

# Contra Costa Health Plan

## Utilization Management

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### Applies to:

Medi-Cal

LIHP

Medicare

State Sponsored

Commercial

All

N/A

### Regulatory/Accreditation:

DHCS:

Other Reg. References:

CMS:

NCQA: UM 3, 4

DMHC:

N/A

### Units:

Administration

Business Services

Marketing

Provider Affairs

Advice Nurses

Case Management

Member Services

Quality Management

All Staff

Health Ed/Cultural Ling.

Planning, Survey, Reg Affairs

Auth/Utilization Management.

## POLICY

Utilization review is an integrated, dynamic function, which encompasses:

1. Validating benefits
2. Ensuring streamlined care for members
3. Reviewing and authorizing medically necessary covered services
4. Referring to specialty services
5. Reviewing inpatient and outpatient services throughout the continuum of care
6. Identifying duplication of services, under/over utilization activities
7. Reviewing appeals for denied services
8. Occasionally, securing and coordinating medically necessary covered service(s) for a member, which a provider does not support (Note: In these cases, there is no additional expense to the member per the Department of Health Care Services (DHCS) provision. Further information can be found in the Member Materials handbook).
9. Tracking all of these processes

CCHP Authorization and UM (Auth/UM) departments directly perform these functions for the non-delegated, Contra Costa Regional Medical Center (CCRMC) and Community Provider Network (CPN). The UM Department provides oversight to the Kaiser Network providers to ensure that all aspects of delegated utilization review activities are carried out according to standards established by the Contra Costa Health Plan (CCHP) UM Program.

The main call line to reach the Authorization and UM departments is located in the Authorization department. Normal business hours for the CCHP Auth/UM departments are Monday through Friday from 8:00am to 5:00pm, excluding weekend and holidays. During the

hours of 8:00am to 5:00pm Monday through Saturday, staff is available for inbound and outbound communications regarding the authorization and UM processes. A toll free number, TDD/TTY and language assistance are available and accessible (refer to specific Member Materials handbook). When making outbound or returning calls, staff must identify themselves by their name, title and organization.

After normal business hours, callers may leave a message at the Authorization department to be addressed the next business day. However, if urgently needed services are needed, the caller can remain on the line and the call will be re-routed to the Advice Nurse (AN) Unit. The AN unit is available 24/7, including holidays and weekends. The AN Unit has access to basic authorization procedures, is able to access to a backline at the UM Department for assistance and when necessary, to the UM Manager and Chief Medical Officer.

## **PROCEDURE**

### **APPROPRIATE PRACTITIONER FOR UM DECISIONS**

No individual, other than a licensed physician or a licensed health care professional who is competent to review and evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify authorization requests for health care services to an enrollee, based in whole or in part on medical necessity. Medical necessity determinations are made by the Chief Medical Officer or Medical Consultant. Medical necessity determinations related to medications can be made by the Health Plan Pharmacy Director (refer to Pharmacy program and policies for details).

As clarification, this means that for mental health services, a psychiatrist or other mental licensed mental health professional should be involved in decisions to deny or modify mental health services.

Requestion/treating providers can call the UM Department Physician line or call center to reach the denying physician and discuss the case.

### **MEDICAL NECESSITY AND BENEFIT DETERMINATIONS**

Modifications and denials based on medical necessity are made by the Chief Medical Officer or Medical Consultant.

Chief Medical Officer or Medical Consultant review is not required for benefit determinations. Benefit determinations are decisions for requested services that are never covered in the member's benefit plan under any circumstances. Benefit determinations include requests for extension of treatment beyond the limitations and restrictions stipulated in a member's benefit plan. Chief Medical Officer or Medical Consultant review is also not required for administrative denials, such as for duplicate referrals, requested information not received, and other denials that are not based in whole or in part based on medical necessity. A nonphysician licensed clinician can review and make these denials that are not in whole or in part based on medical necessity. A noncovered benefit determination will remain a physician denial. A list of these denials will be reviewed no less than quarterly by the Chief Medical Officer or designee to ensure quality.

### **Registered Nurses and Nurse Practitioners**

CCHP uses RNs and FNPs to make UM approval decisions that require clinical judgment. *Please see list below:*

1. Genetics at John Muir and CHO (not Stanford or UCSF which require MD review).

2. Transplant request for the initial consult by the transplant service (e.g. if they need a liver, the liver consult) at UCSF, Stanford, CPMC, or out of network (including the labs, imaging, or associated consults e.g. cardiology or pulmonary for a liver transplant).
3. NEMT approvals to contracted or not contracted - can be done by nurses
4. CPAP - initial for purchase if meets guidelines.
5. DME (non-reusable)

CCHP uses licensed health care professionals to supervise UM activities. These licensed health care professionals:

- Provide day-to-day supervision of assigned UM staff.
- Participate in staff training.
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision.
- Monitor documentation for adequacy.
- Are available to UM staff on site or by telephone.

## **ACCESS TO BOARD-CERTIFIED CONSULTANTS**

The Chief Medical Officer, Medical Directors, Assistant Medical Directors, Medical Consultant(s) or their designee can utilize internal or external board-certified consultants/specialists to assist in making initial and appeal medical necessity determinations or to assist with the clinical component of a request. A listing of contracted board-certified providers and their area of certification are provided to the UM department by Provider Relations. The Chief Medical Officer or Medical Consultant(s) can directly access these providers for an expert opinion/consult for requests that are:

1. Beyond the Chief Medical Officer or Consultant's area of expertise,
2. Not considered the standard of practice,
3. Considered investigational/experimental, or
4. Require an opinion of an expert in the field

Communication between the Chief Medical Officer/Consultant and the board-certified specialist are documented in the case record.

In addition to access to contracted board-certified specialist, the Health Plan contracts with independent medical and peer review organizations. These independent peer review organizations provide comprehensive physician expertise from board certified specialists. Full spectrum services include simple to complex including pre-certification/UM, retrospective, concurrent, appeal, quality assessments, policy/guideline/technology review, forensic, and telephone consults. The Chief Medical Officer or Consultant can access these specialists when the Health Plan does not have a contracted board-certified specialist available to give an expert opinion on the case. The Health Plan is responsible submitting all pertinent clinical information and administration documents to the independent review organization (IRO). The IRO is responsible for a written opinion/recommendation that includes a case review summary and the notation of the reviewer's credentials.

## **INFORMATION NEEDED FOR UM DECISION-MAKING**

Providers are encouraged to attach supporting documentation when submitting authorization requests to the Health Plan. Relevant clinical information is essential to make appropriate

decisions. Clinical information that may be requested from the UM Department to support decision-making for any of the review types listed below includes, but is not limited to the following:

1. Past office visits and hospital record
2. Availability of the service within the member network or as necessary, within the Health Plan network
3. Ability of the PCP to perform the necessary service
4. History and physical examination
5. Current treatment plans and progress notes
6. Diagnostic imaging and testing results
7. Past procedures/services
8. Radiological reports
9. Laboratory findings
10. Operative and pathological reports
11. Rehabilitative evaluations and progress notes
12. Conservative or standard treatment/regimens tried and/or failed
13. Psychosocial history and/or living situation
14. Consultation reports
15. Photographs
16. Valid billing codes (e.g. CPT, HCPCS)

The Health Plan may request one or more of the above supporting documents to make a decision. If the requesting provider is unable to submit the requested information in a timely manner or the information is not available, the request may be deferred or denied for insufficient information.

Please note that other supporting documentation may be necessary to support decision-making and are listed under the specific review types.

#### CONDITIONS FOR ADMINISTRATIVE DENIAL

A referral can be considered for administrative denial if it is a duplicate referral.

A duplicate referral is defined as a request for the same provider, same service and same timeframe AND currently has an approved request for the service. All information is verified by UM Staff.

#### **TYPES OF REVIEW**

##### **I. PROSPECTIVE REVIEW**

###### A. Purpose

Prospective review is an integral component of the Plan's review process. It allows for benefit determination, evaluation of proposed treatment, determination of medical necessity for requested treatment and referral, identification of service duplication, assignment of the length of stay and appropriate practitioner or level of care prior to the delivery of service as well as the identification and initiation of referrals to case management.

###### B. Functions

The prospective functions may be completely, or in part, delegated to the CCHP providers based upon agreements between CCHP and individual Health Plan providers. When delegated, the

Health Plan provider performs Utilization Management activities stipulated and overseen by the CCHP UM Program.

The function of prospective review is to determine medical necessity for requested service and to:

- a. Pre-certify inpatient admissions
- b. Prior authorize services or procedures
- c. Validate billing codes and identify potential unbundling activities
- d. Determine initial level of care and length of stay needs
- e. Determine if the requested service is within the PCP's scope of practice
- f. Determine if initial or ongoing specialty or tertiary care is needed or if the care can be directed to an in-network provider or PCP
- g. Identify service duplication, benefit limitation or exclusion
- h. Identify potential quality of care issues by using specified quality indicators and nursing judgment and submitting information to the appropriate Quality Management (QM) personnel
- i. Identify and refer potential fraudulent or abusive practices to CCHP Fraud and Abuse Committee
- j. Identify and refer member who may benefit from case management services

C. Standards for Review and Approval

1. Requests for services requiring prior authorization are submitted to CCHP Authorization Unit.
2. Verification of member eligibility, network assignment, and benefit limitations are secured for all services requiring prior authorization.
3. Initial referrals to and follow up care with specialty providers for medically necessary service/testing/procedure may be approved when there is documented evidence of the following:
  - a. For initial referrals:
    - i. A careful history and physical examination has been completed
    - ii. When applicable, trial and failure of conservative therapy or standard treatment has been attempted
  - b. An explanation that the specialty service/testing/procedure is necessary to define the specific etiology of the member's symptoms and the results will affect the treatment plan
  - c. As appropriate:
    - i. The requested service is not within the PCP's scope of practice.
    - ii. The requested service is not available within the member's provider network, or as appropriate, in the community Health Plan network.
  - d. Coordination and feedback between the specialty care provider and member's primary care provider for ongoing or transition of care.
4. Referrals to noncontracted, tertiary, or quaternary care centers when there is supporting documentation that the member has an unusual medical need that cannot be addressed by local contracted and preferred Health Plan providers.
5. Non-elective inpatient hospitalization requests may be authorized after initial concurrent review has been completed and medical necessity determined, based on clinical guidelines. If a delay in service is identified or the admission did not meet InterQual criteria, the requesting provider and member will be notified according to the timelines noted in policy UM15.018- Timeliness of the Utilization Review Decision and Communication.

## II. CONCURRENT REVIEW

### A. Purpose

Concurrent review is the process of reviewing health care services at the time the services are being rendered to ensure not only the appropriate duration and level of care, but also the medical necessity of services. Concurrent review is generally associated with inpatient care or ongoing ambulatory care. Concurrent review facilitates early discharge planning and identifies concurrent quality case findings.

### B. Functions

1. The functions of concurrent review are to:
  - a. Verify medical necessity
  - b. Determine the need for an extension of previously approved, ongoing treatment
  - c. Determine approximate length of stay or ongoing care
  - d. Determine appropriate level and setting of care
  - e. Assess ancillary usage
  - f. Determine the severity of illness and intensity of services
  - g. Change or determine the level of case management when appropriate
  - h. Initiate timely discharge planning activities
  - i. Same as above, Topic I, Prospective Review, section B. Functions, item d-e
2. As appropriate, CCHP conducts concurrent review, onsite or telephonically, for the community network providers and out of plan providers.
3. Bed holds for skilled nursing facilities are reviewed as per the Medi-Cal Provider Manual for Medi-Cal members as part of the concurrent review process. The bed hold is limited to a maximum of seven days per hospitalization when an attending physician orders the acute hospitalization. See the Medi-Cal Provider Manual: Leave of Absence, Bed Hold, and Room and Board for further details.
4. Members and providers shall be notified in a timely manner about any services identified as medically unnecessary during the concurrent review process. The written communication shall contain information regarding the process for an appeal/reconsideration. For detailed information, refer to UM policy, *UM15.018-Timeliness of UR Decision and Communication*.

### C. Scope

Concurrent review activities may be a focused effort and targeted to identified providers, services, members, method of payment, or any combination thereof.

### D. Frequency

No more frequently than daily and no less than weekly, ongoing, as indicated for Acute Care Hospitals, including Tertiary and Quaternary Care Facilities, Acute Rehabilitation, and Long Term Acute Care Facilities.

No more frequently than weekly and no less than monthly, ongoing, as indicated for skilled nursing facilities where members require skilled services. No more frequently than monthly, and no less than semi-annually, ongoing, as indicated for skilled nursing facilities where members require non-skilled (custodial) services.

For Commercial Mental Health admissions requiring ongoing review (including but not limited to acute hospitalization, residential, Partial Hospitalization), concurrent review will not be conducted at intervals more frequent than those prescribed or recommended by the relevant nonprofit association criteria or guidelines.

### **III. RETROSPECTIVE (POSTSERVICE) REVIEW**

#### **A. Purpose**

Retrospective review is the review of member care and service after it has been rendered and/or the member has been discharged from the inpatient setting. Retrospective review includes, but is not limited to: medical necessity, appropriateness, site of service, nonurgent out-of-network, and quality of care. CCHP may utilize the retrospective review process to monitor utilization activities, which may result in further analysis of encounter and other data to determine the appropriateness of a focus review.

#### **B. Functions**

1. The functions of retrospective review are to:
  - a. Provide review for medical necessity and appropriateness of services in those instances where authorization was not obtained but required.
  - b. Same as above, Topic I, Prospective Review, section B. Functions, item d-e

#### **C. Standards for Review**

Retrospective review decisions will be based on clinical guidelines and/or trends that emerge from medical need and industry standards for appropriateness of care using guidelines defined by the Quality Council, and carried out by CCHP Utilization Management Department. Retrospective reviews shall include, but are not limited to:

- a. Review of aggregate data, such as encounter data, from prospective and concurrent utilization management/case management activities, i.e. emergency department care and outcomes
- b. Coordination of care and linkages with Medi-Cal related services (paid or non-paid)
- c. Any service rendered, in plan or out of plan aggregated for analysis, patterning and determination of need for program changes
- d. Review of services which required prior authorization

#### **D. Scope**

Retrospective review will be performed on any services rendered in, or out of plan, aggregated for analysis, trending and determination of need for program changes or practitioner review.

E. Frequency

Ongoing

**IV. FOCUS REVIEW**

A. Purpose

Focus review is review directed at a specified area of service or population generally to address identified or suspected problems, or to assess provider performance in meeting prescribed standards of care.

B. Functions

- a. Determine over and under utilization of services reviewed
- b. Identify high cost services
- c. Review for deviations from community or the Plan normality
- d. Same as above, Topic I, Prospective Review, section B. Functions, item d-e

C. Responsibility

CCHP reserves the right to conduct a focus review of the contracted providers and affiliated providers. CCHP will conduct focus reviews for CPN providers and out-of-plan providers as needed.

D. Standards

Focus review will be conducted based on internally identified question or problem areas, high volume or high risk services, or requests from the State Department of Health Care Services, Department of Managed Care Services or Center for Medicare and Medicaid Services and other areas that would benefit from investigation.

E. Frequency

Ad hoc

**V. PROFESSIONAL CLAIMS/ENCOUNTER REVIEW**

A. Purpose

To evaluate services and performance based on medical necessity, appropriateness and medical policy criteria.

B. Functions

CCHP, in its oversight function, may review the delegated process at any level of detail. The functions of the claims/encounter review are to:

- a. Provide individual claim/encounter review using established review guidelines. Examples of review guidelines include:
  - By report procedures

- Unusual billing/encounter patterns
- Visit frequency
- Inconsistent procedures and diagnosis
- Unusual types of service
- Use of out-of-plan providers
- Questionable procedures
- High dollar services
- Unusual plan or provider patterns
- Provide medical necessity in relation to the diagnosis and services rendered through the use of automated screens
- Analyze paid claims and encounter data through post-payment or post episode review to identify providers and member whose utilization (both over and under utilization) and cost or potential cost patterns fall outside established norms, current standards and policies or those of their peers
- Review claims/encounter for services identified in system audits
- Identify potential quality of care issues, using specified quality indicators and nursing judgment and submit to the appropriate QM personnel
- Identify the performance of provision of excluded services or procedures
- Identify data for support of quality functions i.e., immunization rates
- Assess access, under and over utilization potential quality issues (i.e. emergency department usage reports)

#### C. Standards

CCHP retrospective review of encounter/claims data can affect the basis for oversight and review function of the Plan. This analysis of encounter data is one of the most important tools in the assurance of quality and appropriate utilization available to the CCHP on a continuous basis in its oversight role. At the Kaiser provider levels, the professional review claims/encounter will be conducted in accordance with the entity's internal policies and procedures. Claims or encounters submitted from CPN providers may be subjected to this review process.

#### D. Scope

Health Plan providers will supply all encounters data to the CCHP. CCHP will utilize all encounter data received from providers to analyze quality and utilization at all levels. Such data will be cross-referenced to determine patterns and create care guidelines by which all Health Plan providers will be measured. Results of oversight review and analysis will be submitted to the CCHP QC for review and shared with the Health Plan providers.

#### E. Frequency

CCHP will use the claim/encounter review process for quality and utilization review as noted in their UM Program policies and procedures. CCHP will use this methodology on a continuous basis. Frequency is ongoing.

## VI. **INDIVIDUAL CASE REVIEW**

### A. Purpose

Individual review can be performed prospectively, concurrently and retrospectively. Individual cases will be assessed for medical necessity, level of care, appropriateness of site and duration, benefit determination and delays in the provision of health care services. An individual review is also performed when the UM Department is notified a provider does not support a medically necessary **covered** service for a member. When a provider is unwilling to perform or otherwise support a covered service because of a moral objection, such as religious or ethical objections, the UM Department will secure, refer, and coordinate care for the member to a provider willing to perform such services. These services, if any, are identified in the Member Services Guide. Individual review is performed in a timely manner as described in policy UM 15.015a, Timeliness of Utilization Review Decision and Communication.

#### B. Functions

CCHP UM Department conducts initial individual case review for CPN providers. Depending on the reason for review, the Quality Council or Appeals Committee may conduct a second level of review. Individual case review includes, but not limited to:

- Admission, prospective, concurrent and retrospective reviews
- Case management activities and discharge planning
- Second opinion request
- Medical claims review
- Issues identification
- Sentinel events

#### C. Scope

Individual review is generally identified under special circumstances such as a sentinel event, member grievance or complaint, potential compensable event.

#### D. Frequency

Ad hoc

### **APPLICATION OF CRITERIA**

When clinical criteria are applied, the individual needs of the member, such as age, comorbidities, complications, progress of treatment, physical limitations, home environment, psychosocial situation, complications, and progress of treatment are considered. The Health Plan also considers the member's benefit package and availability of alternative level of care, such as skilled nursing facilities, long-term acute care, sub-acute facilities and home health services in the local health delivery system. Refer to policy *UM 15.002- Utilization Review Criteria and Guidelines* for detailed information.