Government Business Division
Policies and Procedures

Section (Primary Department) **Utilization Management**	**SUBJECT (Document Title)** **Non-Authorization of Medical Services - CA**		
Effective Date 05/01/1996	**Date of Last Review** 04/22/2024	**Date of Last Revision** 07/27/2023	**Dept. Approval Date** 04/22/2024
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Services that do not meet Anthem Medicaid adopted medical necessity guidelines may be subject to non-authorization. Qualified licensed health care professionals review case specific information against these guidelines. Documentation of appropriate professional review will be noted in the case files. Only licensed physicians can deny a medical service or treatment. Documentation of a denial may consist of an initial note from a UM staff person who attributes the denial decision to the specific professional who reviewed and decided the case. Review decisions are made without regard to financial or other external factors and are based solely on medical necessity and benefit coverage.

Anthem Medicaid does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. In addition, decision to deny or authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition or disease. Anthem Medicaid ensures that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. Anthem Medicaid may place appropriate limits on a service based on criteria such as medical necessity, or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

DEFINITIONS:

***"Medically Necessary"/Medical Necessity*:** Procedures, treatments, supplies, devices, equipment, facilities, or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site, and duration and considered effective for the patient's illness, injury, or disease; and
- not primarily for the convenience of the patient, physician, or other health care provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

PCR Referral: referral of a case to a PCR for review that the Registered Nurse (RN) was not able to approve based on the available clinical information.

Peer Clinical Reviewer (PCR/Medical Director): A physician who is employed by or contracted with Anthem Medicaid to carry out utilization review. The physician is board certified in his/her specialty; and has a valid license to practice medicine in the State of California.

Utilization Review/Management (UM): is the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and facilities.

Utilization Screening Criteria: a set of medical necessity indicators based on clinical profiles, local and national clinical consensus panels, and outcomes research.

PROCEDURE:

I. Denial/Modification of Services

A. Requests for medical services that do not contain clinical information, do not meet medical necessity, or require further medical review; are routed to a PCR.

B. PCRs complete the following steps when making a clinical determination:

1. Fully assess the provided clinical information.
2. Request additional information as needed.
3. Review the case against the plan definition of medical necessity and other applicable benefit language.
4. Review the case against approved clinical review criteria.
5. Consult with other internal or external board-certified specialty matched reviewers for assistance when specific issues and concerns arise. (A listing of board-certified specialty matched reviewers is maintained and available).
6. Utilize available research and industry resources.
7. Confer with the treating provider, as necessary and as provided for above.
8. Communicate the determination of medical necessity or communicate a finding of a lack of medical necessity.
9. Document the determination clearly and completely, including any interactions with providers and/or their staff, the rationale and sources utilized in arriving at the decision, and the specific additional information needed to enable further consideration of the request.

For pre-service and continued stay reviews, when the PCR determines the request is not medically necessary, notification is given to the requesting provider. The requesting provider is offered an opportunity for a peer-to-peer discussion of the case. The PCR is available for peer-to-peer discussion of a decision and may be contacted through the UM department. For continued stay reviews, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient.

C. For pre-service and continued stay reviews when the information sent is not sufficient to determine medical necessity, even after the provider was contacted with a request for the clinical information reasonably necessary to determine medical necessity, the case will be denied for the reason of "requested information not received".

D. For pre-service and continued stay reviews, when the PCR determines that the services are **not** medically necessary, the PCR notifies the Anthem UM Department, who in turn, notifies the requesting provider of the denial, the appeal process and how the PCR responsible for the decision can be reached for a peer-to-peer discussion, and then completes the case. Anthem sends an approved Notice of Action: Denial letter to the member and provider including the "Your Rights" attachments which explain the appeal rights.

E. Peer-to-peer discussions, if conducted and denial decisions are documented within Anthem Care Management Platform (ACMP), Anthem Medicaid's medical management documentation system. Documentation includes the name and title of the caller, the date and time of the call, any pertinent clinical information submitted with the request (timeframe of illness or condition, diagnosis, and treatment plan), and the clinical guideline used to support the denial decision.

F. Anthem Medicaid sends an approved Notice of Action: Denial letter (Not a covered benefit) when a request is determined not to be a covered benefit to the member and provider including the "Your Rights" attachments which explain the appeal rights. The written communication clearly communicates to enrollees the provision in the contract/EOC (evidence of coverage) that excludes that coverage.

G. The criteria utilized in determining medical necessity are made available to the member and provider upon request.

H. The NOA will be translated into the members preferred language or alternate format on file with Anthem, based on the DHCS threshold languages per DHCS APL 21-004 and APL 22-002.

REFERENCES:

- CA_UMXX_010 Continued Stay Review / Care Coordination / /Discharge Planning
- CA_UMXX_041 Pre-service Authorization of Services
- CA_UMXX_055 Retrospective Review of Medical Necessity
- CA_UMXX_065 The Separation of Financial and Medical Necessity Decision-Making

- CA_UMXX_117 Decision and Notification Timeframes
- California Health and Safety Code § 1367.01
- Central Valley/Bay Area, Sacramento, Tulare, Tri-County, and LA Care Contracts, Exhibit a, Attachment 5, 10 & 13
- DHCS APL 21-011, issued 08/31/2021 and 21-004, issued 04/08/2021, APL 22-002 issued 03/14/2022
- Evidence of Coverage for Medi-Cal, MRMIP
- National Committee for Quality Assurance (NCQA) UM Standard 4, 5 and 7

RESPONSIBLE DEPARTMENTS:

Primary Department:
Utilization Management

Secondary Department(s):
Grievance & Appeals (G&A)

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
04/22/24	• Annual Review, no changes
07/27/23	• Off-Cycle Review • Added G&A as a secondary department • Removed “20” from “2023” under Revision History to match format
05/31/23	• Annual Review • Added Medical Director under PCR definition • Replaced “N/A” under Secondary Department(s) section with “None” • Updated Revision History date from “05/30/15” to “05/30/16” to accurately reflect database
05/26/22	• Annual Review • Added alternate format language and APL
02/03/22	• Off-Cycle Review • Added specific verbiage from APL 21-011
12/13/21	• Added translation of NOA per APL 21-011
05/27/21	• Annual Review • Removed AIM from EOC citation • Added what ACMP stands for • Updated the procedure and references
05/27/20	• Annual Review • Added “Modifications” to the Denial section

Review Date	Changes
	• Added language from DMHC about care not being discontinued.
05/29/19	• Annual review, no changes
05/14/18	• Annual Review. • Changed WMDS to ACMP
05/02/17	• Updated denial wording to include denials for lack of information • Updated references to NCQA
05/30/16	• Annual Review • Changed sentence under Procedure "C" • Updated References
06/30/15	• Removed Healthy Families • Removed Blue Cross • Updated references
09/04/14	• Removed Healthy Families • Changed header to Government Business Division
09/11/13	• Added that any peer-to-peer discussions conducted are noted in WMDS. • Updated references
10/10/12	• Added contract language to include: "The Delegate's decision to deny or authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition or disease." • Changed reference from Care Management to Medical Management.
05/22/12	• Added contract language around the fact that Medicaid does not arbitrarily deny services based on diagnosis, illness, or condition. • Updated denial process to include process for obtaining additional clinical and notifying the provider of the decision. • Changed references from Anthem Blue Cross State Sponsored Business to Anthem Blue Cross Medicaid • Updated references • Added revision history to policy
05/01/96	• Policy created