

CONTRA COSTA HEALTH PLAN

Utilization Mgmt.

Title: Disclosure of Utilization Management Criteria or Guidelines **Policy #: UM15.030**

Origin Date: 12/1/99
Revised: 12/05, 03/06, 5/8/09
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Applies to:

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

Regulatory/Accreditation:

- | | | |
|--|--------------------------------|-------------------------------|
| <input checked="" type="checkbox"/> Department of Managed Care | <input type="checkbox"/> HCFA: | <input type="checkbox"/> DHS: |
| <input checked="" type="checkbox"/> Other Reg. References: SB59,SB2094
Health & Safety Code, Section 1363.5 | <input type="checkbox"/> NCQA: | <input type="checkbox"/> N/A |

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

Contra Costa Health Plan (CCHP) will disclose to contracted providers, materials and guidelines used by the Plan to conduct utilization review activities. Guidelines are used by the Utilization Management department to authorize, modify, or deny health care services, which includes but is not limited to outpatient procedures, specialty care referrals, inpatient and skilled nursing facility care. For an unfavorable determination, CCHP will cite the information source on the written denial/modification notice sent to the member and copied to the provider.

The written notice informs the member and/or their authorized representative that upon request, s/he can obtain a copy of the benefit provision, guideline, protocol or other similar criterion used to make the decision. The guidelines, et.al are available without cost. Additionally, members are notified in annual newsletters the availability of guidelines used in the decision-making process. Upon request, CCHP shall disclose the above processes to enrollees or persons designated by an enrollee, or to any other person or organization.

Similarly, contracted providers are notified of guideline availability via their copy of the written denial/modification notice. Providers are also made aware of their ability to obtain guidelines used by the Health Plan in their Provider Manual and periodic newsletters. Provider can contact the Authorization Unit for copies of guidelines used in the decision-making process.

PURPOSE

To ensure regulatory agencies, providers and enrollees that criteria or guidelines used by the Health Plan to make medical necessity determinations are available and:

1. Consistent with evidence-based, sound clinical principles and processes, and standard of practice and; published by nationally recognized health care organizations and/or regulatory agencies
2. Consistent with product line specific clinical guidelines
3. Developed with the involvement of actively practicing health care providers
4. Evaluated, and updated if necessary, at least annually
5. Disclosed to the provider and upon request, to the enrollee when a decision has been made to deny, delay or modify a service
6. Available to the public upon request

PROCEDURE

CCHP uses established criteria or guidelines during the decision-making process for consistency and as a basis for an approval, denial, delay or modification of a treatment request. The criteria or guidelines used will be disclosed automatically to the provider and upon request, to the enrollee.

A written communication (subject to timeframes specified in policy *UM 15.018-Timeliness of the UR Decision and Communication*) for all denials, delays and modifications shall include:

1. A statement of the action that CCHP intends to take
2. A clear and concise explanation of the reason for the decision
3. A description of the criteria/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.
4. The clinical reason for the decision regarding medical necessity. CCHP must explicitly state how the member's condition does not meet the criteria or guidelines.
5. For written notification to the provider, the name and direct telephone number or extension of the decision maker.

Criteria and guidelines are disclosed to members and contracted providers at no cost.

Availability of Criteria or Guidelines to the General Public (*non-member or non-contracted provider*):

CCHP will only disclose the criteria or guidelines for the specific procedures or conditions requested. CCHP reserves the right to charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines. In addition, the following notice will appear on the disclosure: *"The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefit covered under your contract"* (see attachment).

**CONTRA COSTA HEALTH PLAN
UTILIZATION MANAGEMENT UNIT**

DISCLOSURE OF CRITERIA OR GUIDELINES REQUEST FORM
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Phone (925) 957-7260 Option 3, Fax (925) 313-6458, ATTN: INTERNAL AUDIT/CHARGE RN

Date:

Requestor:

Agency/Company:

Address:

Phone: _____ Fax: _____

Specific Criteria or Guideline Requested:

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.

For Contra Costa Health Plan only:

Date request _____

Date Criteria/Guideline _____ Initials: _____

Publisher and Title of Criteria/Guideline sent:
