Government Business Division
Policies and Procedures

Section (Primary Department) **Utilization Management**		**SUBJECT (Document Title)** **Pre-service Authorization of Services - CA**	
Effective Date 12/01/1995	**Date of Last Review** 04/25/2024	**Date of Last Revision** 04/25/2024	**Dept. Approval Date** 04/25/2024
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:

Anthem Blue Cross Medicaid performs pre-service review to determine medical necessity of covered services including but not limited to:

- Non-urgent inpatient admissions
- Selected surgical procedures (performed in an outpatient or ambulatory surgical center)
- Selected Durable Medical Equipment
- Ancillary services (i.e., Home Health, etc.)
- Infusions therapies
- Selected MRIs and CT scans
- Cosmetic procedures
- Experimental or investigational services
- Cardiac and pulmonary rehabilitation
- Transplants
- Hospice
- Skilled nursing facilities
- Out-of-network specialist referrals and services
- Other selected services as specified in the Provider Operations Manual and Member's Evidence of Coverage.

Anthem Medicaid does not require authorization for the following:

- Urgent/emergent services rendered in the emergency department
- Family planning services
- Preventive services
- Services related to sexually transmitted diseases
- HIV testing

- Basic prenatal care does not require authorization when performed by network providers.

Denials for medical necessity can only be made by a Physician Peer Clinical Reviewer (PCR).

Transgender Services are available to Medi-Cal beneficiaries. Anthem Medicaid will apply state requirements when reviewing prior authorization requests related to transgender services. These requirements do not change the types of procedures that require prior authorization or treatment authorization requests.

If a provider refuses to deliver services to a member based upon a personal or moral belief, the member may contact Anthem Medicaid Customer Care Center or the Medical Management department, which includes both Utilization and Case Management for assistance with locating an alternate provider to render medically necessary services.

Anthem Medicaid can arrange, coordinate, and ensure provision of services through referral without expense to the Department of Health Services (DHCS).

DEFINITIONS:

Authorization **-** the approval needed for members to receive certain types of specialty care and health services.

Emergent Care **-** A service provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention immediately could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily function
- Serious dysfunction of any bodily organ or part; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

"Medically Necessary" service **-** 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.

Physician Peer Clinical Reviewer (PCR)/Medical Director - A physician who is employed by, or contracted with, Anthem Medicaid to carry out utilization review. PCR's must meet job description requirements that include education, training, or professional experience in medical or clinical practice. The physician is board certified in his/her specialty and has a valid unrestricted license to practice medicine in the State of California.

Pre-service Request - A request for a service or procedure in advance of the date the requested service or procedure is to occur.

Transgender services - The treatment of "gender dysphoria," which may include psychotherapy, continuous hormonal therapy, laboratory testing to monitor hormone therapy and gender reassignment surgery. Medical Necessity for gender reassignment surgery will be determined based on the medical necessity to treat gender dysphoria and or reconstructive in nature.

Urgent Care - Any request for care or treatment with respect to judgment of timeframes for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

PROCEDURE:

I. Request for Medical Services:

A. The treating physician or provider initiates a pre-service request prior to rendering services to the member. Pre-service requests may be submitted by telephone, fax or through the provider portal to the Anthem Medicaid's Utilization Management (UM) Department. Providers may fax authorization requests during non-office hours. Faxed requests received after business hours are processed on the next business day.

B. Licensed Registered Nurses (a.k.a. – UM Nurse) provide the initial review of medical information, initial determination of benefit coverage, obtaining additional medical information, as needed from providers, and approval of medically necessary referrals.

C. Non-Clinical Associates provide eligibility determination, editing of referral form for completeness, interface with providers to obtain any needed non-medical information, screening services to determine if pre-service authorization is required. Authorization requests that do not require review of medical necessity are certified by Non-Clinical Associates.

D. If a provider refuses to deliver services to a member based upon a personal or moral belief, the member may contact Anthem Medicaid's Customer Care Center or Medical Management department for assistance with locating an alternate provider to render medically necessary services. Furthermore, Anthem Medicaid will arrange for the timely referral and coordination of covered services to which the member's Primary Care Provider has religious or ethical objections to perform or otherwise support.

E. Requests regarding pharmacy services are referred to Medi-Cal RX

F. Requests regarding medical injectables are reviewed by the pharmacy team.

G. Authorization requests are tracked and managed in the Anthem Medicaid's Medical Management system – ACMP.

II. Review of Medical Necessity:

A. The UM Nurse reviews the relevant clinical information obtained from the provider including, but not limited to, current and historical medical diagnoses,

medical treatment needs and social/environmental factors impacting the member's medical care. The UM Nurse can approve the requested services after establishing medical necessity using Anthem Medicaid's approved guidelines. Appropriate documentation should include, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history
- Information on consultations with the treating practitioner
- Evaluations from other health care practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitative evaluations
- A printed copy of criteria related to the request
- Benefits information for services or procedures
- Information regarding the local delivery system
- Information from responsible family member or care giver.

B. If there is insufficient clinical information to determine medical necessity, the request is deferred per policy CA_UMXX_117 "Decision and Notification Timeframes" and CA Health and Safety Code 1374.30.

C. When the Nurse is unable to approve the services because they do not meet the medical necessity criteria, the case is routed to a PCR with sufficient expertise to evaluate the specific clinical issues involved in the health care services requested by the provider.

D. If the PCR determines the services to be medically necessary, he/she notifies the UM staff, who in turn notifies the requesting provider of the approval and completes the case.

E. If the PCR determines that the services are **not** medically necessary, the PCR notifies the Anthem UM Department, who in turn, notifies the requesting physician of the decision, the appeal process, how to reach the PCR responsible for the decision for a peer-to-peer discussion, and then completes the case. Anthem sends a Notice of Action: Denial letter to the member and provider. *(Refer to CA_UMXX_117 "Decision & Notification Timeframes".)*

Section (Primary Department)	SUBJECT (Document Title)
Utilization Management	**Pre-service Authorization of Services - CA**

REFERENCES:

- CA_UMXX_013 "Non-authorization of Medical Services"
- CA_UMXX_117 "Decision and Notification Timeframes"
- CA Health & Safety Code, Section 1374.30
- CA Welfare & Institution Codes, 14131-14138, 14059.5
- Department of Health Care Services, All Plan Letter #20-018 "Ensuring Access to Transgender Services"
- Department of Health Care Services (DHCS) Central Valley/Bay Area, Sacramento, Tulare, Stanislaus, and Tri-County (Kings, Fresno, Madera) Contracts, Exhibit A, Attachments 5, 9, 10
- LA Care Contract, Exhibit A, Attachments 5, 9, 10
- Medi-Cal Evidence of Coverage - Member Handbook Effective 2024
- National Committee for Quality Assurance (NCQA) UM 4, 5 and 6
- Provider Operations Manual 2024

RESPONSIBLE DEPARTMENTS:

Primary Department:
Utilization Management

Secondary Department(s):
None

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
04/25/24	• Annual Review • Updated Policy section to update Anthem reference, per recent rebranding guidelines • Updated References section for EOC and provider manual to the 2024 version
05/31/23	• Annual Review • Added Medical Director to PCR definition under Definitions section • Updated "2022" to "2023" under References section • Replaced "N/A" with "None" under Secondary Department(s) sub-header

Review Date	Changes
05/26/22	• Annual Review • Update References • Updated transgender services wording • Added Medi-Cal RX
05/27/21	• Annual Review • Added provider portal as a means to submit a request • Updates made to the procedure
03/11/21	• Off-Cycle Review • Changed APL Reference from 13-011 to 20-018 • Added language about med nec for transgender services per DHCS
05/27/20	• Annual Review • Changed Express Scripts to Ingenio RX • Updated references
05/29/19	• Annual Review • Updated references
05/14/18	• Annual Review • Updated references • Changed WMDS to ACMP
05/02/17	• Updated transgender paragraph wording • Added medical injectables • Changed deferred policy reference
05/30/16	• Annual review • Updated References
06/30/15	• Updated references • Removed Formula from the Pre Auth list • Deleted retention of medical records statement
09/04/14	• Removed Healthy Families • Changed header to Government Business Division
10/21/13	• Added verbiage regarding the coverage and consideration of transgender services during the prior authorization process. • Put the Definitions in alphabetical order. • Updated References
06/20/13	• Removed sensory integration therapy as well as PT/OT/ST from list of services requiring pre-service review. This was requested by Lynn West based on the implementation of our new WLP-AGP precert list (eff 7/1 and 8/1). • Replaced “WellPoint Pharmacy” with “Express Scripts, Inc.” in I.E. • Removed verbiage from II.E. that advises that the PCR would discuss the case with the treating physician prior to rendering a medical

Review Date	Changes
	necessity determination and added that the UM Department would inform the provider how they can reach the PCR responsible for the decision for a peer-to-peer discussion.
09/28/12	• Changed reference from Anthem Blue Cross State Sponsored Business to Anthem Medicaid. • Expanded list of services requiring pre-service review to match what is listed in the Provider Operations Manual. • Updated DEFINITIONS section with additional definitions to provide clarity to policy. • Changed reference from Care Management to Medical Management • Updated references • Added revision history to policy
12/01/95	• Policy created