	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

## PURPOSE

To describe Central California Alliance for Health's (the Alliance) Utilization Management Program (the Program) which serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and actively pursues identified opportunities for improvement. The program serves to accomplish the following:

1. Ensure that members receive the appropriate quantity and quality of health care services.
2. Ensure that the service is delivered at the appropriate time.
3. Ensure that the setting the service is delivered in is consistent with the medical care needs of the individual.
4. Ensure that medical management decisions will not be influenced by fiscal and administrative management.
5. Ensure compensation of staff or Subcontractors that conduct utilization management activities shall not be structured to provide incentives to deny, limit, or discontinue Medically Necessary services.

The Program provides a reliable mechanism to review, monitor, evaluate, and address utilization-related concerns as well as recommend and implement interventions to improve appropriate utilization and resource allocation. On an annual basis, identified data will be reviewed, to evaluate, and address efficacy-related concerns, and suggest improvements to the Program as a whole.


The Alliance recognizes the potential for over-and underutilization of health care services and takes appropriate steps and actions to monitor for this. The processes utilized for decision-making are based solely on the clinical appropriateness of care and services. Practitioners are rewarded for providing appropriate quality of care and ensuring appropriate utilization of services.

The Health Services Division (HS) oversees the Program. The Division consists of Utilization Management (UM), Care Management, Enhanced Health Services, Pharmacy, Behavioral Health and the Quality Improvement and Population Health (QIPH) Departments.

The Alliance service area includes Santa Cruz, San Benito, Mariposa, Monterey, and Merced counties, with offices located in Scotts Valley, Salinas and Merced. Utilization management processes described in the Program are followed at all locations throughout the organization.


## UM PROGRAM OBJECTIVES

The Program serves to ensure appropriate, high quality, cost-effective utilization of health care resources and that these resources are available to all members. This is accomplished through the systematic and consistent application of utilization management processes based on current,

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

relevant medical review of criteria and expert clinical opinion when needed. The utilization management process provides a system that ensures equitable access to high-quality health care across the network of providers for all eligible members. The Program will:

1. Coordinate thorough and timely investigations and responses to member grievances and appeals as well as provider disputes associated with utilization issues.
2. Conduct operational revisions to prevent problematic issues from reoccurring.
3. Ensure that services are medically needed and consistent with the diagnosis and level of care required for each individual. This determination should consider any co-morbid condition that exists and the ability of the local delivery system to meet the individual's needs.
4. Educate members, practitioners, providers, and internal staff about the Alliance's goals for providing quality, cost-effective managed health care.
5. Define the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review.
6. Promote and ensure the integration of utilization management with Quality Improvement and Health Equity Transformation Program; Program Integrity monitoring and reporting; risk management; and disease and case management activities.
7. Ensure a process for critical review and assessment of the Program on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates practitioner and member input along with any regulatory changes, changes to current standards of care, and technological advances.
8. Ensure authorized Medi-Cal services are covered per the plan contract with the State of California Department of Health Care Services (DHCS) and conform to the California Code of Regulations Title 22.
9. Ensure that medical services are consistent with the benefit design of each plan.
10. Evaluate the ability of delegates to perform utilization management activities and to monitor performance.
11. Promote high level of satisfaction across members, practitioners, stakeholders, and partner organizations.
12. Ensure compliance with all applicable regulatory and accrediting rules, regulations and standards, and applicable state and federal laws that govern the utilization management process.
13. Ensure processes are developed to protect the confidentiality of member protected health information and other personal/provider information.
14. Ensure that no staff member uses a title or designation when speaking to a member that may cause a reasonable person to believe that the staff member is a licensed, certified, or registered professional described in Section 4999.2 of the Business and Professions Code unless the staff member is a licensed, certified, or registered professional.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	


- a. The Alliance provides access to staff and information about UM processes and the authorization of care to members and practitioners via:
  - i. Alliance Provider and Member Manuals
  - ii. Direct phone calls: Alliance toll free and local contact information provides direct access to Alliance staff for members and practitioners seeking information about Alliance UM processes and the authorization of care. Phone contact information is also provided via the Alliance site and Member Notice of Action correspondence letters.
  - iii. After hours availability: Alliance staff are available at least 8 hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
  - iv. Staff identification: Alliance staff are identified by name, title and organization name when initiating or returning calls regarding UM processes and the authorization of care.
  - v. Alliance staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.
  - vi. Alliance staff can receive inbound communication regarding UM issues after normal business hours. See Policy #: 404-1202
  - vii. Title: After-Hours Availability of Plan or Contract Physician
  - viii. Deaf and Hard of Hearing Assistance TTY 800-735-2929 (Dial 711)

Alliance staff are available to receive inbound communication regarding UM issues after normal business hours. See Alliance policy 404-1202 After-Hours Availability of Plan or Contract Physician

15. Identify and resolve problem issues that result in over or under utilization and the inefficient or inappropriate delivery of health care services.
16. Optimize the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs via case management.
17. In partnership with Provider Services, educate practitioners and providers on the Alliance's UM policies, procedures and program requirements to ensure compliance with the goals and objectives of the UM program.

#### **UTILIZATION MANAGEMENT PROGRAM SCOPE**

Utilization management activities are developed, implemented and conducted by the HS Division under the direction of the Chief Medical Officer or designee. Behavioral Health Utilization Management is delegated to a Managed Behavioral Health Organization (MHBO) until June 30, 2025. Beginning July 1, 2025, the Alliance will manage covered services related to behavioral health for all members in-house through its core organizational functions. UM staff will perform specific activities, in accordance with Health and Safety Code section 1367.01. All staff responsible

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	


for the UM program are qualified, experienced, licensed nurses, practitioners, and other health care professionals.

Specific functions performed include:

1. Prospective, concurrent and post-service utilization review for medical necessity, appropriateness of hospital admission, level of care and continued inpatient confinement on a daily basis. This review is performed cooperatively with the personnel at the facility, attending physician(s) and any associated health care personnel that can provide information that will substantiate medical necessity and level of care.
2. Discharge planning in coordination with discharge planning personnel or appropriate case management personnel at the facility providing care for the member.
3. Care transitions activities include coordination with the member / member's representative and Primary Care Provider (PCP) following inpatient discharge for members at high risk for readmission.
4. Review inpatient and outpatient utilization data to determine appropriateness of member and provider utilization patterns, including inappropriate over- and under-utilization.
5. Use of evidence-based guidelines, such as Medi-Cal guidelines, MCG care guidelines, California Children Services (CCS) Numbered Letters, and other Alliance utilization criteria as developed and approved by the Quality Improvement and Health Equity Committee (QIHEC) for authorization decisions.
6. Use of California Department of Health and Welfare Code of Regulations Title 22 for Medi-Cal members.
7. Review authorization requests for skilled nursing care, home health care, durable medical equipment, ambulatory surgery, and ambulatory diagnostic and treatment procedures such as Physical, Occupational and Speech Therapy.

The Program encompasses monitoring and evaluation for the following services:

1. Acute hospital services
2. Ambulatory care
3. Ancillary care services, including but not limited to home health care, long-term care, skilled nursing care, subacute care, pharmacy, laboratory and radiology services
4. Emergency and urgent care services
5. Durable Medical Equipment and supplies
6. Non-Emergency Medical Transportation
7. Palliative Care
8. Pharmacy services

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

## BEHAVIORAL HEALTH

A PCP is responsible to care for mental health conditions that are responsive to physical health care-based treatment, non-specialty mental health conditions (e.g. anxiety and depression) and may elect to offer care for members with severe mental illness (SMI) that the PCP deems are within their scope of practice. See Alliance policy 405-1312 - Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home.

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.

In accordance with W&I Code sections 14059.5 and 14184.402, for individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service meets the Early Periodic Screening, Diagnostic and Treatment (EPSDT) standard set forth in Section 1396d(r)(5) of Title 42 of the USC. A service is considered medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

Covered Services do not include California Children’s Services (CCS), pursuant to Exhibit A, Attachment III, Section 4.3.15 (California Children’s Services (CCS), or Specialty Mental Health Services (SMHS), pursuant to Exhibit A, Attachment III Section 4.3.13 (Mental Health Services).

The federal EPSDT mandate requires states to furnish all appropriate and medically necessary services that could be covered under a Medicaid State Plan (as described in Title 42 USC Section 1396d(a) as needed to correct or ameliorate health conditions, including behavioral health conditions, discovered by a screening service, regardless of whether those services are covered in the state’s Medicaid State Plan.

Consistent with federal guidance from CMS, behavioral health services, including NSMHS, need not be curative or completely restorative to ameliorate a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

considered to ameliorate the condition and are thus medically necessary and are covered as EPSDT services.


The Alliance will ensure referral to case management for Medically Necessary services authorized by CCS, county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System Plans under this Paragraph is equivalent to that provided by The Alliance for Covered Services for Members less than 21 years of age under this Contract and must, if indicated or upon the Member's request, provide additional Care Coordination and case management services as necessary to meet the Member's medical and behavioral health needs.

The Alliance contracts with a Managed Behavioral Health Organization (MBHO) to provide non specialty mental health services (NSMHS) from licensed mental health care providers for Medi-Cal members until June 30, 2025. Severe conditions requiring Specialty Mental Health Services will be referred to the local County Mental Health Plan (MHP). See Alliance policy 408-1305 – Behavioral Health Services for details about Behavioral Health coverage for IHSS members. There is an expectation that Primary Care Providers and Mental Health Practitioners will coordinate care and services according to the Alliance/County Mental Health Memorandum of Understanding (MOU) executed with each County MHP.

The Alliance provides coverage for all medically necessary physical health components of eating disorder treatment and providing or arranging for NSMHS for Medi-Cal members, specifically:

- Inpatient hospitalization for members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and do not meet criteria for psychiatric hospitalization, as well as for NSMHS for members requiring these services.
- Emergency Room professional services as described in 22 CCR§ 53855. Including professional physical, mental, and substance use treatment services, including but not limited to: professional physical, mental and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services that are medically necessary to stabilize the member.
- Medically necessary physical health components of partial hospitalization and residential eating disorder programs.

For partial hospitalization and residential eating disorder programs, the County Mental Health Plan is responsible for all medically necessary SMHS components. The Alliance will maintain a Memorandum of Understanding (MOU) between the Alliance and the County Mental Health Plan as documented in Alliance Policy 800-1002 Memorandum of Understanding.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

The Alliance will refer members to Care Management, to ensure Comprehensive Medical Case Management Services, including the coordination of care, to ensure the provision of all medically necessary services, whether those services are delivered within or outside the Alliance’s provider network. The Alliance will coordinate all medically necessary care for members, including locating, arranging, and following up to ensure services were rendered for partial hospitalization and residential eating disorder programs, when such treatment is medically necessary for a member.

The Alliance also arranges for the provision of NSMHS for Medi-Cal members including:


- 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 the purposes of monitoring drug therapy;
- Psychiatric consultation; and,
- Outpatient laboratory, drugs, supplies, and supplements.

For the IHSS Line of Business (LOB), the Alliance will not limit benefits or coverage for medically necessary services on the basis that those services should be or could be covered by a public entitlement program. For Medi-Cal members, the Alliance coordinates with the County in provision of hospital, medical, or surgical coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child. For additional details, see Alliance policy 408-1305 – Behavioral Health Services.

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.



	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

The Alliance will provide coverage for medically necessary treatment of non-specialty mental health and substance use disorders (MH/SUD) for MediCal members and for both specialty and non-specialty services for IHSS members,, including behavioral health crisis services provided by a 988 center, mobile crisis team, or other behavioral health crisis service providers, regardless of whether the service is provided by an in-network or out-of-network provider or facility. MH and SUD services are provided under the same terms and conditions applied to other medical conditions, for both the Medi-Cal and IHSS lines of business. If the Alliance cannot provide a medically necessary treatment of a MH/SUD to a plan enrollee using the Alliance’s contracted providers, within required geographic and timely access standards, the Alliance coordinates to arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services who are qualified to provide such services. If medically necessary services are not available within the Alliance’s network, the Alliance arranges for the provision of covered services from providers outside the Alliance’s network. Additionally, if medically necessary MH/SUD services are not available in network within the geographic and timely access standards, the Alliance coordinates internally to arrange coverage outside the Alliance’s network in accordance with HSC section 1374.72 and Alliance policy 300-1509 Timely Access to Care. The Alliance will notify the member, or their authorized representative, within 24 hours of scheduling an out-of-network appointment. The notification will be provided in the most expeditious manner possible to the Member and include the following details about the appointment:

- Confirmation of the scheduled appointment or admission,
- The name of the provider,
- The date and time of the appointment or admission, and
- The location and contact information for the provider.


The Alliance shall document and retain a record of all the communications with the Member including:

- The description of the requested MH/SUD service,
- The name, type and location of the provider contacted,
- The MH/SUD service authorized, and the selected provider (s), location(s) and duration of the services provided.

The Alliance will allow members to see any appropriately licensed provider if the plan cannot arrange for covered services, as long as the appointment or admission, occurs within 90 days of the service request, or at the earliest available date after 90 days, as long as the date is confirmed within 90 days. For more information, refer to Alliance Policy #300-7030-Reimbursement of non-contracted providers.

The Alliance provides covered SUD services, including alcohol and drug use screening, assessment, brief interventions, and referral to treatment (SABIRT) for members ages 11 and older, including pregnant members, in primary care settings and tobacco, alcohol, and illicit drug



	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

screening in accordance with American Academy of Pediatrics Bright Futures for Children recommendations and United States Preventive Services Taskforce grade A and B recommendations for adults as outlined in APL 21-014, Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. Further, the Alliance arranges for the provision of:

- Medications for Addiction Treatment (also known as Medication-Assisted Treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings.
- Emergency services necessary to stabilize the member.

Upon implementation effective, 01/01/2022, pharmacy services billed as pharmacy claims are carved out to fee-for-service (FFS) under Medi-Cal Rx for Alliance Medi-Cal members. 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. Coverage of mental health medications is an Alliance benefit for the Alliance Care IHSS LOB.


Behavioral Health Treatment (BHT) is covered when medically necessary as part of the Early Periodic Screening, Diagnostic and Treatment services (EPSDT) for members under 21 years of age. BHT services covered must be evidence-based and prevent or minimize behavioral conditions. They must also promote, to the maximum extent practicable, the functioning of a member.

BHT services are provided as part of a behavioral treatment plan that has measurable goals over a specific timeline and that has been developed by a BHT Service Provider. The behavioral treatment plan must be reviewed, revised, and/or modified no less than once every six months by a BHT Service Provider. BHT services may be discontinued when the treatment goals are achieved, goals are not met, or services are no longer medically necessary.

Covered BHT services must be provided in accordance with treatment plan and continuity of care requirements outlined in APL 23-022. For more details, please refer to Alliance policy 408-1305 – Behavioral Health Services.

The Alliance ensures that, consistent with state law, clinically appropriate and covered NSMHS are covered even when:

- 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;
- Services are not included in an individual treatment plan;
- The member has a co-occurring mental health condition and SUD; or,

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

- NSMHS and SMHS are provided concurrently if those services are coordinated and not duplicated.

More information regarding these services and the No Wrong Door for Mental Health Services Policy can be found in APL 22-005.

## **PROGRAM STRUCTURE, AUTHORITY AND RESPONSIBILITY**

### **Committee Functions**

#### Governance

The Santa Cruz-Monterey-Merced-San Benito-Mariposa Managed Medical Care Commission (Alliance Board) promotes, supports, and has ultimate accountability, authority and responsibility for a comprehensive and integrated Program. The Alliance Board has delegated oversight and performance responsibility of the program to the QIHEC.

#### Quality Improvement and Health Equity Committee (QIHEC)

The QIHEC is the contractually required quality improvement committee with oversight and performance responsibility of the Quality Improvement & Health Equity Transformation and Program (QIHETP) – excluding credentialing/recredentialing activities, which are directed by the Peer Review and Credentialing Committee (PRCC) – as described in Alliance policy 401-1201 – Quality Improvement Health Equity Committee.


#### Pharmacy and Therapeutics Committee (P&T)

The P&T Committee operates under the authority of the QIHEC and participates in the UM Program as described in Alliance policy 403-1104 – Mission, Composition and Functions of the Pharmacy & Therapeutics Committee.

#### Utilization Management Work Group (UMWG)

The UMWG operates under the authority of the QIHEC. UMWG is co-chaired by an Alliance Medical Director and the UM Director. UMWG membership includes representatives from all major areas of Health Services (HS), including the Chief Medical Officer, Medical Directors, UM Managers, and Supervisors, QIPH Director, Pharmacy Director, and CM Director, and other staff or delegates as needed. The UMWG meets, at a minimum, 12 times a year and once a quarter, and as needed. UMWG activities and recommendations are reported to the QIHEC quarterly. The UMWG provides guidance and direction to the Program. UMWG activities include, but are not limited to:

1. Reviewing and making recommendations to the Program policy annually.
2. Reviewing and approving the UM Work Plan and Evaluation quarterly.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

3. Approving and ensuring implementation of utilization management criteria and UM policies.
4. Analyzing summary data and making recommendations for action.
5. Recommending medical policy, protocol, and clinical practice guidelines.
6. Monitoring delegated utilization management activities through regular reports as described in Alliance policy 105-0004 – Delegate Oversight.

### **Program Staff**

Alliance staff participating in Program activities are described below.

#### Chief Medical Officer


The Chief Medical Officer (CMO) ensures that medical decisions are made by qualified personnel that are not duly influenced by fiscal or administrative management considerations. The CMO, in collaboration with the Medical Director(s), is responsible for providing professional judgment regarding matters of resource utilization. The CMO is responsible for providing executive management and leadership to all of the departments under the HS Division: CM, Pharmacy, Behavioral Health, Enhanced Health Services, QIPH, and UM. Only the CMO, the Medical Director/Physician designee, or the Pharmacist can deny a service request.

#### Medical Director

The Medical Director(s) has significant involvement in all UM activities and provides support to the UM Director in the oversight and implementation responsibility for the Program on a day-to-day basis. Only the CMO, the Medical Director/Physician designee, or the Pharmacist can deny a service request. Specific functions include:

1. Supports the UM Director in assuring that the Program fulfills its purpose and goals and complies with regulatory agencies and accreditation bodies.
2. Participates in developing and coordinating policies and procedures.
3. Serving as committee co-chair of the UMWG.
4. Guiding and assisting in the development and revision of clinical criteria, clinical practice guidelines, and performance standards for UMWG review and approval.
5. Reviewing and evaluating new technology assessments, including referral to UMWG for benefit determinations.
6. Plays an active role in developing and implementing utilization management strategies.
7. Communicating utilization management activities to the QIHEC.
8. Presenting updates on utilization management activities to the QIHEC and the Alliance Board in collaboration with the UM Director.
9. Performs medical necessity reviews for complex authorization requests, including all recommendations for denial.

#### Utilization Management Director (RN)

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	


Under the direction of the CMO, the UM Director is responsible for directing all aspects of utilization management. In collaboration with the Medical Director, the QIPH Director, the CM Director, and other Health Plan Directors, the UM Director's duties include the development, implementation, maintenance, and evaluation of an efficient, effective and systematic Program. The UM Director promotes efficient resource utilization throughout the organization, providing the leadership, team building, and direction needed to ensure attainment of UM goals. The UM Director is responsible for overall Program management, with duties including, but not limited to:

1. Reviewing and submitting issues, updates, and recommendations to governing forums.
2. Coordinating completion of activities.
3. Presenting work plan status reports and updates to the QIHEC
4. Monitoring compliance with standards.
5. Making recommendations for interventions to improve utilization management issues.
6. Coordinating implementation of interventions.
7. Developing UM policies and procedures for QIHEC approval.
8. Coordinating development and documentation of UM activities.
9. Providing day-to-day supervision of assigned UM staff.
10. Participating in staff training.
11. Monitoring for consistent application of UM criteria by UM staff, for each level and type of UM decision.
12. Monitoring documentation for adequacy.
13. Is available to UM staff on site or by telephone.

**UM Managers (Prior Authorization & Concurrent Review – RN)**

Responsible for the direct supervision of the concurrent review, or prior authorization staff. Ensures that reviews are accurate and timely and use nationally recognized approved standards such as the MCG care guidelines. Participate in Performance Improvement Projects (PIPs), DHCS mandated study of specific health issues, as needed, and assist the UM Director and CMO in preparation for audits. Duties include:

1. Coordinate concurrent review/prior authorization/authorization coordination activities.
2. Ensure that criteria adopted by the Alliance are applied consistently and correctly to reviews.
3. Work with the UM Director, and the Medical Director(s) to evaluate and improve the departmental review processes.
4. Coordinate with other departments as appropriate.
5. Investigate and follow up on complaints, grievances, and quality issues.
6. Providing day-to-day supervision of assigned UM staff.
7. Participating in staff training.
8. Monitoring documentation for adequacy.
9. Is available to UM staff on site or by telephone.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

*UM Manager (Authorization Coordinators/Non-Emergency Medical Transportation)*

Responsible for the direct supervision of the UM Authorization Coordinator and Non-Emergency Medical Transportation (NEMT) staff, acts as a subject matter expert and provides guidance related to UM activities and departmental operations. Performs program effectiveness evaluation. Duties include:

1. Coordinate authorization and NEMT activities.
2. Ensure timeliness of decisions and quality of documentation are consistent with mandated guidelines.
3. Work with the UM Director and the Medical Director(s) to evaluate and improve the departmental review processes.
4. Coordinate with other departments as appropriate.
5. Providing day-to-day supervision of assigned UM staff.
6. Participating in staff training.
7. Monitoring documentation for adequacy.
8. Is available to UM staff on site or by telephone.

*UM Regulatory Reporting Supervisor*


Responsible for research and analytical work related to the development of regulatory reports and audit responses, supervises the UM department State reporting function, and drafts policies and procedures to ensure regulatory compliance. Duties include:

1. Oversee and perform administrative functions and manage special projects and initiatives in support of the UM Director and Managers
2. Supervise, mentor and train assigned staff
3. Review All Plan Letters to ensure that UM policies comply with current state and Federal policies and directives
4. Draft, revise, recommend, process and assist with the implementation of administrative policies and procedures related to department operations.
5. Work with department managers and subject matter experts to implement reporting requirements, and work as a liaison with the Information Technology Services team.

*Utilization Management Supervisor – Concurrent Review (RN)*

Responsible for direct supervision of Concurrent Review staff including Concurrent Review Nurses, Medical Social Workers, and other staff as assigned, performs duties as a Concurrent Review Nurse as needed, participates in UM projects, oversees Notice of Action (NOA) processes, and assists UM Manager - Concurrent Review and department Director in preparation for audits and other regulatory activities. Coordinates and implements effective and efficient UM processes.

1. Providing day-to-day supervision of assigned UM staff.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

2. Participating in staff training.
3. Monitoring for consistent application of UM criteria by UM staff, for each level and type of UM decision.
4. Monitoring documentation for adequacy.
5. Is available to UM staff on site or by telephone.

*Utilization Management Supervisor – Prior Authorizations (RN)*

Responsible for direct supervision of Prior Authorization staff, including Prior Authorization Nurses, and other staff as assigned. Performs duties as a Prior Authorizations Nurse as needed, participates in UM projects, oversees Notice of Action (NOA) processes, and assists UM Manager and department Director in preparation for audits and other regulatory activities.

1. Providing day-to-day supervision of assigned UM staff.
2. Participating in staff training.
3. Monitoring for consistent application of UM criteria by UM staff, for each level and type of UM decision.
4. Monitoring documentation for adequacy.
5. Is available to UM staff on site or by telephone.

*Health Services Authorization Supervisor*

Responsible for the direct supervision of Health Services Authorization Coordinators, processing authorizations and referrals, preparing various departmental reports, and inputting data regarding utilization of services.


1. Providing day-to-day supervision of assigned UM staff.
2. Participating in staff training.
3. Monitoring for consistent application of UM criteria by UM staff, for each level and type of UM decision.
4. Monitoring documentation for adequacy.
5. Is available to UM staff on site or by telephone.

*Health Services Transportation Supervisor*

Responsible for the direct supervision of Non-Emergency Medical Transportation (NEMT) Coordinators, processing NEMT authorizations and preparing various departmental reports.

1. Providing day-to-day supervision of assigned UM staff.
2. Participating in staff training.
3. Monitoring for consistent application of UM criteria by UM staff, for each level and type of UM decision.
4. Monitoring documentation for adequacy.
5. Is available to UM staff on site or by telephone.

*Concurrent Review Nurse / Prior Authorization Nurse*

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

Work collaboratively with the UM Managers, UM Director, the CMO/ Medical Director(s), and other Alliance staff to develop, implement, and evaluate health outcomes, practitioner and provider performance and other performance indicators pertinent to quality of care within their scope of practice. Duties include:

1. Concurrent Review Nurse / Prior Authorization Nurse is a licensed health care professional (RN or LVN)
2. Concurrent Review Nurse (RN) / Prior Authorization Nurse (RN) provides oversight of the work completed by the Licensed Vocational Nurse (LVN) (as assigned)
3. Review and authorization of DME, Ancillary and Medical authorizations based on established guidelines.
4. Review and authorization of Skilled Nursing authorizations based on established guidelines.
5. Review and authorization of Inpatient hospital authorizations based on established guidelines on site and remotely (Concurrent Review only).
6. Post-service review of services to determine medical necessity.
7. Refer cases to the CMO/ Medical Director(s) for requests that may not meet medical necessity criteria.
8. Determine if requested services are part of the member's benefit package.
9. Work collaboratively with the CM, QIPH staff on UM issues.
10. Review each patient admission for quality management issues per the Alliance's QM guidelines (with special attention to Health Care-Acquired Conditions (HCACs), including Provider-Preventable Conditions (PPCs) and Other Provider-Preventable Conditions (OPPCs)) and report any areas of concern to the Medical Director by completing a Potential Quality Issue (PQI) form.


*Concurrent Review Nurse LVN / Prior Authorization Nurse LVN*

Under the direction of a Concurrent Review Nurse (RN) or Prior Authorization Nurse (RN), the LVNs work collaboratively with the UM Managers, UM Director, the CMO/ Medical Director(s), and other Alliance staff to develop, implement, and evaluate health outcomes, practitioner and provider performance and other performance indicators pertinent to quality of care within their scope of practice.

Per the Board of Registered Nursing (BRN) guidelines (Vocational Nursing Practice Act, CA Business & Professions Code 2, Section 2518.5), the licensed vocational nurse performs services requiring technical and manual skills which include the following: Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan.

Duties include:



	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

1. Review of authorization requests based on established guidelines.
2. Retrospective review of services to determine medical necessity
3. Refer cases to Medical Director(s) for requests that may not meet medical necessity criteria
4. Determine if requested services are part of the members benefit plan
5. Work collaboratively with the CM, Pharmacy, and QIPH staff on UM issues

#### Utilization Management Medical Social Worker

Participates in the UM interdisciplinary team in the psychosocial management of high-risk members and participates in Quality Improvement studies. Works directly with members and educates providers, external agencies and internal departments on utilization management programs, and provides assistance as needed.

#### Health Services Authorization Coordinator

Responsible for the accurate and timely handling, distribution, and processing of Authorization Requests and Provider Referrals, including processing of non-emergency medical transportation. Not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are explicit UM criteria, and no clinical judgment is required.

#### Care Management (CM) Director (RN)

Under the direction of the CMO, the CM Director is responsible for the strategic direction, planning, and management of the Alliance CM Programs, to include development and implementation of new programs and services as they relate to Care Coordination; collaborates with UM Director and other staff on special projects as required; provides direct supervision to CM and ECM Managers, and other staff in department as required. Duties include:


1. Designing, developing, implementing and managing Care Management Programs.
2. Collaborating with UMin coordinating CM activities to improve health outcomes and promote appropriate use of resources.

#### Care Coordination Manager (RN)

The Community Care Coordination Manager is responsible for providing operational leadership including oversight development, implementation, and evaluation of the Alliance's clinical CM Program. The Manager has day-to-day direction and management responsibility for the implementation of the CM Program and reviews and submits issues, updates, recommendations, and information to the CM Director.

#### Complex Case Management Supervisor (Pediatric – RN or MSW):

Responsible for direct supervision of Complex Case Management staff, including Nurses, Medical Social Workers, Coordinators, and other staff as assigned. Performs duties as a Complex

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

Case Management nurse or coordinator as needed, participates in CC projects, and assists CC Manager and department Director in preparation for audits and other regulatory activities.

Care Coordination Supervisor (RN or LCSW)

Supervises the daily activities of the clinical nursing, social work and care coordinator staff. Assists in the development, implementation, and evaluation of department programs and processes; and coordinates, and participates in staff training and development opportunities.

Complex Case Manager (RN) – Adult Members


Develops and manages an individualized comprehensive plan of care for members referred into the Complex Case Management Program with the goal of promoting optimal, achievable outcomes in the most cost effective and appropriate manner. Duties include:

1. Performing comprehensive assessment of physical and psychosocial needs of the member via telephonic means and/or through face-to-face interaction or review of relevant and available medical records and developing a plan of care with member centric goals that are implemented, evaluated, and closed upon completion of member's goals
2. Recognizing barriers to compliance and alterations in member's condition in a timely manner and planning and executing appropriate interventions, evaluating outcomes and adjusting the plan as needed
3. Maintaining regular member contact. Documenting and managing the development and implementation of a member-specific care plan in a timely and accurate manner with consideration of benefit coverage and regulatory program policies
4. Facilitating completion of member goals through a multidisciplinary approach of collaboration with internal and external resources and family members, and making recommendations and authorizing services to appropriate agencies
5. Advocating appropriately based on the scope of the health plan on member's behalf to ensure quality of care and attainment of appropriate goals
6. Preparing and sending member correspondence that meets contractual requirements;

Care Coordination Nurse Case Manager

Responsible for managing a plan of care for members referred into the CM Program with the goal of promoting optimal, achievable health outcomes. They also work with and educate members, providers, external agencies on the community care coordination program, and provide assistance as needed. The Nurse Case Manager is responsible for the assessment, planning, facilitation, and advocacy for options and services to meet the member's health care needs.

Complex Case Manager (RN) – Pediatric Members

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

Develops and manages an individualized comprehensive plan of care for members referred into the Pediatric Complex Case Management Program with the goal of promoting optimal, achievable outcomes in the most cost effective and appropriate manner. Duties include:

1. Performing comprehensive assessment of physical and psychosocial needs of the member via telephonic means and/or through face-to-face interaction or review of relevant and available medical records and developing a plan of care with member centric goals that are implemented, evaluated, and closed upon completion of member's goals
2. Recognizing barriers to compliance and alterations in member's condition in a timely manner and planning and executing appropriate interventions, evaluating outcomes and adjusting the plan as needed
3. Maintaining regular member contact. Documenting and managing the development and implementation of a member-specific care plan in a timely and accurate manner with consideration of benefit coverage and regulatory program policies
4. Facilitating completion of member goals through a multidisciplinary approach of collaboration with internal and external resources and family members, and making recommendations and authorizing services to appropriate agencies
5. Advocating appropriately based on the scope of the health plan on member's behalf to ensure quality of care and attainment of appropriate goals
6. Preparing and sending member correspondence that meets contractual requirements;
7. Supporting the established pre-authorization review process for outpatient and inpatient services
8. Making utilization recommendations based upon evidence-based guidelines adopted by the Alliance, such as CCS numbered letters and MCG care guidelines
9. Communicating with physicians, ancillary providers and county service agencies to coordinate member care


#### Care Coordination Medical Social Worker

The Medical Social Worker ensures effective psychosocial intervention, impacting the member's ability to manage illness using available community, government, and/or community resources as needed.

#### Care Coordinator

Responsible for assisting the UM and CM teams with non-clinical care coordination activities for Alliance members involved in our utilization management and CM programs; establish and maintain effective working relationships with Provider offices, County and other various community agencies on care coordination for members.

#### Enhanced Health Services (EHS) Director

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

Under the direction of the CMO, the EHS Director is responsible for providing guidance related to the Enhanced Care Management and Community Support Unit

*Enhanced Care Management Manager*

Manages and leads the Enhanced Care Management (ECM)/Community Supports (CS) Unit. Acting as a subject matter expert, for both programs and provides guidance related to the implementation and management of the ECM and CS benefit. Provides management oversight related to ECM/CS Unit and departmental operation.

*Senior Enhanced Care Management Advisor, RN*

Acts as a liaison between the Enhanced Care Management (ECM)/Community Supports (CS) Program and providers and community agencies to promote effective implementation of program objectives and requirements. Performs ECM/CS Program oversight and support activities internally and externally. Supports Complex Case nurses as needed to develop and manage an individualized comprehensive plan of care for members referred into the assigned Case Management Program with the goal of promoting optimal, achievable outcomes in the most cost effective and appropriate manner, as needed.

*Behavioral Health Program Director*


Under the direction of the CMO, the Behavioral Health Director is responsible for providing strategic leadership for the Behavioral Health program and for management of the behavioral health benefits for Alliance members. Oversees coordination of behavioral health services between the Alliance, the delegated MBHO, Regional Centers, and County BH Departments.

*Behavioral Health Medical Director*

Effective July 1, 2025, the Behavioral Health Medical Director....Manages day-to-day operational issues related to Behavioral Health (BH) activities and provides oversight on the referral and monitoring of members with BH needs into appropriate internal and external care coordination and case management programs with the goal of promoting optimal, achievable outcomes for members. They also oversee coordination of behavioral health services between the Alliance, the delegated MBHO, Regional Centers, and County BH Departments.

*Pharmacy Director (Pharm.D.)*

Under the direction of the CMO, the Pharmacy Director is responsible providing strategic leadership for the Pharmacy program and for management of the pharmacy benefit for Alliance members which includes the development of pharmacy authorization criteria and evaluations of new drug information for Pharmacy and Therapeutics Committee review. Serves as the primary clinical contact for the Pharmacy Benefits Manager (PBM) and Alliance practitioners. Pharmacy Director must have an active unrestricted license as a Pharmacist issued by the State of California.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

*Pharmacy Clinical Manager (Pharm.D.)*

Responsible for providing day-to-day operational leadership for the pharmacy department and for supervision of prior authorization process, including medical necessity decisions. Assists the Pharmacy Director in the management of the department which includes staff training, supervision, and project management. Investigates and follows up on clinical appeals and clinical grievances/complaints. Monitors compliance with authorization processing turnaround times, clinical quality and all regulatory compliance items. Provides daily supervision of Clinical Pharmacists, Pharmacy Services Supervisor, and Pharmacy Technicians by conducting regular evaluations of processes and medical necessity reviews, and is available to staff by telephone for urgent or immediate questions. Facilitates staff trainings for policy/benefit updates, regulatory requirements and performance improvement. Monitors consistent application of authorization criteria by Clinical Pharmacists and Pharmacy Technicians through routine evaluations, and monitors documentation for adequacy by routinely assessing their review notes and provider/member letters. Pharmacy Clinical Manager must have an active unrestricted license as a Pharmacist issued by the State of California.

*Clinical Pharmacist (Pharm.D.)*


Responsible for the implementation of the Alliance pharmacy authorization criteria, performs pharmacy utilization review, and develops cost-effective pharmacy measures. Reviews for authorization any pharmaceutical requests for service. Only the CMO, the Medical Director/Physician designee, or the Pharmacist can deny a service request. The clinical pharmacist also serves as a resource to internal and external contacts including pharmaceutical and medical communities relative to prescription of medications. Ensures the timely delivery of provider noticing for authorizations. Clinical Pharmacist must have an active unrestricted license as a Pharmacist issued by the State of California.

*Pharmacy Services Supervisor*

Responsible for supervising the Pharmacy Technicians and managing daily operations of technician-related Pharmacy services, including developing, updating, and reviewing Standard Operating Procedures (SOP) for all technician duties. Assists the Pharmacy Manager with regards to any issues impacting timeliness of authorizations and other performance metrics. The Pharmacy Services Supervisor investigates and follows up on operationally related grievances and quality issues related to the prior authorization process. Pharmacy Services Supervisor must have an active unrestricted license as a Pharmacy Technician issued by the State of California.

*Pharmacy Technician*

Working under the direction of the Pharmacy Services Supervisor, responsible for processing, triaging and monitoring prior authorization requests. Follows established protocol for initial Authorization Request review and approval. Under supervision of Pharmacy Clinical Manager,

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

Pharmacy Technician can only approve requests that meet all the criteria established by the Plan's Medical Director and Pharmacy Director and no clinical judgment is required. Pharmacy Technician may not deny or modify requests, and any requests that cannot be approved are routed to Clinical Pharmacist. Assists the department with internal and external issue resolution and communications requiring specialized pharmacy technical ability and expertise. Responds to calls received from providers through the ACD line and provides telephonic assistance to providers regarding claims processing and other requests for information. Coordinates and ensures the timely mailing of member notice of action correspondence. Pharmacy Technician must have an active unrestricted license as a Pharmacy Technician issued by the State of California.

#### Registered Dietitian (RD)

The RD is responsible for the management and implementation of the Medical Nutrition Therapy (MNT) benefit and Enteral Nutrition Products benefit for Alliance members. The RD reviews medical necessity of authorization requests for enteral nutrition products, reviews authorization requests for Medical Nutrition Therapy (MNT), and reviews authorization requests for Medically Tailored Meals/Medically Supportive Food. Approves requests based on established guidelines and refers requests that may not meet medical necessity criteria to Medical Director(s) for denial or modification. Performs Quality Improvement and evaluation of the Alliance's health education interventions to assess and seek need for effective change and participates in collaborative meetings within the Alliance's tri-county service area to identify additional resources for the Alliance's members. The Registered Dietitian must be registered through the Commission on Dietetic Registration (CDR) of the American Dietetic Association (ADA).

#### Other Staff


The Alliance encourages active involvement of staff plan-wide in the design and implementation of the Program. This includes, but is not limited to, support from Information Technology Services (ITS), the Provider Services Director, and the Member Services Director (or designees) participating in the development and review of Alliance policies and ensuring compliance with regulatory requirements. In addition, non- Alliance personnel may be contracted, as needed, to fulfill Program requirements.

### **COMMUNICATION SERVICES**

The Alliance provides access to staff for members and practitioners seeking information about the UM processes and the authorization of care in the following ways:

Health Services staff are accessible to practitioners and members to discuss UM issues during normal working hours when the health plan is in operation (Monday-Friday 8AM-5PM).

After normal business hours, members and providers may contact the Alliance via phone and a message can be left that will be given to the appropriate staff person on the next business day.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

For urgent UM authorization needs an Alliance Medical Director or licensed Physician acting on behalf of the Alliance's Medical Director can be reached 24 hours a day at 831-430-5588. 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. For more information, see Alliance Policy 404-1202 After-Hours Availability of Plan or Contract Physician or 404-1201-Authorization Request Process.

Available on the Alliance Website:

1. Alliance policy information is featured on the Provider Website in the Provider Manual, and in Provider Bulletins as needed.
2. Member Handbook, newsletters and requests for member ID cards are available on the Member Website

#### **SPECIFIC UTILIZATION MANAGEMENT ACTIVITIES**


The Alliance uses a variety of sources to assist in making determinations for care. These are described in detail in the UM policies and procedures. 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 medical co-morbidities and mental health conditions
4. Psychosocial situation
5. Home environment
6. Availability of service being considered
7. Benefit coverage\*

\*Benefit coverage and limitations are determined by the Alliance contract with the Department of Healthcare Services. These are considered by UM reviewers however the final determination is based on medical necessity; thus, benefits can never truly be exhausted if they continue to be medically necessary. This also applies to benefit terminations so long as Alliance coverage is active. Additionally, the Alliance does not impose quantitative treatment limitations or non-quantitative treatment limitations more stringently on covered mental health and substance use disorder services in accordance with the parity in mental health and SUD requirements in 42 CFR section 438.900, et seq.

Referrals and requests for prior authorization of services are to be submitted by the provider of the service to the Alliance UM department by mail, fax or through the Provider e-portal. The



	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

following information is to be provided on all requests. If information is missing or incomplete, the request will be returned to the requester.

1. Member demographic information
2. Practitioner demographic information
3. Requested service/procedure to include specific CPT/HCPCS code(s)
4. Member diagnosis (specific current version of ICD Code/Description)
5. Clinical indications requiring 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 enable a thorough assessment of medical necessity.

#### ***Elective Admission Prior Authorization***


The Alliance evaluates prior authorization requests for elective admissions considering factors such as the proposed treatment plan, member benefit and coverage, contract status of facility, suitability of location, and the level of care. Utilizing criteria that has been approved annually by the QIHEC, professional staff of the HS Division may review and approve appropriate authorization requests from practitioners or providers. Requests are reviewed utilizing evidence-based medical necessity criteria as described in Alliance Policy 404-1112 – Medical Necessity – The Definition and Application of Medical Necessity Provision to Authorization Requests. Only the CMO or Medical Director/Physician designee has the authority to deny a request for service. The Alliance offers the practitioner the opportunity to discuss any denial determination based on lack of clinical justification with the physician reviewer.

#### ***Referral Management***

Referrals are generated by the primary care provider or specialist, and are entered, monitored, reviewed (when appropriate) and tracked within the Alliance software system allowing for the identification of referrals requiring follow up, authorization and/or redirection. Referrals are monitored to screen and redirect requests for “carved out” benefits and non-covered benefits. The Alliance does not require authorization for In-Network referrals, both PCP to Specialist and Specialist to Specialist referrals. Authorizations are required for out of network providers.

#### ***Second Opinions***

Obtaining second opinions are guided by Alliance policy 404-1307 – Medical Second Opinions. Second opinions may be requested by the member or health care professional with whom the member is under care. Second opinions may be rendered outside the Alliance’s provider network

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

or service area with prior authorization in instances where a qualified specialist is not available within the network or service area; this includes Centers of Excellence such as academic tertiary centers. The Alliance does not require authorization for in-network specialty referrals, both PCP to Specialist and Specialist to Specialist referrals. However, the Alliance does require in-network specialty referrals be submitted for tracking purposes and coordination of care. The Alliance monitors utilization for specialty referrals and may require authorization where patterns of overutilization are identified. Authorizations are required for out-of-network providers.

#### ***Referral to Out of Network Providers***


Referrals to out of network providers are guided by good professional practice and with the clinical standards set forth in sections HSC sections 1374.721 and 1374.722 and in alignment with Alliance policy 404-1310 – Authorization Process for Referrals to Out of Network Providers, Non-contracted Specialty Providers. Indications for referrals to an Out of Network Provider include continuity of care, complexity of member’s medical needs, or service or consultation expertise not available through a provider in the Service Area.

Out-of-network referrals are monitored to determine if the service(s) can be provided by a network practitioner/provider and to redirect the member within the network as appropriate. Data gathered from out-of-network referrals assists in determining the network adequacy for providing services in meeting the members’ needs and identifying the need for network enhancement. Assessment of available services in local delivery systems and their ability to meet member needs include, but are not limited to, reviewing availability for inpatient services, highly specialized services, and skilled nursing facilities.

#### ***Continued Stay/Concurrent Review***

The Alliance reviews hospitalized members for whom the Alliance is the primary payer source. Concurrent review is conducted to ensure the medical necessity of the admission and of the continued hospital stay, and that the correct level of care is being provided. This is conducted either on site or telephonically using evidence-based medical necessity criteria as described in Alliance policy 404-1102 – Inpatient Review. All members are reviewed within two business days of admission and of notification by the facility. The Alliance provides coordination support with discharge planning including care transitions, case management, and social services referral as appropriate. Only the CMO or Medical Director/Physician designee has the authority to deny a request for service. The Alliance offers the practitioner the opportunity to discuss any denial determination based on lack of clinical justification with the physician reviewer. Care shall not be discontinued until the member’s treating provider has been notified of the Alliance decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

#### ***Skilled Nursing/Rehabilitation Facility Review***

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

Review of short or long-term placement needs using Alliance criteria, MCG care guidelines, Medi-Cal criteria and/or other evidence-based guidelines for both initial placement and continued care.

#### ***Post-Service Review***

Care that has not been prior authorized and requires authorization will be retrospectively reviewed for medical necessity, appropriateness of setting, and length of stay. Review of these factors may result in an adverse determination. This may also occur when a member is granted Medi-Cal benefits post-service by the State of California, when services are not authorized prior to member's receipt, when services rendered do not match those authorized, and when delivery of services is beyond the specified time frame. All reviews will be completed within 30 days of receipt of pertinent medical information.

#### ***Emergency Care***

Emergency room visits needed to screen and stabilize members DO NOT require prior authorization in cases where a prudent layperson, acting reasonably, would believe that an emergency condition exists.

#### ***Behavioral Health Crisis Services***


Behavioral health crisis services that are provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, regardless of whether the service is provided by an in-network or out-of-network provider, or facility do not require prior authorization. However, the Alliance does require prior authorization for medically necessary mental health or substance use disorder treatment following stabilization from a behavioral health crisis in accordance with 28 CCR Section 1374.721, and it does not require authorization requests to be made by a physician or surgeon.

For information pertaining to post stabilization care refer to Alliance policy 404-1201- Authorization Request Process or Policy 404-1202 – After Hours Availability of Plan or Contract Physician.

#### ***Discharge Planning***

Discharge planning is a critical component of the utilization management process that begins at the time of admission with an assessment of the patient's potential discharge needs. It includes preparation of the family and the patient for these continuing care needs and initiation of arrangements for services or placement needed after acute care discharge. Health Services staff work with the hospital discharge planners, case managers, admitting/attending physicians, and ancillary service providers to assist in making necessary arrangements for post-discharge needs.

In conjunction with the hospital discharge plan, Care Management (CM) and UM/Complex Case Management (CCM) staff provide support to members upon discharge and continuing into the

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

post discharge period. CM and UM/CCM team members consist of Registered Nurses (RNs), and Medical Social Workers (MSWs) who ensure that necessary care, services, and supports are in place after discharge from the hospital.

### ***Pharmaceutical Management***

The Alliance regularly develops, reviews and updates policies and procedures for pharmaceutical management based on sound clinical evidence in conjunction with Alliance P&T Committee for Physician-Administered Drugs (see Alliance policy 403-1104 – Mission, Composition and Functions of the Pharmacy & Therapeutics Committee). Prior authorization requests for medications are evaluated using evidence-based medical necessity criteria and procedures as described in Alliance policy 403-1103 – Pharmacy Authorization Request Review Process.

For Alliance Care IHSS Line of Business, pharmacy services billed as pharmacy claims are delegated to MedImpact. MedImpact is responsible for formulary management, prior authorizations, and claims processing. The Alliance contracts with MedImpact to maintain a drug formulary that:


1. Has been developed in conjunction with actively practicing pharmacists and practitioners from the MedImpact P&T Committee
2. Is reviewed and updated on an ongoing basis
3. Based on evidence based clinical necessity criteria
4. Has an exceptions policy that applies to drugs not included in the formulary
5. Is available to practitioners on the Alliance website and mailed upon request
6. Is available to members upon request.

Pharmacy services billed as pharmacy claims are carved out to fee-for-service (FFS) under Medi-Cal Rx for Medi-Cal Line of Business. Medi-Cal Rx is responsible for formulary management, prior authorization, and claims processing.

The Alliance has a patient safety process in place for Class I or II drug recalls or voluntary withdrawals from the market (see Alliance policy 403-1124 – *Drug Recall Procedure* for more details).

### ***Complex Case Management***

Case Management is the focused arrangement of the sequence of services and resources necessary to respond to the member's overall care requirements in catastrophic or complicated cases. Cases are identified by diagnosis using high risk screening criteria. A team approach which includes the physician, primary care physician, and may include the specialist practitioner, home health agencies, discharge planners, physical therapists, social workers, and other practitioners as appropriate, is initiated by the nurse coordinating care. A collaborative approach is used to meet

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

the health care and community service needs of the patient on a short- or long-term basis. The Program ensures that the highest quality of care is provided to the patient in the most cost-effective manner through complex case management utilization of all available health care resources.

### ***Community Supports***

Community Supports are services or settings offered by the Alliance, 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 Alliance's option and an enrollee cannot be required to use them.


The Alliance will monitor the utilization of and/or outcomes resulting from the provision of Community Supports, including activities, reports, and analyses to understand the impact of delivery services through available data sources (i.e., claims, enrollment files, surveys, etc.) and as required by the DHCS.

For more information about Community Supports and Enhanced Case Management, please refer to Alliance Policies 405-1310 Community Supports Overview, and 405-1308 Enhanced Care Management Overview

### ***Denial Determinations***

Denial determinations may occur at any time in the course of the review process in accordance with timeliness standards. Only the CMO or the Medical Director/Physician designee or the Pharmacist can make a denial. There are a variety of reasons that a request may be denied, including but not limited to, lack of medical necessity or the service not being a covered benefit. The Alliance offers the practitioner the opportunity to discuss any denial determination based on lack of clinical justification with the CMO or Medical Director/Physician designee or the Pharmacist.

1. A denial determination may occur at the time of prior authorization. The process allows for informal discussion of such determinations between the Medical Director/CMO or the Pharmacist and the treating practitioner.
2. A denial determination may occur at the time of continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the CMO or Medical Director/Physician designee or the Pharmacist will occur. The Alliance will provide verbal/written notification of such determination to the facility, attending physician, patient or parents, significant other or guardian.
3. A denial determination may occur at the time of post-service review of claims for non-authorized care, medically unnecessary services, inappropriate level of care, or inappropriate care.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

4. Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the certification was erroneous.

### **Appeals Process**

A member, a member's authorized representative and providers have the right to appeal service authorization determinations. Pre-service appeals must be filed by the member or the member's authorized representative within sixty (60) days from the date on the Notice of Action. Additionally, providers have 365 days in which to file a post-service dispute.

Effective 01/01/2022, Medi-Cal Rx is responsible for appeals on service authorization determinations made by Medi-Cal Rx for pharmacy services billed as pharmacy claims for the Medi-Cal LOB. For Alliance Care IHSS LOB, MedImpact is responsible for appeals on service authorization determinations made by MedImpact for pharmacy services billed as pharmacy claims.

### **Requesting Expedited Appeal of a Denial Determination**


If a member, a member's authorized representative or provider reasonably believes that the Alliance's determination poses an imminent and serious threat to the member's health, they may request an expedited appeal of that determination. Refer to Alliance Policy 200-9008 Expedited Appeals, Grievances and External Exception Reviews for more information.

### **Nurse Advice Line**

A Nurse Advice Line is available 24 hours/ 7 days/week to all Alliance members. Members access this service by calling a toll-free number. All threshold languages are represented.

### **REVIEW CRITERIA**

The Alliance utilizes evidence based medical necessity criteria as described in Alliance policy 404-1112 - Medical Necessity – The Definition and Application of Medical Necessity Provision to Authorization Requests. Criteria include Title 22 criteria, Medi-Cal guidelines (when available), California Children's Services (CCS) guidelines (where available), internally developed Alliance guidelines and policies approved by the QIHEC, evidence based guidelines, such as MCG care guidelines, Medicare (CMS) guidelines, nonprofit professional association guidelines, consensus statements and nationally recognized standards of practice, guidelines developed by other health plans, and expert opinions (such as clinical advisors serving on Alliance Committees and outside independent medical review) to determine the appropriateness of services. For Alliance Care IHSS if the plan adopts nonprofit or other criteria not listed in 28 CCR section 1300.74.721 for MH/SUD determinations, the Alliance shall file a notice of Material Modification with the Department of Managed Health Care consistent with Rule 1300.721(e) Medical necessity determinations take into consideration the needs of individual patients and characteristics of the local delivery system. Relevant clinical information is obtained when making a determination based on medical

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

appropriateness and the treating practitioner is consulted when appropriate. Information collected to support decision-making is documented.

Criteria are developed in conjunction with actively practicing practitioners and non-staff network practitioners and updated and evaluated on an annual basis and in Quality Improvement and Health Equity Committee (QIHEC) routinely. 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.

- Criteria are developed and reviewed with consideration of requirements from relevant regulatory bodies.
- Alliance staff will also perform a literature search regarding the use of the criteria and research benchmark plans regarding the safety, efficacy, fiscal independence, and outcomes for the member. Alliance staff will also consult relevant specialists as needed.
- Criteria change recommendations are presented to UMWG or P&T as appropriate, where department stakeholders and local practitioner committee members have the opportunity to advise and comment.
- Departmental recommendations are then provided to QIHEC for final review and approval.

As part of the annual review process, all Alliance UM policies are submitted to an independent medical review (IMR) agency with non-staff practitioners of corresponding specialties for review. IMR review of Alliance UM policies aid in the revision and further development of the internal UM policies.

### **Inter Rater Reliability (IRR)**

A mechanism exists for evaluation of the consistency with which Alliance health care professionals make authorization determinations. This evaluation is conducted on an annual basis. If opportunities for improvement are identified during this process, corrective action will be implemented, and monitoring may occur more frequently.


The Alliance requires all new UM staff complete IRR evaluation with scores at or above 90% prior to conducting utilization review without supervision. Alliance staff with IRR testing results below 90% require immediate remediation, inclusive of retraining and repeat IRR evaluation before they can conduct utilization review without supervision.

### **DATA SOURCES**

Sources for data may include, but are not limited to:

1. Prospective/concurrent/post-service utilization management activities



	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

2. Claim/encounter (administrative) data
3. Medical records
4. Readmission statistics
5. Member appeals
6. Provider appeals
7. Internally developed databases
8. Pharmacy utilization data
9. Other administrative or clinical data

#### ***Data Collection, Analysis, and Reporting***

Data collection activities are coordinated by the HS Division. At the data gathering/performance measurement phase, participants in the process includes programmers and analysts in the ITS and HS Division staff nurses, and any other personnel required for the collection and validation of data. Data is reported in the UM Work Plan as appropriate.


This data is analyzed for trends, over and underutilization, and compliance with Program requirements and processes to ensure members are receiving the best, most appropriate care. These analyses are reviewed by UMWG to determine the impact on UM functions and any actions to take, if necessary.

#### **EVALUATION OF NEW MEDICAL TECHNOLOGY**

New technologies are handled on a case-by-case basis that includes obtaining information regarding the safety, efficacy, and indications that support the use of the intervention. There must be evidence that the proposed intervention will add to improved outcomes as compared to what is currently available. The service provider must have a record of safety and success with the intervention and cannot be part of a funded research protocol. The CMO/ Medical Director(s) work closely with the requesting physician and specialists as needed in researching these cases. For more information on new technology, please see Alliance policy 404-1714 - Technology Assessment.

#### **DELEGATION OF UTILIZATION MANAGEMENT ACTIVITIES**

The Alliance may delegate UM activities to subcontracting entities. Oversight and performance responsibility of the Alliance's delegated utilization management functions are maintained and monitored by the QIHEC, in collaboration with the Compliance Committee, as described in Alliance policy 105-0004 – Delegate Oversight.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

### **PROTECTED HEALTH INFORMATION**

The Alliance complies with all applicable requirements governing protected health information, as outlined in Alliance Health Insurance Privacy and Accountability Act (HIPAA) policies:

- 105-4001 – Notice of Privacy Practice
- 105-4002 – Accounting of Disclosures
- 105-4003 – No Retaliation or Waiver
- 105-4004 – Privacy Officer Designation and Responsibilities
- 105-4007 – Safeguarding Protected Health Information
- 105-4008 – Uses and Disclosures of Limited Data Sets
- 105-4009 – Minimum Necessary Use and Disclosure
- 105-4012 – Use and Disclosure of PHI, including Member Authorizations to Disclose
- 500-4005 – Security Officer Designation and Responsibilities

### **CONFIDENTIALITY AND CONFLICT OF INTEREST**

The QIHEC ensures confidentiality and avoidance of conflict of interest as described in Alliance policy 401-1201 –Quality Improvement Health Equity Committee.

### **ONGOING PROGRAM EVALUATION**

The UM Program will be evaluated by the QIHEC at least annually. The evaluation includes, at a minimum:


1. Evaluation of select UM policies and procedures.
2. Development and implementation of an annual Utilization Management Work Plan.
3. Evaluation of the UM Work Plan that includes a description of completed and ongoing UM activities and an assessment of barriers and/or limitations.
4. Trending of utilization management indicators to assess performance.
5. An evaluation of delegated activities.
6. An evaluation of the UM Program as a whole.

A summary of the Program evaluation, including a description of the Program, is provided to members or practitioners upon request.

### **ANNUAL WORK PLAN DEVELOPMENT AND TRAINING**

The annual Work Plan will be developed with input from the staff and findings of the Annual Program Evaluation. It is presented and approved at the QIHEC. It includes but is not limited to:

1. Summary of important goals for the Program during the year.
2. Measurable benchmarks for process and utilization.
3. Ability to track performance, assess goals and capture agreed upon strategies and interventions to meet goals.

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	


4. The number and type of appeals, denials, deferrals, and modifications.
5. Identified under- and over-utilization activities.

The Alliance will sponsor a formal education program by a nonprofit clinical specialty association to educate all plan staff that conduct utilization review, within six (6) months of adoption of 28 CCR 1300.74.721, and at least every three (3) years thereafter. If a formal education program from a nonprofit association is unavailable, the Alliance will create and sponsor an internal training program using education materials provided by a recognized nonprofit association, to educate all health plan staff that conduct utilization reviews.

#### **References:**

Alliance Policies:

- 200-9008 Expedited Appeals, Grievances and External Exception Reviews
- 300-1509 –Timely Access to Care
- 105-0004 – Delegate Oversight
- 105-4001 – Notice of Privacy Practice
- 105-4002 – Accounting of Disclosures
- 105-4003 – No Retaliation or Waiver
- 105-4004 – Privacy Officer Designation and Responsibilities
- 105-4012 – Use and Disclosure of PHI, including Member Authorizations to Disclose
- 105-4007 – Safeguarding Protected Health Information
- 105-4008 – Uses and Disclosures of Limited Data Sets
- 105-4009 – Minimum Necessary Use and Disclosure.
- 401-1101 – Quality Improvement & Health Equity Transformation Program (QIHETP)
- 401-1201 – Quality Improvement Health Equity Committee
- 401-1301 – Potential Quality Issue Review Process
- 401-1505 – Childhood Preventive Care
- 403-1101 – Pharmacy Operations Management
- 403-1103 – Pharmacy Authorization Request Review Process
- 403-1104 – Mission, Composition and Functions of the Pharmacy & Therapeutics Committee
- 403-1124 – Drug Recall Procedure
- 404-1102 – Inpatient Review
- 404-1108 – Monitoring of Over/Under Utilization of Services
- 404-1112 – Medical Necessity – The Definition and Application of Medical Necessity Provision to Authorization Requests
- 404-1201 – Authorization Request Process
- 404-1202 – After Hours Availability of Plan or Contract Physician
- 404-1303 – Referral Consultation Request Process
- 404-1307 – Medical Second Opinions

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	


404-1310 – Authorization Process for Referrals to Out of Network Providers, Non-Contracted Specialty Providers  
 404-1714 – Technology Assessment  
 404-1732 – Meals and Lodging (Maintenance) and Related Travel Expenses for Members  
 404-xxxx Behavioral Health Treatment  
 405-1105 –Coordination of Care for Medi-Cal Members in Foster Care  
 405-1312 – Primary Care Provider Responsibilities Including Case Management and the Promotion of Patient Centered Medical Home  
 405-1313 – Adult Complex Case Management  
 405-1315 - Children with Special Health Care Needs  
 405-1316 - Identification and Monitoring of Members for the Hight Risk Infant Follow-up Program  
 405-1317 – Early Intervention Services  
 405-1318 – Pediatric Complex Case Management  
 405-1112 – Care Management of Seniors and Persons with Disabilities for Medi-Cal  
 405-1303 – Identification of and Coordination of Care for Medi-Cal Members with Developmental Disabilities  
 405-1304 – Developmental Disabilities – Services to Plan Members  
 408-1305 – Behavioral Health Services  
 405-1310 – Community Supports Overview  
 460-1308 – Enhanced Care Management Overview  
 500-4005 –Security Officer Designation and Responsibilities  
 Policy 800-1002 Memorandum of Understanding.

**Impacted Departments:**

Claims  
 Compliance  
 Communications  
 Care Management  
 Information Technology Services  
 Member Services  
 Pharmacy  
 Provider Services  
 Quality Improvement and Population Health

**Regulatory:**

Title 45 Code of Federal Regulations Parts 160 and 164-HIPAA Privacy Rule  
 Health and Safety Code Section 1363.5 and 1367.01  
 Health and Safety Code Sections 1374.72(a)(3)(A); Section 1374.721(f)(1); Section 1374.721(b); Section 1374.72(h)  
 Department of Health Care Services and Welfare and Institutions Code  
 Industry: MCG care guidelines

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

Legislative:

Senate Bill SB-855 Health Coverage for Mental Health and Substance Use Disorders  
Assembly Bill (AB) 254 - Confidentiality of Medical Information Act: reproductive or sexual health application information  
Assembly Bill 118 – Budget Act of 2023: Health  
SB-1120 Health Care Coverage: Utilization Review

Contractual (Previous Contract):

Medi-Cal Contract Exhibit A, Attachment 1, Provision 5  
Medi-Cal Contract Exhibit A, Attachment 4  
Medi-Cal Contract Exhibit A, Attachment 5, Provision 1  
Medi-Cal Contract Exhibit A, Attachment 18, Provision 5A  
Medi-Cal Contract Exhibit A, Attachment 18, Provision 5B  
Medi-Cal Contract Exhibit A, Attachment 18, Provision 10A  
Medi-Cal Contract Exhibit A, Attachment 18, Provision 11E  
Medi-Cal Contract Exhibit E, Attachment 3, Provision 5

Contractual (2024 Contract):

Medi-Cal Contract, Exhibit A, Attachment 3, Provision 1.1.5 and 1.1.6  
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 2.3  
Medi-Cal Contract, Exhibit A, Attachment 3, Provision 4.6.4C

DHCS All Plan or Policy Letter:


APL 19-017–Quality and Performance Improvement Requirements  
APL 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment  
APL 23-022–Continuity of Care for Medi-Cal Beneficiaries who newly enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service, and for Medi-Cal members who transition into a new Medi-Cal Managed Care Health Plan on or after January 1, 2023  
APL 22-012–Governor’s Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx  
APL 22-003 – Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders  
APL 22-005 – No Wrong Door for Mental Health Services Policy  
APL 22-006 – Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services

NCQA:

NCQA UM 1: Element A: Factor 1, 2 & 4  
NCQA UM 2: Element A: Factor 4 & 5  
NCQA UM 2: Element C: Factor 1 & 2  
NCQA UM 4: Element A: Factor 1 & 2

Supersedes:

APL 17-014 is superseded by 19-017

	<b>POLICIES AND PROCEDURES</b>
<b>Policy #:</b> 404-1101	<b>Lead Department:</b> Utilization Management
<b>Title:</b> Utilization Management Program	
<b>Original Date:</b> 02/01/1996	<b>Date Published:</b> 04/28/2025
<b>Approved by:</b> Quality Improvement and Health Equity Committee (QIHEC)	

APL 18-008 is superseded by 23-022

APL 20-020 is superseded by 22-012

**Other References:**

Board of Vocational Nursing & Psychiatric Technicians: Vocational Nursing Practice Act,  
CA Business & Professions Code 2, Section 2518.5 <https://bvnpt.ca.gov/pdf/vnregs.pdf>  
Strategic Plan 2022-2026 – Central California Alliance for Health:  
PERSON-CENTERED DELIVERY SYSTEM TRANSFORMATION

**Attachments:**

**Lines of Business This Policy Applies To:**

- ☒ DSNP
- ☒ Medi-Cal
- ☒ Alliance Care IHSS

**Revision History:**

<b>Reviewed Date</b>	<b>Revised Date</b>	<b>Changes Made By</b>	<b>Approved By</b>
5/11/2023	6/23/2023	Tammy Brass, RN UM Director	
8/4/2023	8/4/2023	Carissa Grepo, RN UM Manager – Prior Auth	UMWG
9/22/2023	9/22/2023	Danah Hernandez, UM Regulatory Reporting Supervisor	UMWG
12/27/2023	12/27/2023	Carissa Grepo, RN UM Manager – Prior Auth	UMWG
4/11/2024	4/11/2024	Carissa Grepo, RN UM Manager – Prior Auth	UMWG
12/10/2024	12/10/2024	Kelly Tlemcani, Business Analyst II	UMWG (pending QIHEC approval in March)
03/10/2025	03/10/2025	Kelly Tlemcani, Business Analyst II	QIHEC