

CONTRA COSTA HEALTH PLAN

Utilization Management

Title: Timeliness of the Utilization Review Decision and Communication

Policy #: UM15.018 (formerly UM15.015.a)

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Applies to:

- | | | |
|-----------------------------------|--|--|
| <input type="checkbox"/> Medi-Cal | <input type="checkbox"/> Medicare | <input type="checkbox"/> Commercial |
| <input type="checkbox"/> | <input type="checkbox"/> State Sponsored | <input checked="" type="checkbox"/> All <input type="checkbox"/> N/A |

Regulatory/Accreditation:

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> DMHC | <input type="checkbox"/> HCFA: | <input checked="" type="checkbox"/> DHCS: Contract A.13.8A |
| <input checked="" type="checkbox"/> Other Reg. References: CCR 22, Sections 51014.1-2, 53894. Health & Safety Code, Section 1363.5 | <input checked="" type="checkbox"/> NCQA: UM 3 | <input type="checkbox"/> Other: |

Units:

- | | | |
|--|---|---|
| <input type="checkbox"/> Administration | <input type="checkbox"/> Advice Nurses | <input type="checkbox"/> All Staff |
| <input type="checkbox"/> Business Services | <input type="checkbox"/> Care Management | <input type="checkbox"/> Health Ed/Cultural Ling. |
| <input type="checkbox"/> Marketing | <input type="checkbox"/> Member Services | <input type="checkbox"/> Planning, Survey, Reg Affairs |
| <input type="checkbox"/> Provider Affairs | <input type="checkbox"/> Quality Management | <input checked="" type="checkbox"/> Auth/Utilization Management |

POLICY

The Utilization Review process at Contra Costa Health Plan (CCHP) maintains standard timeframes for making determinations on all prospective, concurrent and retrospective authorization requests as required by regulatory agencies. In addition, 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. Medical necessity denials are made by Chief Medical Officer, physician designee, or pharmacist designee. The Chief Medical Officer or designee will sign and make an indication in the member's medical record.

PURPOSE

To ensure decisions are made and communicated to the provider and member in a timely manner by maintaining a standardized guideline for the Utilization Review process. Additionally, defines preservice requests that are considered "urgent" in nature, in which case decisions are made within 72 hours after receipt of information "reasonably necessary" and requested by the Plan to make the decision. Effective January 1, 2026, for DSNP and Medi-Cal Lines of Business, CCHP must make a decision and notify the member within seven calendar days for standard prior authorization requests or

72 hours for expedited requests. These timeframes begin on the date the request is received, regardless of whether all necessary information has been submitted.

PROCEDURE

Authorization Timeframes

Decisions to approve, modify, delay or deny service requests from providers or members will be made within specific timeframes by the Plan and its delegated entities. Specifically, CCHP will render a decision on a provider's request for authorization of health care services for a member and notify the provider and the member using the appropriate Notice of Action (NOA) template within the timeframes outlined below and in accordance with notification requirements in federal and state law.

For purposes of auditing, the postmark on CCHP's notice to the member will be used to confirm compliance with all prior authorization request timeframes and notice requirements.

Depending on the type of service requested, the length of time to review the request and make a determination shall not exceed the below authorization timeframes:

I. Routine PA (Standard) Requests

Excluding pharmacy services, CCHP will approve, modify, or deny a provider's prospective or concurrent request for health care services for a member within the shortest applicable timeframe that is appropriate for the member's condition. This timeframe should be no longer than five business days from CCHP's receipt of information reasonably necessary and requested by CCHP to make a determination.

- For Medi-Cal members: This timeframe should not exceed 7 calendar days following CCHP's receipt of the request for service.
- For Commercial members: This timeframe should not exceed 5 business days following CCHP's receipt of the request for service.

In certain circumstances, a timeframe extension may be required. Please refer to the section of this policy on timeframe extensions.

CCHP's failure to render a decision for standard authorization requests within the required timeframes above is considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires. In this situation, the member has the right to request an appeal with CCHP and CCHP will send the member written notice of all appeal rights.

II. Urgent PA (Expedited) Requests

In instances where a provider indicates, or CCHP determines, that the standard request timeframe may seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, CCHP will approve, modify, or deny a provider's prior authorization or concurrent request for health care services for a member, and notify the provider and the member, using the appropriate NOA template, in a timeframe that is

appropriate for the nature of the member's condition, but is no longer than 72 hours after CCHP's receipt of the request for service.

CCHP's failure to render a decision for standard authorization requests within the required timeframes above is considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires. In this situation, the member has the right to request an appeal with CCHP and CCHP will send the member written notice of all appeal rights.

III. Emergency Request

Emergency health care services, include ambulance services to transport a member to the nearest 24-hour emergency facility are available and accessible to members, 24-hours a day, 7-days a week within the service plan area.

In-area and out-of-area emergency services may be rendered to enrollees without any prior authorization up to the point of stabilization. Prior authorization is not required until the enrollee is stabilized.

Upon stabilization of the member in a noncontracted hospital, the Health Plan will respond to a request for authorization of continued service or admission within 30 minutes, or otherwise, the admission request is considered approved. The Health Plan will also respond to a request for non-urgent care following an emergency room exam within 30 minutes, or otherwise, the request is considered approved. During work hours, the Utilization Management Unit is available to collaborate and coordinate post-stabilization follow up and transitional services for the enrollee. During after hours, the Advice Nurse Unit, which operates 24-hours, 7-days a week, is available to assist with the coordination of follow up services. Please refer to *UM15.016- Hospital Post Stabilization Care* for further information.

IV. Concurrent Review

Upon receipt of current clinical information for urgent concurrent care, CCHP shall make a decision within 72 hours. The timeframe begins on the first day of the initial request. A request for authorization of an acute inpatient stay after the member is discharged is considered a retrospective request.

V. Retrospective (Post-service) Requests

In cases where the review is retrospective, CCHP will communicate its decision to the member who received services, or to the member's designee, within 30 days of the receipt of information that is reasonably necessary to make the retro-authorization decision. CCHP is also required to communicate the decision to the provider in a manner that is consistent with current law.

- Please note: The maximum time allowed for a provider to submit a retroactive authorization is 180 days from the date of service. However, CCHP may decide, on a case-by-case basis, to process a retroactive authorization beyond the maximum timeframe noted above when there is documented evidence of extenuating circumstances.

VI. Hospice Inpatient Care Request

The Health Plan will respond to a request for in-network hospice care within a 24-hour timeframe. Prior authorization is not required for contracted hospice agencies to initiate services.

VII. Long Term Care Requests

Please see UM Policy 15.071 Long Term Care for details regarding Long Term Care Requests. Effective 1/1/2023, prior authorization requests for members who are transitioning from an acute care hospital are to be considered urgent, requiring a response time of no greater than 72 hours, including weekends.

VIII. Terminations, Suspensions, or Reductions

For terminations, suspensions, or reductions of previously authorized services, CCHP 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.

Extension of Authorization Timeframes

Pursuant to the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule (CMS-0057-F), effective January 1, 2026, no extension of authorization timeframes will be permitted for Medi-Cal or DSNP plan determinations.

I. Routine PA (Standard Requests)

Federal law permits an extension of the initial 7 calendar day authorization timeframe by up to 14 days if the member or the provider requests an extension, or if CCHP can justify its need for additional information and demonstrate how the extension is in the member's interest.

If CCHP requires an extension of the initial 7 calendar day authorization timeframe, CCHP must either deny the authorization request or immediately notify the requesting provider to request all specific information that CCHP still needs to make its authorization decision. The requesting provider is contacted, no less than twice, during the timeline extension. CCHP must also document its justification in the member's medical record of the need for the extension to obtain additional information and demonstrate how the extension is in the member's interest. CCHP will provide this documentation upon request. CCHP will also notify the member of the need for extension.

CCHP's written notice requesting additional medical information will specify the information CCHP requested but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied. CCHP must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the member's health condition requires, and advise the member that they have a right to file a grievance to dispute the delay. CCHP will send this written notice within the required timeframe, or as soon as CCHP becomes aware that it will not meet the initial authorization timeframe, whichever is earlier.

Following CCHP's notification and request for additional and specific information, CCHP will approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the member's condition but no longer than five business days from

CCHP's receipt of information reasonably necessary and requested by CCHP to make a determination, not to exceed the additional 14 calendar days.

II. Urgent PA (Expedited Requests)

Federal law permits an extension of the initial 72-hour authorization timeframe by up to 14 calendar days if the member requests the extension, or if CCHP can justify its need for additional information and demonstrates how the extension is in the member's interest.

If CCHP requires an extension of the initial 72-hour authorization timeframe, CCHP must either deny the authorization request or document its justification in the member's medical record of the need for the extension to obtain additional information and demonstrate how the extension is in the member's interest. If CCHP requires the extension, it must send written notice to the member and the provider, using the appropriate NOA template, to request the specific information it needs to determine if the service is medically necessary. This notice must be sent within the required timeframe, or as soon as CCHP becomes aware that it will not be able to meet the initial timeframe, whichever is earlier.

The written notice must specify the information CCHP needs but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied. CCHP must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the member's health condition requires, and advise the member that they have a right to file a grievance to dispute the delay.

Following this notification and request for specific information, CCHP must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the member's condition, but is no longer than 72 hours from CCHP's receipt of the additional information reasonably necessary and requested by CCHP to make a determination, not to exceed the additional 14 calendar days.

Communication to Members and Providers – Notices of Action

I. Medi-Cal Members

Decisions to approve, modify, or deny requests, must be communicated by CCHP to the provider within 24 hours of the decision and to the member within two business days using the appropriate Notice of Action (NOA) template.

CCHP must provide members with written notice of an adverse benefit determination using the appropriate DHCS-developed, standardized NOA template and the NOA "Your Rights" template. CCHP is not permitted to 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, as set forth in APL 21-004. The NOA is comprised of two components: (1) the appropriate DHCS standardized NOA template and (2) the DHCS standardized NOA "Your Rights" template.

For decisions based in whole or in part on medical necessity, the written NOA must contain all of the following:

- A statement of the action that CCHP intends to take
- A clear and concise explanation of the reasons for the decision
- 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 guidelines.
- The clinical reasons for the decision. CCHP must explicitly state how the member's condition does not meet the criteria or guidelines.
- For written notification to the provider, the name and direct telephone number or extension of the decision maker.

For all other adverse benefit determinations that are not based on medical necessity (i.e. denials based on a lack of information, or benefit denials, etc), CCHP will still ensure that the NOA provides a clear and concise explanation of the reasons for the decision.

II. Commercial Members

Decisions to approve, modify, or deny requests, must be communicated by CCHP to the provider within 24 hours of the decision and to the member within two business days using the appropriate Notice of Action (NOA) template.

CCHP must provide members with written notice of an adverse benefit determination using the appropriate state-required standardized NOA template and the NOA "Your Rights" template. CCHP is not permitted to make any changes to the NOA templates or NOA "Your Rights" templates without prior review and approval from the State, 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. The NOA is comprised of two components: (1) the appropriate DHCS standardized NOA template and (2) the DHCS standardized NOA "Your Rights" template.

For decisions based in whole or in part on medical necessity, the written NOA must contain all of the following:

- A statement of the action that CCHP intends to take
- A clear and concise explanation of the reasons for the decision
- 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 guidelines.
- The clinical reasons for the decision. CCHP must explicitly state how the member's condition does not meet the criteria or guidelines.
- For written notification to the provider, the name and direct telephone number or extension of the decision maker.

For all other adverse benefit determinations that are not based on medical necessity (i.e. denials based on a lack of information, or benefit denials, etc), CCHP will still ensure that the NOA provides a clear and concise explanation of the reasons for the decision.

The Health Plan keeps member files, including written communication, such as Notice of Action, for a period of no less than ten years.

Internal Training:

All Authorization/Utilization management staff (Health Plan Authorization Representatives [HPARs], Nurses, and Physicians) will be provided training by Authorization/Utilization Management leadership or designee regarding Authorization/Utilization processes pertaining to the timeliness of Utilization Management decisions and communications. This training will include, but is not limited to: review of relevant policies, procedures, All Plan Letters (APLs), and relevant sections of our CCHP contracts; shadowing of fellow staff members, and facilitated review of referrals in collaboration with a more senior Authorization/Utilization Management team member

Internal Audit Processes and Remediation:

CCHP will be monitoring the UM department timeliness for UM timeframes and all required elements via multiple mechanisms:

- Monthly Turnaround Time Audit (TAT)
 - Review of a random sample of authorization requests that were processed outside of turnaround time requirements
 - Review will include, but is not limited to: root case analysis, opportunities for improvement, track/trend of percentage of requests that are within TAT
- Inter-Rater Reliability (RN, physicians)
 - Review will include, but is not limited to: timeliness of decision, content and readability of NOA, application of appropriate clinical criteria/guidelines
- Monthly audits of at least five referrals of each type (urgent, concurrent, routine, retrospective)
 - Review will include timeliness of decision
- Monthly audits of at least ten NOA letters of each type (Approvals, Modifications, Denials, Delay)
 - Review will include, but is not limited to: timeliness of letter being sent, content and readability of letter

If auditing reflects group-level concern, training will be provided to all staff via either role-specific meetings or all-staff meeting. If auditing reflects individual-level concern, the identified staff will be counseled by relevant supervisor, will be provided retraining, and will conduct utilization management with close monitoring by supervisor.

DECISION TYPES

AUTHORIZED- The requested service is approved.

DEFERRED- A delay in making a decision until a later date in order, allowing time to obtain and/or review necessary information, procedures, or consultations.

PARTIALLY AUTHORIZED- A change, restriction or limitation to a requested service; not an outright refusal (denial) to provide/approve the requested service.

- Example #1- A provider requests 5 follow up visits but instead of authorizing 5 follow up visits, the Health Plan approves only 2 follow up visits.
- Example #2- A provider requests a tertiary care center for specialty care; instead of approving the specialty care at the tertiary care center, the Health Plan authorizes the specialty care but with a community provider.

DENIED- The refusal to provide, approve or pay for a requested service.

Decision	Member Notification	Requesting Provider Notification	Documentation Required in Written Communication*
Approved Routine Request	Written notice within 2 business days from the date of the decision	Verbal or facsimile notification within 24 hours to the requesting provider (or treating provider if care is underway), followed by written communication within 2 business days	Specify the specific health care services (s) approved
Approved Urgent Request	Written communication within 2 business days from the date of the decision	Verbal or facsimile notification within 24 hours of decision, followed by written communication within 2 business days	Specify the specific health care services (s) approved
Denial, Partially Authorized	Written communication within 2 business days (or up to 3 business days for Medi-Cal members) from the date of the decision.	<p>Verbal or facsimile notification to the requesting provider (or treating provider for care underway*) within 24 hours, followed by written communication within 2 business days (or up to 3 business days for Medi-Cal members).</p> <p><i>*care shall not be discontinued until a care plan has been agreed upon by the treating provider appropriate for the medical needs of the patient</i></p>	<ol style="list-style-type: none"> 1) A statement of the action that CCHP attends to make 2) Clear and concise and understandable 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) Availability of the referenced document to the member and provider. 5) The clinical reasons for the decision. CCHP will explicitly state how the member's condition does not meet the criteria or guidelines Grievance, IMR, "Your Rights" (applicable to Medi-Cal members only) and/or administrative hearing rights, including the option to continued coverage/service(s) pending appeal outcome. 6) UM Physician will sign and make indication in medical record appropriate Practitioner for utilization management decisions.

<p>Delay (Need for Timeline Extension)</p> <p><u>*If a delay in making a decision is required:</u> A deferral letter shall be sent to a commercial enrollee and requesting provider within 5 business days, or prior to January 1, 2026, within 7 calendar days for a Medi-Cal or Medicare enrollee from the receipt of the request.</p>	<p>Written communication within 2 business days (or up to 3 business days for Medi-Cal members) from the date of the decision.</p>	<p>Verbal or facsimile notification to the requesting provider (or treating provider for care underway*) within 24 hours, followed by written communication within 2 business days (or, prior to January 1, 2026, up to 3 business days for Medi-Cal members).</p>	<p>CCHP's written notice requesting additional medical information will specify the information CCHP requested but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied. CCHP must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the member's health condition requires, and advise the member that they have a right to file a grievance to dispute the delay.</p>
<p>Retrospective Request</p>	<p>Written communication within 30 days</p>	<p>Written communication within 30 days</p>	<p><i>(For approvals:</i> same as Approved Routine Request. <i>For all others:</i> same as Denial, or Modification of Request)</p>
<p>AFTER receipt of External Review determination (Maximus CHDR, Fair Hearing, IMR, or IRO) and the internal determination is overturned</p>	<p>Final decision will be promptly processed and written notice to the member & provider as noted below:</p> <ol style="list-style-type: none"> 1. <u>Reimbursement for past services</u>- 5 business days 2. <u>Authorization for future services</u>- 5 business days 3. <u>Concurrent review decision denied, delayed or modified (services that are underway)</u>- 2 business days 	<p>Final determination will be promptly processed and written communication sent to the external reviewer and provider explaining actions taken, within specified timeframe noted under the Member section. <u>Exception:</u> For concurrent review decisions that are denied, delayed or modified. Telephone or fax communication within 24 hours followed by written communication within 2 business days.</p>	<p>Specify the health care service(s) approved</p>

**Please note: The term "written communication or notice" in this table refers to Medi-Cal's Notice of Action, Medicare's Notice of Non-Coverage, and other approval or denial letters/notices.*