Government Business Division
Policies and Procedures

Section (Primary Department) **Utilization Management**	**SUBJECT (Document Title)** **Utilization Management Decision and Screening Criteria - CA**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
08/29/2003	04/18/2024	04/18/2024	04/18/2024

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:

When making Utilization Management (UM) decisions, Anthem Medicaid utilizes the following criteria

- Federal and State Mandate
- Member Benefits
- Anthem Medical Policy/Coverage Guidelines and Clinical Guidelines
- MCG
- CarelonRx Pharmacy Criteria
- Anthem Medicaid Policy and Procedures
- Carelon Benefits Management Guidelines

Decision and screening criteria are designed to assist UM Program associates in assessing the appropriateness of care and length of stay for clinical health situations. Application of criteria is not absolute but based upon the individual healthcare needs of the member and in accordance with the member's specific benefit plan and the capability of healthcare delivery systems.

Decision criteria incorporate nationally recognized standards of care and practice, [i.e. American College of Cardiology (ACC), American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), American Academy of Orthopedic Surgeons]. Actively practicing physicians are involved in the development and adoption of the review criteria.

Screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the Medical Policy and Technology Assessment Committee (MPTAC). MPTAC submits California-specific medical policies to the Anthem Blue Cross Medical Policy Subcommittee (MPS) for review and adoption. Once approved by the MPS, the policies are sent to the Physician's Quality Improvement Committee (PQIC).

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DEFINITIONS:

Medically Necessary or 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. “Physician Specialty Society” means a United States medical specialty society that represents diplomats certified by a board recognized by the American Board of Medical Specialties.

Nurse Reviewer: A Registered Nurse (RN) who is employed with Anthem Blue Cross Medicaid to carry out utilization review. The RN has a valid license to practice in the state of California.

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

PROCEDURE:

I. The nurse reviewers, medical directors and/or physician reviewers use the decision and screening criteria when making a decision based on medical necessity for requested services.

II. The intent of utilizing decision criteria is to promote consistency of reviews. UM reviewers consider at least the following when applying criteria to a given individual:
   - Age
   - Co-morbidity

- Complications
- Progress of treatment
- Patient's psychosocial history and situation
- Home environment, when applicable.

III. Anthem only collects information necessary to perform utilization review and only requires submission of the section(s) of the medical record necessary for each case reviewed, so not to be overly burdensome for the member, provider, or the health care delivery organization's staff. When making a determination of coverage based on medical necessity requests, the designated UM Program clinical reviewer obtains relevant clinical information, including but not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- 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
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

IV. The nurse reviewers, medical directors who apply screening and decision criteria also consider characteristics of the local delivery system available for specific patients, such as:

- Availability of skilled nursing facilities, sub-acute care facilities or home care in the organization's service area to support the patient after hospital discharge
- Coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care where needed
- Local hospital's ability to provide all recommended services within the estimated length of stay.

V. Requests for medical services that do not meet the criteria for medical necessity, or require further medical review, are routed to a PCR. Only licensed physicians can deny a medical service or treatment.

VI. The nurse reviewers, medical directors and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually, for inter-rater reliability and these results are analyzed and reported to the Clinical Service Committee.

VII. UM Reviewers are licensed health care professionals that report to UM Managers who provide oversight and supervision, including, but not limited to:

- Providing day-to-day supervision of staff
- Participating in staff training
- Monitoring for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Monitoring documentation for adequacy
- Being available to UM staff on site or by telephone

VIII. Decision criteria are presented for review and approval to the MPTAC, the Anthem MPS and PQIC. This annual review and approval by the committees and designated physicians includes reviewing potential new criteria as well as development and review of procedures in which they are utilized.

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

REFERENCES:

- Anthem Blue Cross Provider Operations Manual, June 2023
- Anthem Medical Policy #ADMIN.00001 “Medical Policy Formation”
- Anthem Medical Policy #ADMIN.00004 “Definition: Medically Necessary”
- Anthem Medical Policy #ADMIN.00006 “Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline”
- CA_UMXX_013 “Non-authorization of Medical Services”
- CA_UMXX_050 “Non-Physician Review Audits- Process, Inter-rater and Focused”
- CA_UMXX_065 “Separation of Financial and Medical Necessity Decision Making”
- CA_UMXX_078“Physician Review Audits- Process and Inter-rater”
- CA_UMXX_081 “Application of Utilization Management Criteria”
- CA Health & Safety Code, Section 1367.01
- Central Valley/Bay Area, Sacramento, Tulare, and Tri-County (Fresno, Kings, & Madera) Contracts, Exhibit A, Attachment 5
- Enterprise Policy “Medical Policy Review and Approval for Use by Anthem Blue Cross”
- NCQA UM Standards

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RESPONSIBLE DEPARTMENTS:

Primary Department:
Utilization Management (UM)

Secondary Department(s):
None

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
04/18/24	• Annual Review • Updated Policy section • Ingenio Rx was replaced with Carelon Rx • AIM guidelines have been replaced by Carelon Benefit Management guidelines
05/31/23	• Annual Review • Updated “2022” to “2023” under References section • Updated primary department name from “Medical Management: Utilization Management (UM) & Case Management (CM)” to “Utilization Management (UM)” to match primary department name in header
05/26/22	• Annual Review • Updated References • Changed UM Committee to Clinical Services Committee
05/27/21	• Annual Review, no changes
05/27/20	• Annual Review • Added Ingenio under criteria • Updated References
05/29/19	• Added UM NCQA language about supervision of UM staff.
03/06/19	• Updated Definitions of PCR and added Nurse Reviewer • Updated References
06/30/18	• Updated References • Updated wording
06/30/17	• Added CA_UMXX_065 as a reference

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Review Date	Changes
06/30/16	• Annual Review, no changes
07/31/15	• Updated references • Changed policies from WellPoint to Anthem • Removed "formally known as Milliman"
09/04/14	• Changed header to Government Business Division • Deleted Healthy Families • Removed the words physician review • Changed the wording on the frequency of training
09/06/13	• Clarified chain of command for Anthem Blue Cross medical policy approval. • Changed Wellpoint Medical Policy/Coverage Guidelines and Clinical Guidelines to Anthem Blue Cross Medical Policy/Coverage Guidelines and Clinical Guidelines to reflect what is specifically used in California. • Deleted Wellpoint Behavioral Health Medical Necessity Criteria • Updated References
02/11/13	• Minor grammar and formatting revisions • Added "Progress of treatment" to Procedure, II. • Added reason for collecting only pertinent information • Updated references
04/09/12	• Added additional review criteria, Physician specialties statement, added UM only collects needed information to review request. Updated policy- reference section, and UM staff training bullet. • Updated references. • Revised mentions of SSB to Anthem Medicaid