



UTILIZATION MANAGEMENT

Utilization Review Criteria and Guidelines, Policy #15.102

PRODUCT LINE: Care Plus (HMO D-SNP)

AGENCY: Contra Costa Health Plan

UNITS: Utilization Management

I. **PURPOSE:**

The purpose of this policy is to define the process by which Care Plus establishes Utilization criteria and guidelines to ensure that Organization Determination decisions related to Utilization Management (UM) are made in a consistent manner and comport with program requirements, including Medicare laws, rules, National Coverage Determinations, and Local Coverage Determinations, and local and national care standards.

II. **POLICY:**

- A. Care Plus shall be responsible for ensuring that decisions related to UM and coverage or denial of requested Covered Services, and/or supplies, are consistent with the criteria and guidelines set forth in this Policy.
- B. Care Plus shall make UM decisions based only on appropriateness of care and service, and existence of coverage (including consideration of hierarchy of coverage for Medicare vs Medi-Cal covered benefits). Care Plus should not reward Practitioners, or other individuals, for denying, limiting, or discontinuing coverage or care. Care Plus adheres to all applicable requirements when making initial determinations.
- C. Care Plus shall dismiss requests for an initial determination when any of the following conditions exist:
 - The individual or entity making the request is not permitted to request an initial determination under the applicable regulation. •
 - The plan determines that the individual or entity making the request failed to make a valid request for an initial determination that substantially complies with 42 CFR §§ 422.568(a) or 423.568(a). A valid request, includes sufficient information to identify the enrollee to allow the plan to adjudicate the request (or, at a minimum, make contact with the enrollee to clarify the request), including a full name or member ID number or at least one means of contact (i.e number, email).
 - In addition, under Part D, an enrollee may not request a tiering exception for an approved non-formulary prescription drug. See 42 CFR § 423.578(c)(4)(iii). In this circumstance, a plan would dismiss the request and issue a dismissal notice in accordance with the notice requirements at § 40.15.1.
 - The enrollee dies while the request is pending and the enrollee's spouse or estate

has no remaining financial interest in the case and no other individual or entity with a financial interest in the case wishes to pursue the initial determination. Financial interest means having financial liability for the item(s) or service(s) underlying the coverage request.

- The individual or entity who requested the review submits a timely verbal or written request for withdrawal of their request for an initial determination with the plan. Care Plus shall ensure that criteria and practice guidelines and UM activities and decisions:
 - Are developed in consultation with contracted Providers; and are reviewed and updated annually, as appropriate, by submitting the recommended criteria and guidelines to the Utilization Management Committee (UMC) voting physician Members for review and approval, in accordance with Title 28, California Code Regulations, § 1300.70 (b)(2)(H) & (c) and 42 CFR 422.137(d).
- D. Care Plus shall conduct the Utilization Review using criteria and guidelines that are approved and adopted in the Care Plus UM Program. Criteria and guideline hierarchy includes the following:
- Medicare
 - a. CMS National Coverage Determinations (NCD), including NCD with Coverage of Evidence Development (CED);
 - b. CMS Local Coverage Determination (LCD) (Noridian Local Contractor for California);
 - c. CMS Local Coverage Article (LCA);
 - d. Original Medicare laws and regulations (unless superseded by Medicare Advantage laws or regulations, and CMS Manuals (Medicare Benefit Policy Manual, Medicare National (NCD) Manual, Medicare Claims Processing Manual, etc.);
 - e. Drug Compendia: Micromedex DrugDex, American Hospital Formulary Service-Drug Information (AHFS-DI), Clinical Pharmacology, National Comprehensive Cancer Network® (NCCN) Drugs and Biologics Compendium, Lexi-Drugs for off-label anti-cancer Part B drugs only.
 - f. InterQual; and Internally-created and publicly available coverage guidelines based on the following:
 - i. Peer-reviewed literature
 - ii. Other: Medical Societies, National Guidelines, and other Authoritative Publications:
 - World Professional Association for Transgender Health (WPATH);
 - U.S. Food and Drug Administration (FDA);
 - Centers for Disease Control and Prevention (CDC);
 - American Board of Medical Specialties;
 - Up-to-Date;
 - Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines);
 - National Comprehensive Cancer Network® (NCCN) Guidelines.
 - Medi-Cal:
 - a. Medi-Cal Provider Manual, and Department of Health Care Services

- (DHCS) All Plan Letters (APL);
 - b. Care Plus Medical Policy / Clinical Guidelines / Evidence of Coverage / Member Handbook;
 - c. InterQual Guidelines;
 - d. Drug Compendia: Micromedex DrugDex and American Hospital Formulary Service- Drug Information (AHFS-DI);
 - e. Peer-Reviewed Medical Literature;
 - f. National Comprehensive Cancer Network® (NCCN) Guidelines; and
 - g. Other: Medical Societies, National Guidelines, and other Authoritative Publications:
 - i. World Professional Association for Transgender Health (WPATH);
 - ii. U.S. Food and Drug Administration (FDA);
 - iii. Centers for Disease Control and Prevention (CDC);
 - iv. American Board of Medical Specialties;
 - v. Up to Date;
 - vi. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines);
 - vii. National Correct Coding Initiative (NCCI) Policy Manual.
- E. Upon a treating Physician’s, Member’s, or Authorized Representative’s request, Care Plus shall provide, in writing, all criteria used in making a UM decision including, but not limited to, discharge and continued stay criteria, and clinical practice guidelines, in accordance with Health and Safety Code, § 1363.5 (b)(5) and the CMS Coverage Decision Letter instructions and template.
- F. Care Plus shall ensure its UM policies, processes, strategies, evidentiary standards, and other factors used for UM or Utilization Review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits. (in accordance with Health and Safety Code, § 1363.5 (a).

G. **DEFINITIONS:**

Term	Definition
Authorized Representative	For the purposes of this policy, any individual authorized by a Member, or under state law, to act on their behalf in obtaining an Organization Determination or in dealing with any level of the Appeal process. An Authorized Representative is subject to the rules described in Title 20 of the Code of Federal Regulations, Part 404, Subpart R, unless otherwise stated in the Medicare Managed Care Manual.
California Children’s Services Program (CCS)	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by Care Plus, the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or Care Plus departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by Care Plus and its regulators.

Covered Services	Those medical services, equipment, or supplies that Care Plus is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Evidence-Based	A document or recommendation created using an unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients.
Inter-Rater Reliability (IRR)	An assessment tool that measures the degree of reliability of different licensed staff when utilizing criteria for authorizing or denying Covered Services.
Member	A beneficiary enrolled in a Care Plus program.
Organization Determination	Any determination made by Care Plus or its delegated entity with the respect the following <ol style="list-style-type: none"> 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a that the Member believes: <ol style="list-style-type: none"> a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by Care Plus. 3. Refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged - by Care Plus 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and 5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Prior Authorization	A process through which a physician or other health care provider is required to obtain advance approval, from Care Plus and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Provider	Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.

Utilization Management (UM) or Utilization Review	The evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.
Utilization Management (UM) Program	A written document evaluated and revised on an annual basis, that describes the Utilization Management policies, procedures, processes, and programs that are implemented organizationally to attain goals set forth by the health plan, to meet health plan, State, Federal, and accrediting agency requirements.
Whole Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions

III. PROCEDURE:

A. Source of Criteria and Guidelines

Contra Costa Health Plan (CCHP) draws and follows recommendations from a number of nationally recognized sources in the development of clinical authorization guidelines and the application of criteria in the decision-making process. These recommendations and guidelines are used to evaluate the medical necessity for preventive care, admissions, outpatient surgeries, diagnostic and therapeutics, and ancillary services, such as durable medical equipment, orthotics, and prosthetics.

Quality Council (QC) approves the following organizations and resources for the Utilization Management Department to use in the decision-making process unless otherwise mandated by federal/state law, policies, or regulations.

Usage preference is explained in section “Application of Criteria and Guidelines.” The guidelines listed below demonstrate the breadth of guidelines that CCHP uses but is not exhaustive.

1. Center for Medicare/Medicaid Services (CMS)- *CCHP Care Plus*
2. Noridian Administrative Services-DMERC Reg D- *CCHP Care Plus*
3. State Department of Health Care Services-DHCS (Medi-Cal) - *CCHP Care Plus Medi-Cal*
4. InterQual Intensity of Service and Severity of Illness Criteria
5. Apollo Guidelines
6. World Professional Association for Transgender Health
7. Health Plan established clinical authorization guidelines
8. American Academy of Pediatrics (<http://pediatrics.org>)
9. American Congress of Obstetricians and Gynecologists (<http://www.acog.org>)
10. National Comprehensive Cancer Network (<http://www.nccn.org/>)
11. National Institute for Health (<http://www.nih.gov/>)
12. American Academy of Family Physicians
13. American Academy of Neurology
14. American Academy of Sleep Medicine

15. American College of Physicians
16. American Psychiatric Association
17. American Psychological Association
18. Council of Autism Service Providers
19. Canadian National Network for Mood and Anxiety Treatments
20. American Society of Addiction Medicine
21. American Association for Community Psychiatry
22. American Academy of Child and Adolescent Psychiatry
23. American Medical Association Practice Parameters
24. National Committee for Quality Assurance
25. Joint Commission Accreditation for Hospital Organizations
26. National Guideline Clearinghouse
(http://guidelines.gov/resources/guideline_index.aspx)
27. Contra Costa County Health Services' Approved Electronic Library Web-Based Resources (Including Up-to-Date and other resources)
28. Guidelines from other national societies and nonprofits, as appropriate

Please see "Application of Criteria and Guidelines" section for additional details.

In addition, other statistical data and resources are considered that may influence the frequency of review and revision of guidelines including: admits/1000, bed days/1000, visits/1000, under and over utilization of services, and any standards or goals published by professional organizations and approved by QC prior to use.

B. Development of Clinical Criteria or Guidelines

In consultation with providers from the Contra Costa Regional Medical Center (RMC) and/or Community Provider networks (CPN), the CCHP UM department review and create guidelines based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field(s). The guidelines also consider the needs of members and stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines or are developed with the involvement of board-certified Providers from appropriate specialties. These practices will be used to establish authorization and utilization review guidelines. Policies containing new or revised clinical criteria or guidelines will be reviewed and approved by the UM Committee (UMC). This will be done after review by the Chief Medical Officer, or designee. Documentation of above activities is noted in the QC minutes. All policies are reviewed on an annual basis by Quality Council following approval at UMC.

C. Utilization of Criteria or Guidelines by Participating Providers

Participating providers will be notified by CCHP that Health Plan established guidelines, Medicare, Medi-Cal, InterQual, Apollo, , and guidelines from national societies and nonprofits are the primary criteria for the decision-making process.

CCHP review guidelines are available to providers for free and applicable to all utilization activities.

D. Application of Criteria and Guidelines

The consistency of applying approved criteria and guidelines is measured at all levels of delegation via periodic retrospective review by Utilization Management leadership, Utilization

Management rounds, or periodic audits of determinations made by using these criteria.

As part of the UM Physician's secondary review, the physician who serves as the ultimate decision maker will verify that the nurse has selected and applied appropriate criteria and guidelines.

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.

In general, guidelines used in the decision-making process (prospective, concurrent and retroactive reviews and determinations) are as follows:

1. For hospital admission review (emergency room admissions, concurrent stay and retroactive review):
2. Based on enrollee's product line:
3. Medicare National Coverage Determinations, laws, rules and other guidelines (including Local Coverage Determinations) for Care Plus enrollees,
4. Medi-Cal guidelines (including but not limited to the Medi-Cal Provider Manual and DHCS APL's) if Medicare guidelines do not exist, are nonspecific, or relate to Medicare non-covered benefits for Care Plus members.
5. InterQual guidelines when #3 or #4 are nonexistent or non-specific.
6. Apollo Medical Review guidelines when #5 are nonexistent or non-specific.
7. For elective admissions, long term acute care hospitals, skilled nursing facilities, specialty care referrals, Outpatient and ancillary services the following priority order are used for decision-making, **except as noted under ADOPTED GUIDELINES:**

1. Based on enrollee's product line:
2. Medicare National Coverage Determinations, laws, rules and other guidelines (including Local Coverage Determinations) for Care Plus enrollees,
3. Medi-Cal guidelines (including but not limited to the Medi-Cal Provider Manual and DHCS APL's) if Medicare guidelines do not exist, are nonspecific, or relate to Medicare non-covered benefits for Care Plus members.
4. Apollo Medical Review Criteria guidelines when #2 and #3 are nonexistent or non-specific.
5. InterQual guidelines when #4 are nonexistent or nonspecific
6. Current (within 24 months of last revision or update) Health Plan clinical authorization guidelines when the above are nonexistent or non-specific.
7. If above sources do not have authorization guidelines specific to the requested service, CCHP follows guidelines established by nationally recognized sources listed in subheading, "Source of Criteria and Guidelines".

1. For CCHP Care Plus members accessing Mental Health Services, **no authorization** is required for medically necessary services rendered by a contracted provider working in the scope of their practice.

These services do not require PA:

1. MH Psychiatric observation including but not limited to CCRMC Psychiatric

Emergency Services (PES).

2. **Admission** MH inpatient psychiatric hospitalization and MH partial hospitalization program (PHP) does not require a PA, however **Continued** hospitalization beyond the 72-hour involuntary hold requires ongoing concurrent review and authorization.
3. Community resources are recommended for SUD group therapies. For example, Alcoholics Anonymous, Narcotics Anonymous, LifeRing. Otherwise, group therapies are not covered.

Substance Use Disorder (SUD) services handled by the PCP:

1. SUD medication treatment for withdrawal.
2. SUD individual consultation, evaluation, or care.

IV. REFERENCES:

- A. Care Plus Contract with the Centers for Medicare & Medicaid Services (CMS) for Applicable Integrated Plan
- B. Care Plus Contract with the Department of Health Care Services (DHCS) for Medi-Cal
- C. Care Plus Network Service Agreement
- D. Care Plus Utilization Management Program
- E. 42 CFR 422.101 and 42 CFR 422.137
- F. Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual Chapter 4 – Benefits and Beneficiary Protections, Section 10.7.3 (Issued 04/22/16)
- G. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-034: California Children’s Services Whole Child Model Program (Supersedes APL 21-005)
- H. Health and Safety Code (HCS), §§ 1363.5, 1363.5(a), 1363.5(b)(5), 1363.5(c), 1367.01, 1367.01(h)(6), and 1367.01(l)
- I. Medicare and Medi-Cal Coverage Guidelines
- J. Medicare Part D: CMS-approved Compendia
- K. Milliman Care Guidelines (MCG)
- L. National Correct Coding Initiative (NCCI) Policy Manual
- M. National Comprehensive Cancer Network® (NCCN) Guidelines
- N. Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance, Effective November 18, 2024
- O. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines))
- P. Specialty Society Guidelines (e.g., American Academy of Pediatrics (AAP) and American Heart Association (AHA) Guidelines)

- Q. Title 28, California Code Regulations (CCR), §1300.70(b)(2)(H) & (c)
- R. Title 42, Code of Federal Regulations (CFR), §438.910(d)
- S. Transplant Centers of Excellence Guidelines
- T. Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual Chapter 15 – Covered Medical and Other Health Services, Section 50 (Rev. 12684; Issued 06/13/24)
- U. Social Security Administration (SSA), §§ 1927, subsections (g)(1)(B) and (K)(6)