Policy:	GG.1535
Title:	**Utilization Review Criteria and Guidelines**
Department:	Medical Management
Section:	Utilization Management
CEO Approval:	*/s/ Michael Hunn 12/20/2024*
Effective Date:	11/01/2015
Revised Date:	12/01/2024
Applicable to:	☒ Medi-Cal ☒ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

The purpose of this policy is to define the process by which CalOptima Health and its Health Networks establishes Utilization criteria and guidelines to ensure that Organization Determination decisions related to Utilization Management (UM) are made in a consistent manner and comport with program requirements and local and national care standards.

II. POLICY

A. CalOptima Health shall be responsible to ensure that decisions related to UM and coverage or denial of requested Covered Services, and/or supplies, are consistent with the criteria and guidelines set forth in this Policy.

B. CalOptima Health and its Health Networks shall make UM decisions based only on appropriateness of care and service, and existence of coverage. CalOptima Health and its Health Networks shall not reward Practitioners, or other individuals, for denying, limiting, or discontinuing coverage or care.

C. CalOptima Health shall ensure that criteria and practice guidelines and UM activities and decisions:

1. Are based on reasonable local and national medical evidence, or a consensus of health care professionals in the particular field;

2. Consider the needs of the enrolled population; and

3. Are developed in consultation with contracted Providers; and are reviewed and updated annually, as appropriate, by submitting the recommended criteria and guidelines to the Utilization Management Committee (UMC) voting physician Members for review and approval, in accordance with Title 28, California Code Regulations, § 1300.70 (b)(2)(H) & (c).

D. CalOptima Health shall conduct the Utilization Review using criteria and guidelines that are approved and adopted in the CalOptima Health UM Program. Criteria and guideline hierarchy includes the following:

1. Medi-Cal:

a. Medi-Cal Provider Manual, and Department of Health Care Services (DHCS) All Plan Letters (APL);

b. National Correct Coding Initiative (NCCI) Policy Manual;

c. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook;

d. Milliman Care Guidelines (MCG);

e. Drug Compendia: Micromedex DrugDex and American Hospital Formulary Service-Drug Information (AHFS-DI);

f. Peer-Reviewed Medical Literature;

g. National Comprehensive Cancer Network® (NCCN) Guidelines; and

h. Other: Medical Societies, National Guidelines, and other Authoritative Publications:

i. Hayes Criteria;

ii. World Professional Association for Transgender Health (WPATH);

iii. U.S. Food and Drug Administration (FDA);

iv. Centers for Disease Control and Prevention (CDC);

v. American Board of Medical Specialties;

vi. Up to Date;

vii. Optum 2023 Current Procedural Coding Expert (Encoder Pro);

viii. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines); and

ix. National Guideline Clearinghouse.

2. Medicare (OneCare)

a. CMS National Coverage Determinations (NCD), including NCD with Coverage of Evidence Development (CED);

b. CMS Local Coverage Determination (LCD) (Noridian Local Contractor for California);

c. CMS Local Coverage Article (LCA);

d. CMS Manuals (Medicare Benefit Policy Manual, Medicare National (NCD) Manual, Medicare Claims Processing Manual, etc.);

e. National Correct Coding Initiative (NCCI) Policy Manual;

f. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook;

g. Drug Compendia: Micromedex DrugDex, American Hospital Formulary Service-Drug Information (AHFS-DI), Clinical Pharmacology, National Comprehensive Cancer Network® (NCCN) Drugs and Biologics Compendium, Lexi-Drugs;

h. National Comprehensive Cancer Network® (NCCN) Guidelines;

i. MCG Care Guidelines; and

j. Other: Medical Societies, National Guidelines, and other Authoritative Publications:

i. Hayes Criteria;

ii. World Professional Association for Transgender Health (WPATH);

iii. U.S. Food and Drug Administration (FDA);

iv. Centers for Disease Control and Prevention (CDC);

v. American Board of Medical Specialties;

vi. Up to Date;

vii. Optum 2024 Current Procedural Coding Expert (Encoder Pro);

viii. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines); and

ix. National Guideline Clearinghouse.

3. Whole Child Model (WCM)

a. California Children's Services (CCS) Numbered Letters, and CCS Information Notices;

b. Medi-Cal Provider Manual, and DHCS APLs;

c. National Correct Coding Initiative (NCCI) Policy Manual;

d. CalOptima Health Medical Policy/Clinical Guidelines/Evidence of Coverage/Member Handbook;

e. MCG Care Guidelines;

f. Drug Compendia: Micromedex, DrugDex, American Hospital Formulary Service-Drug Information, Clinical Pharmacology;

g. National Comprehensive Cancer Network® (NCCN) Guidelines; and

h. Other: Medical Societies, National Guidelines, and other Authoritative Publications:

i. Hayes Criteria;

ii. World Professional Association for Transgender Health (WPATH);

iii. U.S. Food and Drug Administration (FDA);

iv. Centers for Disease Control and Prevention (CDC);

v. American Board of Medical Specialties;

vi. Up to Date;

vii. Optum 2023 Current Procedural Coding Expert (Encoder Pro);

viii. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG) Guidelines; and

ix. National Guideline Clearinghouse.

E. If CalOptima Health delegates Utilization Review, in accordance with CalOptima Health Policy GG.1541: Utilization Management Delegation, the Delegate shall utilize criteria as indicated above in Section II.C. of this Policy.

F. Upon a treating Physician's or Member's request, CalOptima Health or the Member's Health Network shall provide, in writing, all criteria used in making a UM decision including, but not limited to, discharge and continued stay criteria, and clinical practice guidelines, in accordance with Health and Safety Code, § 1363.5 (b)(5).

G. CalOptima Health shall ensure its UM policies, processes, strategies, evidentiary standards, and other factors used for UM or Utilization Review are consistently applied to medical/surgical, mental health, and substance use disorder services and benefits. (in accordance with Health and Safety Code, § 1363.5 (a).

H. CalOptima Health shall not apply UM decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion.

III. PROCEDURE

A. CalOptima Health shall document Utilization Review criteria and guidelines utilized for decisions related to Utilization Management and coverage or denial of requested services.

B. CalOptima Health shall automatically incorporate all Medicare and Medi-Cal changes into its Utilization Review criteria and guidelines, no later than the effective date of the change and will seek UMC approval at the next regularly scheduled UMC meeting.

C. On an annual basis, CalOptima Health's Director of Utilization Management or Designee shall submit criteria and guidelines, as specified in Section II.D. of this Policy, to the UMC and Quality Improvement Health Equity Committee (QIHEC) for review and approval, in accordance with Health and Safety Code § 1363.5 and Title 28, California Code Regulations, § 1300.70 (b)(2)(H) & (c).

D. Upon the UM Committee's and QIHEC's approval of the criteria and guidelines, CalOptima Health shall:

1. Adopt and implement the approved criteria into the UM Program.

2. Distribute the criteria and guidelines to all CalOptima Health's professional reviewers;

3. Activate the criteria and guidelines in the UM systems; and

4. Make the criteria and guidelines available to Members and Providers, upon request. For the OneCare program, criteria can also be accessed on the CalOptima Health website.

E. Delegated Health Networks shall, pursuant to the CalOptima Health Network Service Agreement, comply with the requirements outlined in this policy, adopt and implement Evidence-Based criteria and guidelines related to utilization Organization Determinations. The CalOptima Health Delegation Oversight Department, in accordance with CalOptima Policies GG.1541: Utilization Management Delegation and GG.1619: Delegation Oversight shall monitor and ensure this requirement is reviewed annually by the Delegate's Utilization Management Committee for all CalOptima programs.

F. Inter-Rate Reliability Audits

1. On an annual basis, CalOptima Health and its Health Networks shall audit all staff who make UM decisions for Inter-Rater Reliability to evaluate the consistency and accurate application of Utilization Review criteria in decision-making.

2. CalOptima Health Director of Utilization Management or Designee shall forward results of the CalOptima Health Inter-Rater Reliability audits to the UMC and QIHEC for review and action on opportunities to improve consistency, if applicable.

3. CalOptima Health's Director of Utilization Management or Designee shall issue competency testing results with documented reasons and actions taken to CalOptima Health staff who score below the acceptable threshold, in accordance with CalOptima Health Utilization Management Program.

4. CalOptima Health uses hypothetical UM test cases established from the MCG Learning Management System. CalOptima Health, Health Networks can apply the following:

   a. Hypothetical cases; and/or

   b. A sample consisting of 5% or 50 of its UM determination files, whichever is less or utilize the NCQA 8/30 methodology rule or another statistically valid method.

G. If the CalOptima Health Medical Director identifies a need to update any criteria or guidelines, CalOptima Health's Director of Utilization Management or Designee shall submit a request to the UMC to implement such update; updates approved by the UMC will be presented to the next regularly scheduled QIHEC for final review and approval.

H. CalOptima Health shall monitor a Health Network's UM activities including the Health Network use of CalOptima Health's criteria and guidelines, in accordance with CalOptima Health Policy GG.1541: Utilization Management Delegation, and Title 28, California Code of Regulations (CCR) § 1300.70(b)(2)(h).

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. California Children's Services Numbered Letter Index
B. CalOptima Health Contract with the Centers for Medicare & Medicaid Services (CMS) for Applicable Integrated Plan
C. CalOptima Health Contract with the Department of Health Care Services (DHCS) for Medi-Cal
D. CalOptima Health Network Service Agreement
E. CalOptima Health Policy GG.1541: Utilization Management Delegation
F. CalOptima Health Policy GG.1619: Delegation Oversight
G. CalOptima Health Utilization Management Program
H. Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual Chapter 4 – Benefits and Beneficiary Protections, Section 10.7.3 (Issued 04/22/16)
I. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-034: California Children's Services Whole Child Model Program (Supersedes APL 21-005)
J. Health and Safety Code (HCS), §§ 1363.5, 1363.5(a), 1363.5(b)(5), 1363.5(c), 1367.01, 1367.01(h)(6), and 1367.01(l)
K. Medicare and Medi-Cal Coverage Guidelines
L. Medicare Part D: CMS-approved Compendia
M. Milliman Care Guidelines (MCG)
N. National Comprehensive Cancer Network® (NCCN) Guidelines
O. Preventive Health Guidelines (e.g., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACOG Guidelines))
P. Specialty Society Guidelines (e.g., American Academy of Pediatrics (AAP) and American Heart Association (AHA) Guidelines)
Q. Title 28, California Code Regulations (CCR), §1300.70(b)(2)(H) & (c)
R. Title 42, Code of Federal Regulations (CFR), §438.910(d)
S. Transplant Centers of Excellence Guidelines
T. Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual Chapter 15 – Covered Medical and Other Health Services, Section 50 (Rev. 12684; Issued 06/13/24)
U. Social Security Administration (SSA), §§ 1927, subsections (g)(1)(B) and (K)(6)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
05/30/2024	Department of Health Care Services (DHCS)	File and Use
12/13/2024	Department of Health Care Services (DHCS)	File and Use

VII. BOARD ACTION(S)

Date	Meeting
10/04/2018	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2015	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect

Action	Date	Policy	Policy Title	Program(s)
Revised	11/01/2017	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	01/01/2018	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	10/04/2018	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	10/01/2019	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare OneCare Connect
Revised	01/01/2023	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare
Revised	12/31/2023	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare
Revised	05/01/2024	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare
Revised	12/01/2024	GG.1535	Utilization Review Criteria and Guidelines	Medi-Cal OneCare

IX. GLOSSARY

Term	Definition
California Children's Services Program (CCS)	A State and county program providing Medically Necessary services to treat CCS-Eligible Conditions.
Corrective Action Plan (CAP)	A plan delineating specific identifiable activities or undertakings that address and are designed to correct program deficiencies or problems identified by formal audits or monitoring activities by CalOptima Health, the Centers of Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS), or designated representatives. FDRs and/or CalOptima Health departments may be required to complete CAPs to ensure compliance with statutory, regulatory, or contractual obligations and any other requirements identified by CalOptima Health and its regulators.
Covered Services	Medi-Cal: Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members); 6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis);

Term	Definition
	7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012. <u>OneCare</u>: Those medical services, equipment, or supplies that CalOptima Health is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Designee	A person selected or designated to carry out a duty or role. The assigned Designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Evidence-Based	A document or recommendation created using an unbiased and transparent process of systematically reviewing, appraising, and using the best clinical research findings of the highest value to aid in the delivery of optimum clinical care to patients.

Term	Definition
Health Network	For purposes of this policy, a Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Inter-Rater Reliability	An assessment tool that measures the degree of reliability of different licensed staff when utilizing criteria for authorizing or denying Covered Services.
Member	A beneficiary enrolled in a CalOptima Health program.
Organization Determination	Any determination made by CalOptima Health or its delegated entity with the respect the following 1. Payment for temporarily Out-of-Area renal dialysis services, Emergency Services, post-stabilization care, or urgently needed services; 2. Payment for any other health services furnished by a that the Member believes: a. Are covered under Medicare; or b. If not covered under Medicare, should have been furnished, arranged for, or reimbursed by CalOptima Health. 3. Refusal to provide or pay for services, in whole or in part, including the type or level of services, that the Member believes should be furnished or arranged - by CalOptima Health 4. Discontinuation of a service if the Member believes that continuation of the service is medically necessary; and 5. Failure to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the Member with timely notice of an adverse determination, such that a delay would adversely affect the Member's health.
Prior Authorization	Medi-Cal: A formal process requiring a Provider to obtain advance approval for the amount, duration, and scope of non-emergent Covered Services. OneCare: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Provider	Medi-Cal: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so. OneCare: Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier) providing Covered Services under Medicare Part B. Any organization, institution, or individual that provides Covered Services to Medicare members. Physicians, ambulatory surgical centers, and outpatient clinics are some of the providers of Covered Services under Medicare Part B.
Utilization Management (UM) or Utilization Review	The evaluation of the Medical Necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.
Utilization Management (UM) Program	A written document evaluated and revised on an annual basis, that describes the Utilization Management policies, procedures, processes, programs that are implemented organizationally to attain goals set forth by the health plan, to meet health plan, State, Federal, and accrediting agency requirements.

Term	Definition
Whole Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified county CCS program administrative functions to provide comprehensive treatment of the whole child and care coordination in the areas of primary, specialty, and behavioral health for CCS-eligible and non-CCS-eligible conditions