	POLICIES AND PROCEDURES
Policy #: 404-1201	Lead Department: Utilization Management
Title: Authorization Request Process	
Original Date: 02/01/1996	Date Published: 06/13/2025
Approved by: Utilization Management Workgroup (UMWG)	

Purpose:

To describe the authorization request process used at Central California Alliance for Health (the Alliance).

Policy:

The Alliance ensures authorization requests are processed and reviewed in a timely manner and notification to Members and providers is consistent with regulatory requirements. Status determinations are made based on medical necessity criteria according to Alliance Policy 404-1112 - *Medical Necessity - The Definition and Application of Medical Necessity Provision to Authorization Requests*.

Nondiscrimination Notice:

Discrimination is against the law. Central California Alliance for Health (the Alliance) follows State and Federal civil rights laws. The Alliance does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. The Alliance's nondiscrimination notice encompasses all Alliance activity including authorization request and review processes.

Definitions:


Authorization Request Determination Status: Authorization requests may be placed in the approved, extended (delayed), deferred, or California Children's Services (CCS) hold, void, incomplete, modified or denied status during the course of a health care service review.

Behavioral Health: Behavioral Health refers to both mental health and substance use disorders.

- "Mental health and substance use disorders" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
- "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment.

California Children's Services (CCS): CCS is a state program for children with certain diseases or health problems. Through this program, children up to 21 years of age can get the health care and services they need for CCS-eligible conditions. CCS also provides medical therapy services that are delivered at public schools through their Medical Therapy Unit (MTU).

California Children Services (CCS) Provider: Means any of the following Providers when used to treat Members for a CCS condition:

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- a. A medical Provider that is paneled by the CCS program, pursuant to Health and Safety Code, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106.
- b. A licensed acute care hospital approved by the CCS program
- c. A special care center approved by the CCS program.

Community Support (CS): Services or settings offered by a Medi-Cal health plan that are offered in place of services or settings covered under the California Medicaid State Plan, and are medically appropriate, cost-effective substitutes for services or settings under the State Plan. Services are offered at the plan's option and an enrollee cannot be required to use them.

Covered Service: Medical Case Management and those services set forth in Title 22, California Code of Regulations (CCR), Division 3, Subdivision 1, beginning with Section 51301; and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840; excluding services listed in the State Medi-Cal contract.

Deferral: Additional time to process authorization requests for Medi-Cal members beyond the fourteen (14) calendar days of receipt of request, but only where the Member or the Member's provider requests additional time or the Alliance can provide justification for the need for additional information, and when this is in the best interest of the member.

Denial Determinations: Denial determinations may occur at any time in the course of the authorization review process. There are a variety of reasons that a request may be denied, including but not limited to, a lack of medical necessity or the service is not a Covered Service.


Durable Medical Equipment (DME): Medically Necessary medical equipment that is prescribed for the Member by provider and is used in the Member's home, in the community or in an institution that serves as the Member's home.

Emergency Services: Covered inpatient and outpatient services that are furnished by a Provider that is qualified to furnish those services and that are needed to evaluate or stabilize an emergency medical condition.

Enhanced Care Management (ECM): ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person centered.

Excluded Service: A service that is covered by the Medi-Cal program but is not covered by the Alliance because it is carved out of the Alliance's contractual obligations for the provision of Covered Services.

Expedited/Urgent Request: An expedited request is one in which provider or Alliance staff determines that following the standard timeframe could jeopardize Member's life or health or ability to attain, maintain or regain maximum function. Authorization decisions and notification of

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providers are made as expeditiously as the Member's health condition requires and no later than 72 hours after receipt of the request for services.

Extension (Delay): Additional time to process routine authorization request beyond the five (5) business day timeline, but not delayed longer than fourteen (14) calendar days from the receipt of the request for Medi-Cal or IHSS LOB.

High Risk Infant Follow-Up Program (HRIF): The HRIF program helps identify infants who might develop CCS-eligible conditions after they are discharged from a NICU. The Alliance is responsible for determining HRIF program eligibility, coordinating and authorizing HRIF services for members, and ensuring the provision of HRIF case management services.

In Process: Authorization Request status for receipt of complete information reasonably necessary to render a decision.

Incomplete: Additional information is required in order to process the authorization request (i.e. prescription, coding information, demographic information, provider information).


MCG care guidelines: Updated as needed, evidenced-based clinical guidelines that span the continuum of care, including chronic care and behavioral health management.

Medically Necessary or Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, maintain or regain functional capacity per Title 22 CCR Section 51303(a) and 42 Code of Federal Regulations (CFR) 438.210(a)(5).

Medically Necessary Treatment of a Mental Health or Substance Disorder: Section 1374.72(a)(3)(A) of the CA Health and Safety Code (HSC) describes this to mean a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- (i) In accordance with the generally accepted standards of mental health and substance use disorder care.
- (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
- (iii) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

Medical Therapy Program (MTP): The MTP is a program within California Children's Services that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders. PT and OT services are provided at Medical Therapy Units (MTUs). MTUs are outpatient clinics located in designated public schools. The Alliance makes referrals to and

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coordinates with the local CCS Medical Therapy Unit (MTU) to ensure appropriate access to MTU services, and other non-MTU services.

Modified: Determination status where some of the services/items requested have been approved while others have been denied or altered based on whether the requests meet medical necessity criteria.


Notice of Action (NOA): The notification of an adverse benefit determination that is sent by the Alliance to a Member in accordance with the notice and timing requirements set forth in Health & Safety Code 1367.01(h) and 42 CFR 438.404. A NOA is a formal letter, in a format reviewed and approved by DHCS, informing a Member, within a specified timeframe, of adverse benefit determinations taken by the Alliance. In cases where the review is retrospective (Post-service), the decision to approve, modify or deny based on medical necessity is communicated to the Member and Provider within 30 days of the receipt of information. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the second working day after the decision is made, not to exceed decision is delayed because an extension is requested or justified.

NOA Translation: The Alliance fully translates and provides written member information in a member's threshold or concentration language, including all notices. Member information shall be provided in alternative formats (including Braille, large-size print font no smaller than 20- point, accessible electronic format, or audio format) and through Auxiliary Aids at no cost upon request, and in a timely fashion appropriate for the format being requested and taking into consideration the special needs of Members with disabilities or LEP. The Alliance will not deny, reduce, suspend, or terminate services or treatments without providing adequate notice within applicable legal timeframes. The Alliance calculates the deadline for a member with a visual impairment or other disabilities requiring the provision of written materials in alternative formats, to take action from the date of adequate notice, including all deadlines for appeals and aid paid pending.

The Alliance includes the clinical rationale for the decision. If a partially translated notice must be sent, a sentence is included in the member's threshold or concentration language explaining how the member can obtain oral interpretation of the clinical rationale on an expedited basis. The Alliance will send a fully translated letter to the member as soon as possible, but not later than thirty (30) days from the date the partially translated letter was sent. The Alliance's approved nondiscrimination notice and language taglines are sent as attachments to all NOAs sent to members.

Non-Specialty Mental Health Services (NSMHS): The Alliance arranges for the provision of the following non-specialty mental health services:

- Mental health evaluation and treatment, including individual, group, and family psychotherapy and dyadic services;
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition;
- Outpatient services for purposes of monitoring drug therapy;

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- Psychiatric consultation; and,
- Outpatient laboratory, drugs, supplies and supplements.

The Alliance provides or assists in coordination for the provision of the NSMHS listed above for the following populations:

- Members who are 21 years of age and older with mild to moderate distress, or mild to moderate impairment of mental, emotional, or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders;
- Members who are under the age of 21, to the extent they are eligible for services through the Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of the level of distress or impairment, or the presence of a diagnosis; and
- Members of any age with potential mental health disorders not yet diagnosed.

Post-service: An authorization request submitted following the provision of a service and the review is retrospective.

Prior Authorization: A formal process requiring a Provider to obtain advance approval of Covered Services Medically Necessary and to that amount, duration, and scope, except in the case of an emergency.


Provider Change Request (PCR): After an authorization has been processed, providers may request a change to the original authorization by submitting a PCR request on-line or via facsimile (fax). Examples of allowable changes are: dates of service or extension of dates of service, service location, for contracted service, prior to service being rendered, quantity of home visits with physician order. The PCR should be submitted within 180 days of the original authorization end date.

Receipt: The date and time the authorization request is received in the Utilization Management (UM) Department.

Routine: An authorization request submitted with all the information reasonably necessary to render a determination status decision. Routine authorization requests are handled/processed within five (5) business days.

Standing Referral: A referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

Terminal Illness: An incurable or irreversible condition that has a high probability of causing death within one year or less.

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Utilization Review: The process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and facilities.

Void: Alliance staff may void an authorization request, within the first five business days for routine requests, for reasons including:

- Member is not eligible with the Alliance
- Duplicate authorization request
- No authorization is required
- Administrative void; Invalid authorization submission, i.e. when Primary Care Providers submit authorizations for unlinked members.
- Member has other health care coverage
- Provider or member requests to withdraw or void request, or
- Requests remain incomplete, following the Alliance's outreach to the provider to obtain valid and correct information, or after unsuccessful attempts to contact the provider within the required timeframe.


Whole Child Model (WCM): The purpose of the WCM program is to incorporate services covered by the CCS Program into Medi-Cal managed care for Medi-Cal-eligible CCS Program members. Managed care plans (MCPs) operating in WCM counties will integrate Medi-Cal managed care and 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.

Scope of Authorization Request and Utilization Review Processes

The Alliance ensures that its authorization processes for prior authorization, concurrent review and post-service review procedures meet the required contractual standards for all Alliance Lines of Business (LOB). The Alliance will not rescind or modify already approved authorizations for specific types of treatment by a provider, for any reason, after such authorized services have been rendered.

The Alliance's authorization processes and UM review apply to the following healthcare services, including requests for expedited, concurrent, and retrospective review, as outlined in Alliance Policy 404-1101 - *Utilization Management Program*:

1. Acute Hospital Services
2. Sub-Acute care
3. Ambulatory care
4. Urgent care services
5. DME and supplies
6. Ancillary care services, including but not limited to home health care, skilled nursing care, sub-acute care, pharmacy, laboratory and radiology services
7. Long-term care
8. Skilled Nursing Facility Care and Rehabilitation Facility Care

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9. Pharmacy drug formulary, as described in Alliance Policy 403-1103 - *Pharmacy Authorization Request Review Process*
10. Behavioral Health

For Medi-Cal Members, the Alliance contracts with a Managed Behavioral Health Organization (MBHO) to provide non-specialty mental health services (NSMHS) through June 30, 2025. Severe conditions requiring Specialty Mental Health Services (SMHS) will be referred to County Behavioral Health. Beginning July 1, 2025, the Alliance will manage all behavioral health services in-house through its core organizational functions. There is an expectation that Primary Care providers (PCPs), Behavioral Health Practitioners, Co. Behavioral Health, and the Alliance will coordinate care and services according to the Alliance/Behavioral Health Memorandum of Understanding and the MBHO contract. For more information on Behavioral Health Services, please see Alliance Policy 408 -1305 - *Behavioral Health Services*.

Coverage of behavioral health medications is an Alliance benefit for all lines of business, including Medi-Cal (with the exception of medications that are carved out to fee-for-service Medi-Cal). (See APL 22-006- *Medi-Cal Managed Care Plan Responsibilities for Non-Specialty Mental Health Services* for requirements relating to Medi-Cal Members). As such, the Alliance does not deny requests for members that meet the NSMHS criteria on the basis of the member having a co-occurring SUD.

Clinically appropriate and covered NSMHS are covered Medi-Cal services, even when:


1. Services are provided prior to determination of a diagnosis, during the assessment period, or prior to a determination of whether NSMHS or SMHS access criteria are met;
2. Services are not included in an individual treatment plan;
3. The member has a co-occurring mental health condition and substance use disorder (SUD); or,
4. NSMHS and SMHS are provided concurrently, if those services are coordinated and not duplicated.

Pharmacy services billed as pharmacy claims are carved out to fee-for-service under Medi-Cal Rx. Medi-Cal Rx is responsible for formulary management, prior authorization, and claims processing. The Alliance will retain responsibility for overseeing and maintaining care coordination activities for Medi-Cal enrollees and providing oversight of all clinical aspects of pharmacy adherence, including providing disease and medication management.


The Alliance will be responsible for authorizing ECM and CS services for each member, based on review of plan data, and referrals. The Alliance will accept referrals for ECM and CS for Medi-Cal members using a “no wrong door” approach, accepting referrals from community-based entities and organizations, members/support people, family members, providers.

The Alliance contracts with the MBHO to provide all behavioral health services (mental health and SUD) for Alliance Care IHSS members until June 30, 2025. Beginning July 1, 2025, the Alliance will manage all behavioral health services in-house through its core organizational functions. Coverage of mental health medications is an Alliance benefit for Alliance Care IHSS lines of business.

Healthcare services that do not require prior authorization include:

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1. Emergency Services, including but not limited to behavioral health crisis stabilization services and care provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services.
 - a. Prior authorization is not required for emergency care for complaints or conditions that a member determines could seriously jeopardize their physical or mental health. Hospital emergency admissions and emergency room outpatient services require the following procedures:
 - i. When a Member presents with an emergency condition at a hospital or other provider facility and is admitted for in-patient services, the attending physician/hospital shall meet the following obligations:
 1. Notify the PCP immediately.
 2. Notify the Alliance within 24-hours or on the next business day and obtain eligibility verification and authorization for the admission at (831) 430-5506 or (800) 700-3874 Ext. 5506.
 - a. For after-hours authorization of post-stabilization requests, the provider should contact The Alliance Medical Director on-call who can be reached 24 hours a day at (831) 430-5588
 - b. Although prior authorization is not required, members can contact the toll-free Nurse Advice Line (NAL) regarding post-stabilization care, 24 hours a day, 7 days a week, at (844) 971-8907 (TTY: Dial 711)
 3. The Alliance ensures that Alliance Members receive appropriate and timely authorization for medically necessary post-stabilization care or transfer of care when their emergency condition has been stabilized. The Alliance, upon receipt of an authorization request for Medically Necessary post-stabilization services and non-urgent care that is provided to a Member following an exam in the Emergency Department (ED), will render a decision within 30-minutes or the request will be deemed approved, pursuant to Title 28, CCR 1300.71.4 and 22 CCR section 53855(a). Furthermore, if a provider contacts the Alliance to authorize post-stabilization care, the Alliance will not require more than one phone call for this purpose, as prior authorization is not necessary.
 4. Non-contracted hospitals will either be provided with authorization to provide post-stabilization care, or the UM Department will arrange for transportation to a contracted facility.
 - a. Post-stabilization: Upon receipt of an authorization request from an emergency services provider, Contractor shall render a decision within 30 minutes, or the request is deemed approved, pursuant to Title 28 CCR Section 1300.71.4.. Additionally, effective July 1, 2025, in alignment with the Alliance's core


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organizational functions for behavioral health services and in accordance with AB 188, a request will be deemed approved if a provider determines that the enrollee requires post-stabilization care and there is an unreasonable delay in the transfer of care.

- b. All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary health care services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the health care provider making the request, and the name of the Alliance representative responding to the request.
 - c. In the event the requesting provider and the on-call Alliance Medical Director are in disagreement regarding post stabilization decisions, the Alliance will assume responsibility for the care of the member, either by having medical personnel contracted with the Alliance personally take over the care of the member within a reasonable time after the disagreement or having another contracted general acute care hospital agree to the transfer of the member.
5. The Alliance has the authority to disapprove payment for:
- a. The delivery of such necessary post-stabilization medical care, or the continuation of the delivery of such care, provided that the Alliance notifies the provider prior to the commencement of delivery such care or during the continuation of the delivery of such care and in both cases the disruption of such care does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.
 - b. The Alliance is not to be obligated to pay for the delivery or continuation of post-stabilization medical care from and after the time it provides such notice to the provider, otherwise, the Alliance shall pay for all Medically Necessary health care services provided to a Member which are necessary to maintain the Member's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.

Emergency services also include screening, evaluation and examination by a physician, or other personnel acting within the scope of their licensure to determine if a psychiatric emergency exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

NOTE: Emergency psychiatric services and care including subsequent evaluation at an acute psychiatric treatment facility shall not apply to services provided under the Alliance's Medi-Cal LOB to the extent that such services are carved out to County Behavioral Health Departments.

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2. Other Health Services

- a. Various other health services that do not require prior authorization or PCP referral include: health education benefits, gender affirming care (GAC) office visits, breast-feeding support, family planning, pregnancy care, routine well-woman care.
- b. Acupuncture and chiropractic services may be available without prior authorization depending upon the LOB.
- c. A complete list of all self-referred services available to Members is described in Alliance Policy 404-1309 - *Member Access to Self-Referred Services*.

Procedures:

All providers must request prior authorization for services requiring Alliance approval prior to rendering the service. The prior authorization requirements apply to all Alliance Members. Providers may request retroactive approval for services provided on an urgent basis, re-authorization, or request for non-acute or acute continuing care services. Providers should always verify eligibility prior to rendering services.

Utilization Management and Utilization Review policies and procedures are available to Members and Providers, through the Alliance website and upon request. These policies and procedures describe how the Alliance authorizes, modifies, delays, or denies health care services via Prior Authorization, concurrent authorization, and retrospective authorization. Providers are notified of all services that require Prior Authorization, concurrent authorization, or retrospective authorization, and are notified of all procedures and timeframes necessary to obtain authorization of these services through the Provider Manual. This information is also available to members and potential members upon request in accordance with Alliance Policy 404-1109 - Disclosure of Utilization Management Process to Providers, Members, and the Public.

I. Provider Authorization Request Submission Process


Submission Methods:

1. Provider portal
2. Fax
3. Mail
4. Telephone


Services Requiring Authorization:

Services that require an authorization request to be submitted for processing prior to provision of those services include but are not limited to the following:

1. Allergy treatments
2. Dermatology therapy
3. Home Health Services

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4. MRI and unlisted CT scans
5. Physical, Occupational and Speech Therapy, required if combined visits exceed two (2) visits per month.
6. Podiatric treatment. Prior authorization for podiatric services rendered by podiatrists is not required if a physician or surgeon rendering the same services would not be required to request prior authorization. Members may self-refer for the initial evaluation.
7. Outpatient surgery
8. All implants should be included on the prior authorization request prior to the services being rendered
9. All non-emergency hospitalizations
10. Medical Supplies and DME
11. Requests for referral to out of area non-contracted providers and facilities
12. Referrals for services to be provided outside of the Alliance service area, for all Members except Medi-Cal administrative Members. For more information on out-of-service area referrals, refer to Alliance Policy 404-1310 - *Authorization Process for Referrals to Out of Network, Non-Contracted Specialty Providers*.
13. Requests for referral for WCM CCS-eligible members. The Alliance shall utilize only paneled CCS Providers to treat CCS conditions in any circumstance in which a CCS-eligible Member's condition requires treatment from a CCS paneled Provider. The Alliance may use an out-of-state Provider if an in-state CCS Provider does not possess the clinical expertise to appropriately treat the CCS condition of the Member.
14. Service authorization activities including Pediatric Intensive Care Unit (PICU), Neonatal Intensive Care Unit (NICU) and referrals arising from Medical Therapy Conference, Medical Therapy Program (MTP), and Medical Therapy Unit (MTU) that are not otherwise the responsibility of the MTU.
 - a. The Alliance will refer members to local county CCS programs if members are suspected of having a MTP eligible condition. As a part of the CCS eligibility review, local county CCS programs review and determine MTP eligibility. Referrals for medically necessary specialty services and follow-up treatment, as prescribed by the MTU Conference Team Physician are submitted by the MTP.
15. The Alliance is responsible for NICU acuity assessment, authorization, and payment function activities in all WCM counties. The Alliance will review authorizations and determine whether or not services meet CCS NICU requirements. The Alliance also assumes responsibility of coverage for PICU/NICU eligible newborns through their second month of life when the newborn's mother is Medi-Cal eligible and enrolled in the MCP.
16. Requests for maintenance and transportation benefits for WCM CCS-eligible members.
17. Where usual frequency limits for member benefits or services have been reached, the Alliance requires an authorization request for review of medical necessity for continuation of benefits. If the request does not meet medical necessity and is denied, the member is referred by the UM reviewer to the Alliance's Case Management (CM) Department through our internal care management system for support and finding alternatives for care as needed. Upon receipt of the internal referral, the Case Management Department assigns the member to a care coordinator or case manager who will attempt to outreach to the member to provide additional support as needed.

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18. Drugs or treatment interventions not included in the Alliance Formulary, quantities exceeding a 90-day supply for maintenance drugs or a 30-day supply for all other agents, or not meeting drug specific quantity, age, or gender restrictions. Effective 01/01/2022, pharmacy services billed as pharmacy claims are carved out to fee-for-service under Medi-Cal Rx for Alliance Medi-Cal Members . Medi-Cal Rx is responsible for formulary management, prior authorization, and claims processing. Current pharmacy policy embodied in CCS Numbered Letters will be integrated into Medi-Cal Rx policy to ensure continuity of services to support the WCM program. Authorized Prescription Drugs CCS-eligible members transitioning into the Alliance are allowed continued use of any currently prescribed drug that is part of their therapy for the CCS-eligible condition. The CCS-eligible member must be allowed to use the prescribed physician administered drug (PAD) until the Alliance and the prescribing physician agree that the particular drug is no longer medically necessary or is no longer prescribed by the county CCS program provider.

Hospice Services: The Alliance will only require prior authorization for inpatient hospice care. The Alliance will also respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and All Plan Letters.

Required Information for Authorization Submission (i.e. complete request):


Referrals and requests for prior authorization of healthcare services are submitted by the provider of service to the Alliance UM department by phone, in the case of afterhours requests, mail, fax or Alliance web-based electronic portal. Required information provided on all requests should include:

1. Member demographic information
2. Practitioner demographic information including phone number and fax
3. Requested service/procedure to include specific CPT/HCPCS code(s)
4. Member diagnosis (Specific current version of ICD Code/Description)
5. Clinical indications necessitating service or referral
6. Pertinent medical history, treatment, or clinical data
7. Location of service to be provided
8. Requested length of stay for all inpatient requests
9. Proposed date of procedure for all outpatient surgical requests

Pertinent data and information are required to for a thorough assessment of medical necessity. If information is missing or incomplete, an incomplete or void notice will be sent.

Timeframes for Authorization Submission: Healthcare services requiring prior authorization are to be submitted to the Alliance prior to rendering services requested unless it is not possible for the provider to obtain authorization before providing a medically necessary service. If an authorization request is submitted after a service has been provided or initiated, it should be received by the Alliance within 30 calendar days of initiation of the service.

Post-service authorization for Members with retroactive eligibility: Requests must be submitted for Members receiving retro-eligibility for coverage by the Alliance. Members with retro-eligibility

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must have their healthcare services authorization requests submitted to the Alliance for authorization within 60 days of receiving eligibility.

Post-service authorization requests not related to eligibility: If it is not possible for the provider to obtain authorization before providing a necessary service or medical item, the Alliance will respond to post-service requests within 30 calendar days of receipt of the request. The Alliance communicates decisions to the Provider and to the Member who received the services, or to the Member's designee, within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and H&S Code section 1367.01(h)(1).

Post-Service Authorization for ECM and CS Members with Presumptive Eligibility: ECM and CS requests for members with presumptive eligibility or where a 48hour+ authorization timeline will preclude effective use of service will be accepted and reviewed by the Alliance as post service authorization requests to avoid delays or disruptions in member service. Post service ECM and CS authorization requests will be processed within 30 calendar days of receipt of the request and as outlined in this policy.

Requests pursuant to Community Assistance, Recovery, and Empowerment (CARE) Court Program: Prior Authorization is not required for services, other than prescription drugs, that are provided to IHSS members pursuant to a voluntary CARE agreement, or a court ordered CARE plan. Requests submitted to the Alliance, where the requesting provider indicates the request is pursuant to a CARE Plan, will be voided, as no prior authorization is required for such requests.

II. Alliance Authorization Request Review Process:


Staff Review of Requested Authorization Requests

The Alliance ensures that its prior authorization, concurrent review and post-service review staff are qualified healthcare professionals who make authorization determinations (whole or in part) based on medical necessity. Review decisions that include service reductions (modifications) and denials are supervised and determined by a qualified Physician (Chief Medical Officer or Medical Director).

Staff Review of Requested Pharmacy Authorization Requests

The Chief Medical Officer, Medical Director or Alliance Pharmacists may approve, defer, modify, or deny prior authorizations for pharmaceutical services provided that such determinations are made under the auspices of and pursuant to criteria established by the Plan's Medical Director, in collaboration with the Alliance Pharmacy and Therapeutics Committee. Procedures for processing pharmaceutical authorization requests are described in Alliance Policy 403-1103 - *Pharmacy Authorization Request Review Process*.

Criteria for Authorized Request Review

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The Alliance utilizes criteria based on sound clinical evidence (e.g. Medi-Cal Criteria, MCG criteria and internally developed Alliance guidelines approved by Quality Improvement and Health Equity Committee (QIHEC) and/or evidence-based guidelines including those from nonprofit professional associations for the Alliance Care IHSS line of business) to determine the appropriateness of requested healthcare services. The Alliance utilizes the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. These are based on needs of individual patients and characteristics of the local delivery system. Criteria are developed or adopted by actively practicing practitioners and updated and evaluated on an annual basis. Relevant clinical information is obtained when making a determination based on medical appropriateness and the treating practitioner is consulted when appropriate. The Alliance will consult with providers as needed for Prior Authorization requests for the purposes of determining Medical Necessity for medical services unless doing so would lead to undue delay in care. Information collected to support decision-making is documented.

The Alliance uses a variety of sources to assist in making determinations for care. Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

1. Input from the treating practitioner
2. Age of member
3. Existence of co-morbidities
4. Psychosocial situation
5. Home environment
6. Availability of service being considered
7. Benefit coverage

Authorization Request Review Timeframes:


1. Authorization requests, including prior authorizations, concurrent review, and retrospective requests, submitted to the Alliance via electronic portal, fax or mail are date stamped upon receipt of request and processed according to the authorization request review time frames described in this policy.
2. Standard authorizations are processed within five (5) business days from receipt of the information reasonably necessary to render a decision (in process status) in accordance with 42 CFR section 438.404(a) and Health and Safety Code Section 1367.01 (h)(1).
 - a. For IHSS Members, if the request cannot be completed within 5 business days because more time is needed to make a determination, the authorization may be Extended (delayed) a maximum of 14 days.
 - i. In instances where the Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard requests because it is not in receipt of information reasonably necessary and

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requested, the Alliance will send out the NOA Extension letter to the provider and Member within the required timeframe or as soon as the Alliance becomes aware that it will not meet the timeframe.

The Extension NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Alliance will also include the anticipated date when a decision will be rendered.


- b. For Medi-Cal Members, requests may be Extended (delayed) or Deferred if the request cannot be completed within 5 business days because more time is needed to make a determination.
 - i. The decision to Extend (delay) may be made for certain circumstances as follows: If it is determined that there is insufficient information to render a medically appropriate decision, the request may be Extended (delayed) for fourteen (14) calendar days from the date of receipt.
 1. In instances where the Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard requests because it is not in receipt of information reasonably necessary and requested, the Alliance will send out the NOA Extension letter to the provider and Member within the required timeframe or as soon as the Alliance becomes aware that it will not meet the timeframe.
 2. The Extension NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Alliance will also include the anticipated date when a decision will be rendered
 - ii. The decision may be Deferred an additional fourteen (14) calendar days only at the request of the Member or the Member's provider, or when the Alliance can provide justification for the need for additional information. A decision to Defer a request must also be in the Member's best interest.
 1. In instances where the Alliance cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard requests because it is not in receipt of information reasonably necessary and requested, the Alliance will send out the NOA Deferral letter to the provider and Member within the required timeframe or as soon as the Alliance becomes aware that it will not meet the timeframe.
 2. The Deferral NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Alliance will also include the anticipated date when a decision will be rendered, in accordance with H&S Code section 1367.01.
3. Any decision delayed beyond these time limits is considered a denial and must be immediately processed as such.

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- a. The Alliance’s written response (NOA) to the Member must be dated and postmarked within two business days of the decision.
4. Expedited/urgent authorizations: For requests in which a provider indicates, or the Alliance determines that, following the standard timeframe for authorizations could seriously jeopardize the Member’s life or health or ability to attain, maintain, or regain maximum function, the Alliance, per our contract, makes an expedited authorization decision and provides notice as expeditiously as the Member’s health condition requires and not later than 72 hours after receipt of the request for services.
 - a. The Alliance treats these requests as urgent requests and processes them as soon as possible.
 - b. Provider requests for standing referrals will be processed under “urgent” status. As such, determinations for standing referrals shall be made within 72 hours from the time the request is made by the Member, the Member’s authorized representative, or the Member’s primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. For more information on standing referrals, see *Alliance Policy 404-1306 - Extended and Standing Referral Authorizations*.
 - c. The Alliance may extend this timeframe up to an additional 14 calendar days only in the Member or the Member’s provider requests an extension, or if the Alliance justifies, to DHCS upon request, a need for additional information and how the extension is in the Member’s interest, in accordance with 42 CFR section 438.210. Similar to extensions for standard authorization, the Alliance notifies the Member’s provider and the Member, in writing, of any authorization request delayed beyond the 72-hour time frame, which will include the anticipated date on which a decision may be rendered.
 - d. Urgent referrals should only be submitted if the normal time frame for authorization will:
 - i. Be detrimental to the member’s life or health, or
 - ii. Jeopardize member’s ability to regain maximum function, or
 - iii. Result in loss of life, limb, or other major bodily function
 - e. Referrals that do not meet the above urgent referral criteria will be downgraded to a routine referral request and follow standard turn-around times.

Notification of Determination to Members

1. Notification of Determination (IHSS Members):
 - a. Approval Determination: Communication of approval is sent to the Provider via fax and will specify the healthcare services approved. Approval of an authorization request is sent directly to the Member and their Provider.

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- i. Out-of-Network (OON) coverage: When the Alliance arranges OON coverage for medically necessary mental health and substance use disorder services for Alliance Care IHSS members, in accordance with Alliance Policy 401-1101-Utilization Management Program, the Alliance will send a written notice to the member, the Member's authorized representative and requesting provider within five (5) days. This notice will explain that the Alliance is responsible for arranging and paying for the OON services due to network inadequacy. The notice will also explain to the member that they are only required to pay their usual in-network cost-sharing amount for these services.
- b. Extension (Delay),
 - i. When a decision cannot be made within five (5) business days of the request for authorization, the Member and provider receive a letter explaining why a decision cannot be made, specify information requested but not received, or the additional tests or examinations required and an anticipated date of when a decision will be rendered.
 - ii. Communication of delay or extension occurs in writing within two (2) business days.
- c. Denial, or Modification Determination:
 - i. Communication of decision occurs in writing within two (2) business days of the decision.
 - ii. Written communication will include:
 1. The condition or service for which the Alliance has conducted a UM review, including the clinician specialty at issue if applicable
 2. Statement of action the Alliance intends to take.
 3. Clear and concise explanation of the reasons for the Alliance's decision;
 4. Description of the criteria or guidelines used; this includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guidelines.
 5. Clinical summary outlining the decisions regarding medical necessity; including the explicit rationale (e.g., application of scoring or criteria) for why the Member's condition does not meet the established criteria or guidelines, along with any reasons for deviation from criteria listed in rule 1300.74.721(l) if applicable,
 6. Information on how to file a grievance or an appeal and the Member's right to contact the Department of Managed Health Care; and
 7. Decisions based, in whole or in part, on a finding that the requested services are not a Covered Service will clearly specify the provisions in the contract excluding the coverage.
 8. Full translation in member's threshold or concentration language.


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iii. If coverage is denied for treatment, services, or supplies deemed experimental for a member with a terminal illness, the member will receive the following information within 5 business days:

1. A statement with the specific medical and scientific reasons for denying coverage.
2. A description of alternative treatment, services, or supplies covered by the plan.
3. Copies of grievance procedures.

2. Notification of Determination (Medi-Cal Members):

- a. Approval Determination: Approval of an authorization request is communicated to the Member through their provider/requesting entity. Approvals are sent directly to the Member and their Provider/requesting entity.
 - i. Approval Determination: Written communication of approval will be sent via fax and/or immediate portal notification to the provider/requesting entity within 24 hours of the decision and will specify the health care or ECM/CS services approved. Approval notices will be sent to the Member within two (2) business days of the decision.
- b. Notice of Action (NOA): A NOA is a formal letter, in a format reviewed and approved by DHCS, informing a Member, within a specified timeframe, of adverse benefit determinations taken by the Alliance.
- c. NOAs and Timeframes: Notice to Members shall be in writing and in accordance with contractual requirements. NOAs are issued for the following actions and are sent within the corresponding timeframes:
 - i. Denial or limited authorization of a requested Covered Service: Sent within 14 calendar days of the request, with a possible delay (deferral) of up to 14 additional calendar days if the Member or provider requests an extension, or if the Alliance justifies a need for additional information and how the extension is in the Member's best interest.
 - ii. Reduction, suspension or termination of a previously authorized Covered Service: Refer to "Advanced Notice" section below for timeframes.
 - iii. Denial, in whole or in part, of payment for a Covered Service: Sent at the time of any action affecting the claim.
 - iv. Failure to authorize Covered Service in a timely manner: Sent on expiration date of service.
 - v. Decision to extend the timeframe to authorize a Covered Service and provide information on filing a Member Grievance in the Member disagrees: Sent within 14 calendar days following receipt of the request.
 - vi. Expedited authorization decision: Sent within 72 hours of receipt of the request.
 - vii. Post service Member approvals.
 - viii. The Alliance notifies members of a decision to deny, delay, or modify requests for Prior Authorization by providing a NOA to members and/or their authorized


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representatives. The Alliance notifies the Member in writing of the delay of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request the Alliance provides written notification of the decision to Members no later than 30 calendar days from the receipt of the original request.

- d. NOA Content and Format: The written NOA shall be in a format and language that, at a minimum meets contractual standards, and must include the following:
 - i. Statement of action the Alliance intends to take.
 - ii. Clear and concise explanation of the reasons for the Alliance's decision;
 - iii. Description of the criteria or guidelines used; this includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guidelines.
 - iv. Clinical reasons for the decisions regarding medical necessity; the Alliance will explicitly state how the Member's condition does not meet the criteria or guidelines.
 - v. Full translation in member's threshold or concentration language.
 - vi. Notification to the Member of the right to request, free of charge, reasonable access to all documents and records relevant to the action, including the medical necessity criteria and standards used;
 - vii. The Member's right to request an Appeal no later than 60 calendar days from the date on the NOA;
 - viii. Procedures for exercising the Member's rights to request a Grievance or Appeal, as described in Alliance Policy 200-9002 - *Member Grievance and Appeal System*;
 - ix. The Member's right to, and method of obtaining, a State Fair Hearing as described in Alliance Policy 200-9002 - *Member Grievance and Appeal System*;
 - x. The Member's right to represent themselves at the State Fair Hearing or to be represented by legal counsel, friend or other spokesperson;
 - xi. The member's right to request an Independent Medical Review (IMR), or a review of the Alliance's decision by DMHC, and that the IMR must be requested before there is a final State Fair Hearing decision;
 - xii. Circumstances under which an expedited Appeal is available and how to request it;
 - xiii. The Member's right to have Covered Services continue pending the resolution of an Appeal;
 - xiv. Instructions on how to request a continuation of Covered Services; and
 - xv. Contact information for the Alliance Grievance Unit and the State of California Department of Social Services toll-free number for obtaining information on legal service organizations for representation.

3. Advanced Notice:

- a. The Alliance shall ensure that at least ten (10) days of advanced notice is given to a Member when a NOA results in a termination, suspension, reduction of services, or

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reduction of previously authorized covered services. The Alliance shall shorten the advanced notice to five (5) days if probable fraud has been verified.

- b. The Alliance shall not be required to provide advanced notice of a termination, suspension, reduction of services, or reduction of previously authorized covered services when the following conditions apply:
 - i. Death of a Member;
 - ii. Member provides a written statement requesting service termination or giving information requiring termination or reduction of services;
 - iii. Member admission into an institution that makes the Member ineligible for further services;
 - iv. Member's address is unknown, and mail directed to the Member has no forwarding address;
 - v. Member has been accepted for Medi-Cal services by another local jurisdiction;
 - vi. Member's PCP prescribes a change in the level of medical care;
 - vii. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989; or
 - viii. The safety or health of individuals in a facility would be endangered, Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Members urgent medical needs, or Member has not resided in the nursing facility for a minimum of 30 days.

4. Expedited Notice:


The Alliance shall provide expedited advanced notice to a Member when the PCP indicates the standard timeframe could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. The Alliance shall ensure an expedited authorization decision and provide an expedited notice as the Member's health condition requires and no later than 72 hours after receipt of the request for services. Upon approval from DHCS, the Alliance may extend the 72 hours expedited period to 14 calendar days if the Member requests an extension, or if the Alliance justifies a need for additional information and that the extension is in the interest of the Member.

5. Record Retention:

The Alliance shall meet the retention requirements for all NOAs as described in Alliance Policy 800-0008 - *Records Retention*.

6. Notification Regarding Determinations to Providers:

The Alliance notifies the requesting Provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

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- a. Approval Determination (IHSS and Medi-Cal Members): Written communication of approvals will be sent via fax and/or immediate portal notification to the provider/requesting entity within 24 hours of the decision and will specify the health care or ECM/CS services approved. Post service approval notices will be sent to the Member within two (2) business days.
- b. Denial, Delay, or Modification Determination (IHSS and Medi-Cal Members): Communication of the decision for IHSS Members will occur via fax within 24 hours of determination, and Member Notification in writing within 2 business days.
- c. Communications for both IHSS and Medi-Cal Members will include the criteria outlined above, along with the name and direct telephone number or extension of the decision maker.

Grievance and Appeals:

Members and providers have the right to file a grievance or an appeal regarding service authorization determination as described in Alliance Policies 200-9002 - *Member Grievance and Appeal System* and 600-1017- *Provider Inquiry and Dispute Resolution*. The Alliance ensures that the person making the final decision for a proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal, nor is a subordinate of any such individual.

In circumstances where an admission does not meet medical necessity, the provider and facility may use the Alliance dispute process to allow for further review of the inpatient stay.

Second Opinions:

The Alliance ensures allowances for a second opinion from a qualified health professional at no cost to the Member as described in Alliance Policy 404-1307 - *Medical Second Opinions*.


Authorization Process Monitoring

1. Member and Provider Grievance Feedback
2. The Member and Provider grievance processes also serve as an evaluation tool for appropriate UM policies with regard to providing feedback on how the process is working.

Utilization Management Work Plan and Evaluation (UM Work Plan)

Authorization processes are monitored and evaluated via the UM Work Plan which is reported to the QIHEC on a quarterly basis as outlined in Alliance Policy 404-1101 - *Utilization Management Program*.

The Prior Authorization Nurses will review each patient authorization request for quality issues per the Alliance's Quality Improvement guidelines (with special attention to Health Care-Acquired

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Conditions (HCACs), including Provider-Preventable Conditions (PPCs) and Other Provider-Preventable Conditions (OPPCs) and report any areas of concern to the Quality Improvement Department by completing a Potential Quality Issue (PQI) form.

Delegation of Authorization Activities

UM activities that are delegated to subcontractors are reviewed quarterly and approved both quarterly and annually by the Compliance Committee as described in Alliance Policy 105-0004 - *Delegate Oversight*. Activities are also reported quarterly to the QIHEC as described in Alliance Policy 404-1101 - *Utilization Management Program*.

References:

Alliance Policies:


- 105-0004 - Delegate Oversight
- 200-9002 - Member Grievance and Appeal System
- 401-1301 - Potential Quality Issue Review Process
- 403-1103 - Pharmacy Authorization Request Review Process
- 404-1101 - Utilization Management Program
- 404-1109 - Disclosure of Utilization Management Process to Providers, Members and the Public
- 404-1112 - Medical Necessity- The Definition and Application of Medical Necessity Provision to Authorization Requests
- 404-1202 - After-Hours Availability of Plan or Contract Physician
- 404-1303 - Referral Consultation Request Process
- 404-1306 - Extended and Standing Referral Authorizations
- 404-1307 - Medical Second Opinions
- 404-1309 - Member Access to Self-Referred Services
- 404-1310 - Authorization Process for Referrals to Out of Network, Non-Contracted Specialty Providers
- 408-1305- Behavioral Health Services
- 800-0008 - Records Retention
- 600-1017 - Provider Inquiry and Dispute Resolution

Impacted Departments:

- Claims
- Care Management
- Member Services
- Pharmacy
- Provider Services

Regulatory:

- Health and Safety Code, Section 1367.01 (h)-(l)
- Health and Safety Code, Section 1367.01(h)(3)
- Health and Safety Code, Section 1374.721(b); Section 1374.72(a)(3)(A); Section 1374.721(f)(1).
- Title 22 California Code of Regulation Sections 51014.1 (a)(1), 53261(d), and 53894(d)
- Title 28 California Code of Regulation Section 1300.71.4

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Parts C&D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance (cms.gov)

Health and Safety Code section 1368.1(a)

Legislative:

Senate Bill, SB-586 Whole Child Model - Children's Services

Senate Bill, SB-855 California Mental Health Parity Act

Contractual (Previous Contract):

DHCS State Medi-Cal Contract Exhibit A, Attachment 4, Provisions 4, 5, & 9

DHCS State Medi-Cal Contract Exhibit A, Attachment 5, Provisions 1, 2, 3, 4, & 5

DHCS State Medi-Cal Contract Exhibit A, Attachment 10, Provision 2

DHCS State Medi-Cal Contract Exhibit A, Attachment 13, Provision 8

DHCS State Medi-Cal Contract Exhibit A, Attachment 14, Provisions 4 & 5

DHCS State Medi-Cal Contract Exhibit A, Attachment 18, Provisions 4 & 5

Contractual (2024 Contract):

Medi-Cal Contract Exhibit A, Attachment 3, Provision, 2.3 and 2.3.1.A-K

Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.3.2.A-G

Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.3.3.A

Medi-Cal Contract Exhibit A, Attachment 3, Provision 2.3.4.A-E

Medi-Cal Contract Exhibit A, Attachment 3, Provision 4.6.3.B

Medi-Cal Contract Exhibit A, Attachment 3, Provision 4.6.4.B-E

Medi-Cal Contract Exhibit A, Attachment 3, Provision 4.6.6.A

Medi-Cal Contract Exhibit A, Attachment 3, Provision 4.6.7.A

Medi-Cal Contract Exhibit A, Attachment 3, Provision 5.1.5

DHCS All Plan Letter:

APL 21-011 - Grievance and Appeal Requirements, Notice and "Your Rights" Templates

APL 21-013 - Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans.

APL 22-005 - No Wrong Door for Mental Health Services Policy

APL 22-006 - Plan Responsibilities for Non-Specialty Mental Health Services

APL 22-012 - Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX

APL 23-034 - California Children's Services Whole Child Model Program

DMHC All Plan Letter:

APL 20-035 - Medi-Cal Pharmacy Benefit Carve Out-Medi-Cal Rx APL 23-016: Implementation of SB 1338 (2022) -Community Assistance, Recovery and Empowerment

NCQA (Effective 07/09/2024):

NCQA QI 3: Element D

Supersedes:


DHCS APL 13-021 - *Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services 17-018 and superseded by 22-006*

APL 18-023 - California Children Services Whole Child Model Program is superseded by 21-005 and 23-034

DHCS APL 20-020 - *Medi-Cal Pharmacy Benefit to Medi-Cal RX is superseded by 22-012*

Other References:

Attachments:

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Lines of Business This Policy Applies To

- ☐ DSNP
☒ Medi-Cal
☒ Alliance Care IHSS

Revision History:

Reviewed Date	Revised Date	Changes Made By	Approved By
02/07/2023	02/07/2023	Paige Harris, Regulatory Reporting Supervisor	UMWG
03/17/2023	03/17/2023	Carissa Grepo, RN UM Manager, Prior Auth	UMWG
02/12/2024	02/12/2024	Carissa Grepo, RN UM Manager, Prior Auth	UMWG
07/09/2024	07/09/2024	Carissa Grepo, RN UM Manager, Prior Auth	UMWG
12/10/2024	12/10/2024	Kelly Tlemcani, Business Analyst II	UMWG
05/21/2025	05/21/2025	Kelly Tlemcani, Business Analyst II	UMWG