnosis to request a referral to receive medically necessary services through any of the following in-network providers unless the enrollee chooses a different cancer treatment provider:

3.1.1 An NCI-designated comprehensive cancer center.

3.1.2 An NCORP-affiliated site.

3.1.3 A qualifying academic cancer center.

3.2 If the NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center refers an enrollee with a complex cancer condition to an out-of-network specialist, or a request for a referral to an out-of-network specialist is received, the Plan will authorize referral for an enrollee to receive medically necessary services through an out-of-network NCI-designated comprehensive cancer center, out-of-network NCORP-affiliated site, or out-of-network qualifying academic cancer center, unless the enrollee chooses a different cancer treatment provider or the Plan and the out-of-network NCI-designated comprehensive cancer center, out-of-network NCORP-affiliated site, or out-of-network qualifying academic cancer center cannot come to an agreement with respect to payment.

- 3.3 The Plan ensures that the services of an NCI-designated comprehensive cancer center, NCORP-affiliated site, or qualifying academic cancer center available to an eligible enrollee are sufficient in amount, duration, and scope as medically necessary for the treatment of the enrollee's condition. The Plan will not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of diagnosis, type of illness, or condition of the enrollee.
- 3.4 The Plan does not deny coverage that is otherwise available under the Plan contract for the costs of solid organ or other tissue transplantation services based upon the enrollee or subscriber being infected with the human immunodeficiency virus (HIV) per CA HSC § 1374.17 (a).

#### C. Prior Authorization Process

1. Utilization Management Staff will validate the members benefit plan in accordance with the members' coverage, California Code of Regulations and Medi-Cal Provider Manual, Part 2 to determine benefit coverage.
2. Utilization Management Clinical Staff will process requests for review of services according to established guidelines.
3. Utilization Management Clinical Staff refer cases that do not meet medical necessity criteria to the Medical Director with supporting clinical information for review.
4. The Medical Director reviews the case, collect additional pertinent clinical information (if needed), and consult with the attending physician, as appropriate.
5. The case may be referred to a Physician Consultant for review and/or a second opinion.
6. Timing of decisions will be consistent with the urgency of the clinical situation and regulatory timeframes in accordance with federal, state and regulatory guidelines.
7. The Plan's Member Services accesses Utilization Management point of contact in the event guidance is required.
8. CalViva Health notifies the requesting provider of any decision to deny, approve, or modify a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested within 24 hours of the decision.
9. The initial notice to the provider will be either fax or telephone.
10. Denials and modifications will be followed by written notice to the provider and member within 2 business days of determination.

#### D. Notification of Prior Authorization Determinations

1. Approvals:
  - 1.1. Written Notification of Approvals are sent to Members and Providers (Requested) by fax, mail or telephone using the appropriate NOA templates within 24 hours of the decision.
2. Denial, Deferral, or Modification of Prior Authorization Requests:
  - 2.1 When a request is denied, the provider (requester) is notified by telephone or fax and given the precertification/authorization number within 24 hours of the decision.
  - 2.2 CalViva Health will notify members of a decision to deny, defer, or modify requests for prior authorizations by providing written notification to members

and/or their authorized representative, regarding any denial, deferral, or modification of a request for approval to provide a health care service in accordance with California Health and Safety Code 1367.01. Denials and modifications will be followed by written notice to the provider and member within 2 business days of determination.

3. Termination, Suspension, or Reduction of a Previously Authorized Covered Service:

3.1. CalViva Health ensures that at least ten (10) days of advance notice is given to a member when a Notice of Action (NOA) results in a termination, suspension or reduction of a previously authorized covered service.

3.2. CalViva Health may shorten the advanced notice to five (5) days if probable recipient of fraud has been verified. This is not applicable when the following conditions apply:

3.2.1. Death of a member

3.2.3 Member provides a written statement requesting service termination or giving information requiring termination or reduction of services

3.2.4. Member admission into an institution that makes member ineligible for further services

3.2.5. Member's address is unknown and mail directed to the Member has no forwarding address

3.2.6. Member has been accepted for Medi-Cal Services by another local jurisdiction

3.2.7 Member's Primary Care Physician prescribes a change in the level of medical care

3.2.8 An Adverse Determination made with regard to the pre-admission screening requirements for nursing facility admission

3.2.9. Safety or health of individuals in a facility would be endangered, Member's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the member's urgent medical needs, or member has not resided in the nursing facility for a minimum of thirty (30) days.

4. Evaluation of Post Stabilization Request from Non-Contracted Hospital (California Health & Safety Code sections 1262.8 and 1371.4)

4.1. Non-contracting hospitals must notify the Plan's Hospital Notification Unit immediately upon identifying a request for Post stabilization care and possible admission.

4.2. See Policy UM-001, "Emergency and Post Stabilization Care" for additional information.

E. Revocation of Authorization (Health and Safety Code – HSC §1367.01)

1. If CalViva or its delegate entities certifies that a proposed treatment is medically necessary for a particular Plan member, CalViva or its designee will not subsequently revoke that medical necessity determination.

1.1. Exceptions can be made in the following instances: If the service has not yet been rendered, fraud, submission of erroneous information, member not a Plan enrollee, member ineligible for the service or member's health status no longer makes the service medically necessary.

2. CalViva will ensure that a provider is paid appropriately after the provider renders a service in good faith pursuant to an authorization and without notice that the member

- was no longer eligible. When CalViva, or its delegated entity at risk for covered services, has authorized a specific type of treatment by a provider, they shall not rescind or modify the authorization or the applicable reimbursement for the specific type of treatment authorized, after the provider renders the service in good faith pursuant to the authorization, based solely on, as applicable, CalViva's subsequent rescission, cancellation, or modification of the member's contract or subsequent determination that it did not make an accurate determination on the member's eligibility for treatment. This does not preclude rescinding of such an authorization for any of the causes described in E.1.1 above at any reasonable time before the service is provided.
3. In the event that CalViva Health certifies the medical necessity of a course of treatment limited by number, time period or otherwise, then a request for treatment beyond the certified course of treatment shall be deemed to be a new request and CalViva Health's denial of such request shall not be deemed to be inconsistent with the preceding paragraph.

#### F. Records Maintenance and Retention

1. The member's case file will include but is not limited to the following: the reasons for the deferral, modification or denial of services for lack of medical necessity, a case summary or notes of Utilization/Care Management activity documenting the review steps, timing of decisions, any correspondence and records obtained, all internal or external reviews made, and a copy of letter of notification.
2. Utilization/Care Management records and files (includes review records, correspondence and Notice of Action letters, etc.) will be maintained and available for audits or reviews in accordance with contractual requirements and applicable state and federal laws.
3. These records will be maintained for a minimum of five years from the end of the current fiscal year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created or the CalViva Contract with the DHCS is terminated.
  - 3.1. However, in the event the DHCS, DMHC, DHHS, DOJ, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation, the records and files will be kept and maintained until such time as the matter under audit or investigation has been resolved, or for the five-year period referenced above, whichever is later.

#### G. CalViva Oversight and Monitoring Activities

1. CalViva Medical Management staff will monitor closely on an ongoing basis the thoroughness and timeliness with which Health Net or other delegated entities reviews and resolves UM authorizations and denials and the resources dedicated to this function.
2. CalViva Medical Management staff will monitor and evaluate Health Net or other delegated entities on an ongoing basis to ensure Precertification and Prior Authorization activities are performed in accordance with required timeframe standards, CalViva approved criteria and other contractual, state, and federal requirements.
  - 2.1. The CalViva Medical Management staff will review reports on a periodic basis (i.e. weekly, monthly, quarterly as applicable) and as designated in the ASA with CalViva.

3. Summary reports and results of monitoring and evaluation activities will be presented to the CalViva QI/UM Committee for review and recommendations as needed.
4. The Plan will perform a pre-delegation audit and annual audits of entities with delegated UM functions. The audits include a review of the Health Net or delegated entities authorization and medical necessity denial/modification processes and policies including compliance with the approved time frames. In addition, the annual audits include review and evaluation of UM case files for compliance with requirements.
  - 4.1. If Health Net/delegated entity fails to meet standards or requirements, a corrective action plan is required and monitored for improvement.
  - 4.2. Additional focused audits may be scheduled as needed to follow up on issues or verify implementation of corrective action.
  - 4.3. The audit findings and corrective action progress are included in reports to the CalViva QI/UM Committee for review and recommendations.

## **V. Authority**

- A. California Code of Regulations, Title 22, Sections 51014.1, 51014.2, 51303(a), 53214, 53855, 53894
- B. DHCS Contract, Exhibit A, Attachments 4 and 5; Exhibit E, Attachment 2, provision 19.B
- C. Health & Safety Code, Section 1363.5, 1367.01, 1371.8, 1371.4
- D. Welfare and Institutions Code, Section 14103.6, 14132(v), 14185
- E. MMCD All Plan Letter 04-006 SB 59 Required Notices of Action
- F. MMCD All Plan Letter 05-005 SB 59 Notice of Action Letters
- G. MMCD All Plan Letter 17-006 Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments
- H. MMCD All Plan Letter 17-018 Responsibilities for Outpatient Mental Health Services
- I. Title 22 California Code of Regulations (CCR) Sections 51340 and 51340.1
- J. Title 42 United States Code (USC) Section 1396.d (r)
- K. Title 42, Code of Federal Regulations (CFR), Section 438.210(a)(5)
- L. DMHC All Plan Letter 20-026 Preventive Health Services Coverage for HIV Preexposure Prophylaxis (PrEP)
- M. California Senate Bill (SB) 535 (Limón, Chapter 605, Statutes of 2021)
- N. DMHC All Plan Letter 25-011 Health Plan Coverage of HIV Preexposure Prophylaxis (PrEP) (Superseeds APL 21-018)
- O. All Plan Letter (APL) 21-011 Grievance and Appeal Requirements, Notice and “Your Rights” Templates
- P. All Plan Letter (APL) 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (Supersedes APL 17-018)
- Q. All Plan Letter APL 22-010 Cancer Biomarker Testing.
- R. California Cancer Equity Act, SB 987.
- S. Welfare and Institutions Code, Section 14197.45
- T. CA HSC § 1374.17 (a) Prohibition against denial of coverage for organ or tissue transplantation services based on HIV status

## **VI. References**

- A. CalViva Evidence of Coverage
- B. InterQual Clinical Decision Support Criteria

- C. Guide to Evidence Based Medicine (GEBM)
- D. Clinical Policy: Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources
- E. Clinical Practice Guidelines
- F. EDS Medi-Cal Provider Manual
- G. CalViva Quality Improvement Program Description and UM Policies & Procedures
- H. Health Net or delegated entities Utilization/Care Management Program Description
- I. Notice of Action letters
- J. CalViva Delegation Evaluation and Delegation Determination – Utilization Management and Claims Processing Policy
- K. CalViva Standardized Audit Tools
- L. CalViva Health Policy UM-001 Emergency Care Services & Post Stabilization Care and Services
- M. CalViva Health Policy AG-001 Appeals and Grievances

## VII. Attachments

- A. CalViva Health Prior Authorization Requirements
- B. CalViva Health Utilization Management Timeliness Standards
- C. Notice of Action Template (revised)
- D. Clinical Policy: Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources
- E. CalViva Health FFS Prior Authorization Requirements List.

**APPROVAL:**  
**Officer/QIUM**  
**Committee**  
**Chairperson**



**Date:** \_\_\_\_\_

Name:

Patrick Marabella, MD

Title:

Chief Medical Officer/Committee  
Chairperson

| Date      | Functional Area/Department | Comment(s)                                                                                                                   |
|-----------|----------------------------|------------------------------------------------------------------------------------------------------------------------------|
| 3/1/2011  | Utilization Management     | New Policy                                                                                                                   |
| 2/1/2012  | Utilization Management     | Replace with updated Att. A                                                                                                  |
| 4/16/2012 | Medical Management         | Edited II.B & IV.G to be consistent with practice ARS Attachment A updated                                                   |
| 4/20/2012 | Medical Management         | Added regulatory references & corrected section C.1.4 timeframe for concurrent review of treatment regimen already in place. |
| 1/10/2013 | Medical Management         | Reviewed and updated regulatory references, titles and terminology.                                                          |

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| 2/1/2015   | Medical Management     | Reviewed and updated to clarify procedures and language.                                                                                                                                                                                                                                                                                                                           |
| 07/06/2017 | Utilization Management | Annual review. Updated attachments and policy language to reflect changes regarding APL 17-006.                                                                                                                                                                                                                                                                                    |
| 03/06/2018 | Utilization Management | Reviewed and updated to address APL17-018 Outpatient Mental Health Services                                                                                                                                                                                                                                                                                                        |
| 06/13/2018 | Utilization Management | Annual review. No changes.                                                                                                                                                                                                                                                                                                                                                         |
| 09/20/2018 | Utilization Management | Committee approved                                                                                                                                                                                                                                                                                                                                                                 |
| 10/30/2018 | Utilization Management | Attached updated Prior Authorization Provider Update.                                                                                                                                                                                                                                                                                                                              |
| 08/06/2019 | Utilization Management | Annual review. No changes.                                                                                                                                                                                                                                                                                                                                                         |
| 11/21/2019 | Utilization Management | Updated definitions and regulatory references to be consistent with EPSDT requirements.                                                                                                                                                                                                                                                                                            |
| 09/28/2020 | Utilization Management | Annual review. Sensitive services list and “Hot Links” in section D removed. Added that Member Services accesses UM point of contact if guidance is required. Removed section E regarding Post Stabilization. Other minor edits to definitions, references, language and formatting. Updated Attach A.                                                                             |
| 10/15/2020 | Utilization Management | Committee approval                                                                                                                                                                                                                                                                                                                                                                 |
| 08/06/2021 | Utilization Management | Added language and updated Authorities list pertaining to APL 20-026 & 21-018.                                                                                                                                                                                                                                                                                                     |
| 11/09/2021 | Utilization Management | Annual review. No changes.                                                                                                                                                                                                                                                                                                                                                         |
| 11/18/2021 | Utilization Management | Committee approved.                                                                                                                                                                                                                                                                                                                                                                |
| 02/28/2022 | Utilization Management | Included section for Evaluation of Post Stabilization Request from Non-Contracted Hospital. Updated to be consistent with APL 21-011 and other formatting edits.                                                                                                                                                                                                                   |
| 09/19/2022 | Utilization Management | Medical Necessity definition updated to be consistent with APL 22-006. Added services that do not require Referral or Prior authorization. Added SB535 Authority. Added APL-22-010 Cancer Biomarker Testing. Added Attachment D Clinical Policy: Medical Necessity Criteria, Technology Assessment and Hierarchy of Resources and as a reference to be consistent with APL 22-010. |
| 10/03/2022 | Utilization Management | Annual Review. Minor format edits.                                                                                                                                                                                                                                                                                                                                                 |
| 11/17/2022 | Utilization Management | Committee approval.                                                                                                                                                                                                                                                                                                                                                                |

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| 12/12/2022 | Utilization Management | Added SB 987 California Cancer Equity Act. Updated Definitions section.                                                                    |
| 07/21/2023 | Utilization Management | Added FFS Prior Authorization Requirements List as an attachment.                                                                          |
| 11/06/2023 | Utilization Management | Annual review. Updated Definitions section. Added reference CA HSC § 1374.17 (a).                                                          |
| 11/16/2023 | Utilization Management | Committee approval.                                                                                                                        |
| 03/07/2024 | Utilization Management | Added updated Attachment B.                                                                                                                |
| 06/11/2024 | Utilization Management | Removed “no notification required of approvals” and included NOA requirements for Members for authorization approval. Updated definitions. |
| 08/05/2024 | Utilization Management | Minor edits to definitions and Health & Safety Code Section in Authority.                                                                  |
| 09/23/2024 | Utilization Management | Minor update to definitions section.                                                                                                       |
| 08/27/2025 | Utilization Management | Updated APL 25-011 reference.                                                                                                              |