.✦. Astrana Health	Policies and Procedures Utilization Management Department

Policy Number: UM - 001	Policy Name: Referral - Authorization Process – Criteria Availability

☒ **Cal-Med Connect** ☒ **Commercial** ☒ **Medicare Advantage** ☒ **MediCal**

Date Approved by UMC:	On file	**Effective Date:**	**05/2016**
		Replacing Policy	
Revision Date:	2/2024		
Signature:	(on-file)		

SCOPE:
ASTRANA HEALTH and its affiliated entities, globally referred to as "ASTRANA HEALTH" shall follow the procedures set forth in this policy.

PURPOSE:
To provide a formal process for the effective and timely management of the authorization referral process and identification of the appropriateness of health care services provided to Health Care Service Plan (HCSP) Members. ASTRANA HEALTH applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.
The Utilization Management (UM) Department will also take into account any Department of Health Care Services (DHCS), Medi-Cal All Plan Letter (APLs) or Centers for Medicare and Medicaid Services (CMS) directives, in response to current crises, including but not limited to COVID 19 pandemic, California Wildfires and or a Federal Disaster, or other Public Health State of Emergency. Our UM department

DEFINITION:
Medically Necessary Services- For Medicare services: reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member, or otherwise medically necessary under 42 CFR §1395(y); For Medi-Cal services: reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury as under Title 22California Code of Regulations (CCR) Section 51303.

Economic Profiling- As referenced in California Health and Safety Code, HSC § 1367.02, Economic Profiling means any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group, or individual practice association.

POLICY:

Under the oversight and involvement of the Medical Director, Departmental Directors, and the ASTRANA HEALTH Utilization Management Committee (UMC), the Utilization Management (UM) department will manage the authorization and referral process.

The ASTRANA HEALTH Medical Director will have overall responsibility for review and evaluation of the operation and results of the referral and UM processes. The Medical Director will report any issues to the UMC for review and approval as applicable.

A medical necessity review requires consideration of the member's circumstances, relative to appropriate clinical criteria and the organization's policies. Criteria are objective and based on sound medical evidence.

Internal guidelines to provide directions as to who may release an authorization, has been reviewed by our Medical Director, and accepted as the guidelines for the approval process.

Approval/denial determinations will be based on medical necessity, plan benefits and eligibility and will reflect appropriate application of the clinical practice guidelines and objective, evidence-based medical criteria approved by the UMC. Medicare coverage and benefit criteria as reflected in Medicare statutes and regulations, NCDs and LCDs and prohibiting the use of internal coverage criteria or additional medical necessity standards except in limited situations. Medicare plans are still permitted to use utilization management policies, such as Prior Auth (PA) in situations where they are not permitted to use internal coverage criteria.

In situations where ASTRANA HEALTH may not use internal coverage criteria, ASTRANA HEALTH may still use PA to confirm criteria for determining whether an item or service is one for which benefits are available under Traditional Medicare. PA approval to be valid for as long as medically necessary to avoid disruptions in care.

ASTRANA HEALTH approves and utilizes the use of National Coverage Determinations (NCD), Local Coverage Determination (LCD), individual Health Plan criteria / Medical Policy, and Milliman Care Guidelines – latest Edition, CMS and information will be clearly documented and appropriately available for review. Only verbal approval is accepted from the Medical Director. The Medical Director's verbal approval will be documented with the date and time of when the discussion took place.

The Medical Director or licensed physician designee will make the adverse determination, review, and sign every denial based on medical necessity. A psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist will review make the determination on every denial of behavioral health care that is based on medical necessity. In addition, Board-certified physicians from appropriate specialty areas will act as a consultant and assist in making determinations of medical necessity when appropriate. Only California licensed physicians or health care professionals who are

competent to evaluate specific clinical issues may deny, defer, or modify requests for services based on medical necessity. An adverse determination is required to be made in writing, and verbal determination will not be accepted.

A qualified healthcare professional reviews every decision to defer, modify or deny based on medical appropriateness (licensed physician, psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist). A qualified healthcare professional must sign all deferrals, modifications, and denials.

All denial determinations will be sent to the member in writing with a copy to the requesting provider and members Primary Care Physician. This written notice will include the reason for denial, an alternative plan of treatment, if appropriate, a description of appeal rights and an explanation of the appeal process including how a member may request an independent, external review for any referral that is denied, modified or delayed because of lack of medical necessity including the right to submit written comments, documents or other information relevant to the appeal, the telephone number for contacting ASTRANA HEALTH for questions or appeals and the Member Services phone number and address for the member’s specific HCSP. The telephone number for contacting ASTRANA HEALTH for questions or appeals and the Member Services phone number and address for the member’s specific HCSP for an expedited appeal process for urgent preservice or urgent concurrent denials which includes notification that expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.

The notification reason must be easily understandable for the member. The reason explains how it pertains to the member’s particular case (personalized) to ensure that members and practitioners understand why the decision was made and have enough information to make a decision about appealing the denial. The reason for a UM denial must be clearly documented in a permanent case record, which can be either manual or automated. If reason is for lack of clinical information, the denial must contain a reference to the clinical criteria not met because of lack of information and must describe the information needed to render a decision in a manner specific enough for the member or member’s authorized representative to understand what is needed.

ASTRANA HEALTH will inform contracted providers of the process used to approve, defer, or deny service requests. ASTRANA HEALTH will also provide members with information about these same processes upon written request from a member (or designee). Criteria used as the basis of a decision to deny services in a specific case under review will be disclosed to the provider, member, or both upon request, in accordance with policy and procedure UM 009- Clinical Criteria – Application of Criteria.

It is ASTRANA HEALTH’s policy that Economic profiling is **NOT** used in Utilization Management decisions.

DEFINITIONS:

Appropriate Health Care Practitioner: an organizational representative who makes appropriate health care management decisions. Depending on the type of case, the reviewer may be a physician, pharmacist, chiropractor, dentist, psychiatrist, or other practitioner type.

Board Certified Specialists: The Medical Director, Associate Medical Directors, and Specialty Physician Advisors to the referral authorization process shall be certified by the American Board of Medical Specialties (ABMS) or an equivalent board in their appropriate specialty areas of medicine, surgery and behavioral health.

Clinical Criteria and Guidelines: Clinical criteria and guidelines and the application hierarchy include, but are not limited, to the following:

- ❖ Order of Criteria: Medicare
  - Plan Eligibility and Coverage (benefit plan package or EOC)
  - Medicare Benefit Policy Manual
  - Medicare National Coverage Determination (NCD)
  - Medicare Local Coverage Determination (LCD)
  - Local Coverage Articles (LCAs) (Active/Retired)
  - Non-LCD Medicare Administrative Contractor(MAC)(Noridian)
  - Medicare Manuals (Internet Only Manuals) -IOM including but not limited to
    - Medicare Managed Care Manual
    - Medicare Benefit Policy Manual
    - Program Integrity Manual
    - Medicare Claims Processing Manual (SCAN health plan requirement)
    - Other Medicare Communications such as Medicare Learning Network Communication (MLN)
  - Health Plan Medical Policies or Medication Policies
  - Nationally Evidenced Based Criteria (MCG, InterQual, Up-To-Date, Hayes)
  - Proprietary guidelines
  - Administrative Policies

- ❖ Order of Criteria: Commercial
  - Federal and State Law Mandates (i.e., Code of Federal Regulations, Department of Managed HealthCare)
  - World Professional Association for Transgender Health (WPATH)
  - Summary Plan Description/Certificate of Coverage
  - Health Plan Medical Policy and/or Clinical Guidelines.
  - Health Plan Medical/Drug Policy/Utilization Review Guidelines (URGs)
  - National Evidence Based Guidelines (Milliman, Up-To-Date, US Preventative Services Task Force, National Comprehensive Cancer

Network, etc.);

- Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, National Guidelines Clearinghouse, National Imaging Associates (NIA) Policies, American Specialty Health (ASH) Policies, etc.);
- Diagnostic and Statistical Manual of Mental Disorders (DSM), current edition.
- Utilization Management Policies and Procedures (Such as Network Adequacy, Out of Network, Lack of Information, Continuity of Care and Transition of Care)
- Administrative Policies

❖ Order of Criteria: Medi-Cal

- Medi-Cal Guidelines (DHCS)
- National Evidence Based Guideline (MCG, InterQual, Up To Date)
- National Guideline Clearing House, National Comprehensive Cancer Network
- Other nationally accredited resources and professional medical associations (e.g., American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American Academy of Pediatrics (AAP), The American College of Obstetricians and Gynecologists (ACOG)
- Health Plan Criteria
- Health Plan Evidence of Coverage

❖ Order of Criteria: Dual Special Needs Program (D-SNP) (Medicare & Medi-Cal) If delegated for both Medicare & Medi-Cal, ASTRANA HEALTH should include both hierarchy of criteria.

For Medicare Delegation:

- Medicare Benefit Policy Manual
- Medicare National Coverage Determination (NCD)
- Medicare Local Coverage Determination (LCD)
- Medicare Managed Care Manual
- Non-LCD Medicare Administrative Contractor(MAC)(Noridian)
- Other Medicare communications such as Medicare Learning Network communications (MLN)
- HP Medical and Medication Policy
- MCG Guidelines Recognized evidenced based criteria, MCG Guidelines, National Imaging Associates (NIA) Radiology Clinical Guidelines, Advisory Committee on Immunization Practices (ACIP)
- DHCS Medi-Cal UM Criteria

For Medi-Cal Delegation:

- Medi-Cal Guidelines, MCG 27th Edition, Apollo 18th Edition, Up to Date, Nelson Textbook of Pediatrics, National Guideline Clearinghouse, InterQual, Hayes, NCCN, Health Plan Evidence of Coverage (EOC)

CMS – Centers for Medicare and Medicaid Services

DHHS- Department of Health and Human Services

DMHC – Department of Managed Health Care

Enrollee Representatives - ASTRANA HEALTH will allow an enrollee's representative to facilitate care or treatment decisions for an enrollee who is incapable of doing so because of physical or mental limitations. ASTRANA HEALTH does not prohibit a health care professional from advising or advocating on behalf of a patient.

HCSP- Health Care Service Plans - a licensed Health Plans (HMO, PPO, etc.) or Payor which contracts with ASTRANA HEALTH to provide certain health care services to its members. ASTRANA HEALTH recognizes that HCSP's retain the right to make final decisions on all recommendations pertaining to HCSP members.

HICE – Health Industry Collaboration Efforts. Previously known as ICE.

Medical necessity review- Medical necessity review is a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. Except where any applicable law or regulation requires a different definition, "Medically Necessary" or "Medical Necessity" shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice, meaning standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Decisions about the following require medical necessity review:

- Any covered medical benefits defined by the organization's Certificate of Coverage or Summary of Benefits, including, but not limited to:
  - Dental and vision services covered under medical benefits, including dental care or services associated with procedures that occur within or adjacent to the oral cavity or sinuses.
  - If medical and dental benefits are not differentiated in the benefits plan, the organization includes requests for care or services associated with dental procedures that occur within or adjacent to the oral cavity or sinuses for medical necessity review.
  - Specialty dental and vision plans only: All dental and vision services covered under the benefits plan.
  - Pharmaceuticals covered under medical or pharmacy benefits.

- Preexisting conditions when the organization has a policy to deny coverage for care or services related to preexisting conditions.
- Care or services whose coverage depends on specific circumstances.
- Out-of-network services that are only covered in clinically appropriate situations.
- Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program.
- “Experimental” or “investigational” requests covered by the organization
- ASTRANA HEALTH may deny coverage (or use internal coverage criteria that are not used in Traditional Medicare), this will limit ASTRANA HEALTH’s ability to approve only part of what a provider has ordered or prescribed.

Decisions about the following do not require medical necessity review:

- Services in the member’s benefits plan that are limited by number, duration or frequency.
- Extension of treatments beyond the specific limitations and restrictions imposed by the member’s benefits plan.
- Care or services whose coverage does not depend on any circumstances.
- Requests for personal care services, such as cooking, grooming, transportation, cleaning, and assistance with other activities of daily living (ADL).
- “Experimental” or “investigational” requests that are always excluded and never covered under any circumstances. In these instances, the organization either:
  - Identifies the specific service or procedure excluded from the benefits plan, or
  - If benefits plan materials include broad statements about exclusions but do not specify excluded services or procedures, the materials state that members have the opportunity to request information on excluded services or procedures and that the organization maintains internal policies or criteria for these services or procedures.
  - Experimental requests are not delegated to IPAs for review and are therefore always forwarded to the Health Plan for disposition.
- Dental and vision services not covered under a member’s medical benefits are not within the scope of denial and appeal file review.

Non-behavioral Healthcare Notification Timeliness: ASTRANA HEALTH adheres to the following UM notification turnaround time. For urgent concurrent decisions, make decisions within 72 hours (3 calendar days) of receipt of the request. Written

decisions will be communicated to the member within 72 hours (3 calendar days) of receipt of the request. ASTRANA HEALTH may inform the hospital Utilization Review (UR) department staff, with the understanding that staff will inform the attending/treating practitioner. Notifications may be addressed to the hospital UR department but must be to the attention of the attending or treating practitioner. For urgent preservice decisions, ASTRANA HEALTH gives electronic or written notification of the decision to practitioners and members within 72 hours of the request. For non-urgent preservice decisions, ASTRANA HEALTH gives electronic or written notification of the decision to practitioners and members within 14 calendar days of the request and within 2 business days from date of decision. For post service decisions, ASTRANA HEALTH gives electronic or written notification of the decision to practitioners and members within 30 calendar days of the request and within 2 business days from date of decision.

Out of Network Referrals: a request for healthcare services from a provider that is not contracted with the IPA/Medical Group. In the dual risk model, out of network refers to physicians, or other healthcare providers who do not participate in the IPA and also the hospital's network.

Tertiary Care: the specialized services provided by centers equipped with diagnostic and treatment facilities not available at general hospitals.

Urgent Requests: A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, ***or***
- Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, ***or***
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request.

Concurrent Requests: A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Nonurgent request*:* A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Preservice request*:* A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.

Post service request*:* A request for coverage of medical care or services that have been received (e.g., retrospective review).

Reclassification of nonbehavioral requests that do not meet the definition *of "urgent."* All types of requests received while the member is receiving care may be reclassified as preservice or post service if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the organization. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or post service

Timeliness of notification

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Commercial HICE TAT Grid -

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Medicare HICE TAT Grid -

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Medi-Cal HICE TAT Grid -

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Web Portal Notification/Provider:

When a practitioner web portal is used to provide electronic denial notifications -ASTRANA HEALTH informs practitioners of the notification mechanism and their responsibility to check the portal frequently. ASTRANA HEALTH documents the date & time when the information was posted in the portal.

ASTRANA HEALTH provides alternative notification method for practitioners who do not have web portal access by sending documentation via fax or USPS mail.

PROCEDURE:

In-Network Referrals

1. Providers will submit requests for referrals and authorizations to ASTRANA HEALTH UM Department via the secured on-line system or fax. In addition,

   1.1 Any documentation received related to a specific referral will be attached to the appropriate referral. If upon review it is noted that the medical records attached are not for the member, a call to the provider will be made.

1.1.1 The referral will be cancelled with documentation. Attached documents will remain, these will not be altered or removed.

1.1.2 The provider will be asked to submit a new referral with the appropriate notes.

1.2 ASTRANA HEALTH will maintain telephone access for providers to request Urgent authorization requests for health care services.

1.3 Verbal and written requests for standard or expedited pre-service determination received from both Medicare members (self-referrals) and providers will be accepted and processed in accordance with the specified turnaround time requirements. Verbal request date and time will be documented in the notes and used for the date and time.

1.4 ASTRANA HEALTH uses an internal guide to determine what level of staff can release specific referrals. See attached.

1.5 Refer to HICE Turnaround Time (TAT) or Health plan specific TAT criteria for each specific line of business. For CMC refer to health plan issued TAT. The date request received, and the date of decision made will be documented in the UM files for reference and tracking.

1.6 Pharmacy Referrals will be processed within 24hrs from date and time received to date and time of notification to the member for the urgent requests and with 72hrs for the routine requests.
Anthem Blue Cross J codes (urgent and or routine) are to be processed within 24 hrs.

1.7 Requests for Medical **Routine Services** will be sent via the secured on-line system or fax to the UM Department.

1.8 Requests for an Extension of an approved authorizations, ASTRANA HEALTH UM staff will ask for the reason for the extension.

1.9 For requests for an **Extension** of a previously approved authorization that has expired, ASTRANA HEALTH UM staff will ask the provider making the request the reason for the extension, why the member has not used the auth within the valid timeframe.

1.9.1 When the reason is valid, the **original** authorization will be CLOSED, documenting in notes why it was closed. A new authorization will be created documenting in notes this replaces original auth number.

1.10 Requests for Medical **Urgent services** will be sent via the secured on-line system or fax to the UM Department and noted as "Urgent" on the request. The turnaround time on urgent services is seventy-two (72) hours.

1.10.1 If the request is for an urgent J code the turnaround time is 24 hrs.

1.11 Requests for Medical **Retrospective** will be sent via a secure on-line system or fax to the UM Department. For post-service requests, ASTRANA HEALTH gives electronic or written notification of the decision to practitioners within thirty (30) calendar days of the request.

1.12 Requests for Behavioral Health **Routine Services** will be sent via the secured on-line system or fax to the UM Department. For non-urgent preservice requests, ASTRANA HEALTH gives electronic or written notification of the decision to practitioners and members within 15 calendar days of the request.

1.13 Requests for Behavioral Health **Urgent services** will be sent via the secured on-line system or fax to the UM Department and noted as "Urgent" on the request. For urgent preservice requests, ASTRANA HEALTH gives electronic or written notification of the decision to practitioners and members within 72 hours of the request.

1.14 Requests for Behavioral Health **Retrospective** will be sent via a secure on-line system or fax to the UM Department. For post-service requests, ASTRANA HEALTH gives electronic or written notification of the decision to practitioners within 30 calendar days of the request.

1.15 Vision Requests for Adults 21 years and older - MMCD 10-010
ensure the provision of eye examinations and prescriptions for corrective lenses as appropriate for all members. Fabrication of optical lenses through Prison Industry Authority (PIA) optical laboratories. The delegate shall cover the cost of the eye examination and dispensing of the lenses for the member.
Vision services should not only be automatically denied as a carve-out benefit but should be reviewed based on medical necessity. Even if the benefit for eye examination covers the member once every two (2) years, Title 22 states, "A second eye examination within 24 months is covered when a sign or symptom indicates a need for this service. The provider of services shall make a reasonable effort to ascertain the date prior to any examination with refraction

2. Upon receipt, the UM Department will verify the following information:
   a. Member Correct/Full Name
   b. Date of Birth
   c. Health plan assigned identification number

d. Facility Name (as appropriate)
e. Primary Care Physician assigned
f. Requesting Provider
g. Requested Provider
h. Diagnosis, including ICD10 code(s)
i. Requested Service, including CPT, HCPS, or other procedural code(s)
j. Clinical information that supports the requested service (history, findings, attempted treatment, laboratory/radiology results, etc.)
k. The attached documents are for the member the request is for.
    1) If the documents are not for the correct member, the staff will call the provider's office to resubmit with the correct documents. The referral will be cancelled with documentation of call.

2.1 UM Department notifies the requesting provider via the secured on-line system or phone to provide missing information.

2.2 Requests for authorizations will be evaluated and authorized by a person with a defined level of responsibility based on the level of skill required to evaluate the necessary protocols and parameters of the requested service.

2.3 DHCS, Medi-cal APLs or CMS directives in response to current crises including but not limited to COVID 19 pandemic, California Wildfires and or a Federal Disaster or other Public Health State of Emergency will be taken into consideration with all requests. During the above, the guidelines are more laxed to allow members to receive the care they required if they identify themselves as being impacted by the disaster

3. Referrals identified as **urgent outpatient** will be processed with the highest priority to ensure compliance with the appropriate regulatory board based on the line of business according to the following process:

3.1 The UM Department verifies member's HCSP eligibility, benefits coverage and reviews the HCSP contract for any requirements to be considered in the review of the case via EZ Cap.

3.2 Within 24-72 hours of receipt of the request, the request is reviewed, and a determination is sent to the provider for the services.

3.3 IVR calls (robo calls) are initiated once a decision has been made. The automated calls are made for all urgent referral requests and for all routine J code referrals. Three attempts are made by the IVR. A failed fax report is generated 4 times a day for staff to make follow-up calls.

4. At the time of receipt of a **routine outpatient** or **retrospective** request, the UM Department will perform the following tasks:

4.1 Verify member's HCSP eligibility, benefit coverage and review the applicable HCSP contract for any requirements to be considered in the disposition of the case.

4.2 Obtain any missing information necessary to complete the review. (Refer to policy and procedure UM 005.)

4.3 Request medical records or other supporting documents as applicable.

4.4 Determine that care was not part of a DHCS, Medi-Cal APLs or CMS directives in response to current crises including but not limited to COVID 19 pandemic, California Wildfires and or a Federal Disaster or other Public Health State of Emergency.
During the above, the guidelines are more laxed to allow members to receive the care they require if they identify themselves as being impacted by the disaster.

5. Using approved practice and HCSP guidelines, an approval or deferral determination is made by the Coordinator, UM Nurse or a deferral, approval or denial/modification Medical Director within five (5) business days of receipt of the routine request. **UM decision making** includes the following:

- Use of written decision-making criteria. Specific criteria are used to evaluate the medical necessity of medical, behavioral health and pharmaceutical services.
- Consideration of individual characteristics such as age, comorbidities, complications, progress of treatment, psychosocial situation and home environment when applicable.
- Assessment of local delivery system to assess if member's specific healthcare needs can be met.
- Practitioner involvement in review of criteria being adopted by ASTRANA HEALTH.
- UM criteria are reviewed and updated as needed and at least annually.
- DHCS, Medi-Cal APLs or CMS directives in response to current crises including but not limited to COVID 19 pandemic, California Wildfires and or a Federal Disaster or other Public Health State of Emergency

5.1 If approved, the UM Department will update the information, including the date of decision, into the secured on-line system and fax written approval and provide secured on-line system lookup capability to the requesting and treating provider who will notify the member. Once the referral is finalized, the system does not allow any changes to the determination status, nor the date and times received and or determination made.
Member Approval Letters use the approved Health Plan Letter Templates for the speakers Health Plan and Line of Business.

5.2 Complex or questionable cases and all potential medical denials/modifications or deferrals will be referred to the ASTRANA HEALTH Medical Director (or licensed physician designee), upon immediate identification by the UM Nurse.

a. The ASTRANA HEALTH Medical Director will review case documentation and will consult with others (specialty advisors, member's PCP or attending physicians, HCSP Medical Director) as applicable. Specialties may be utilized as appropriate in the review process.

b. The ASTRANA HEALTH Medical Director will return an approval/denial/modification decision with applicable basis and reasons for the decision to the UM Nurse.

5.3 An adverse determination of modification and or denial is not accepted verbally. The medical director is required to document the adverse decision in the notes or on a faxed and signed document.

5.4 Concurrently with denial notification to the provider and proposed referral provider (practitioner, facility, or ancillary provider as applicable will include an alternative treatment plan (if applicable), the member's and provider's right to submit an appeal to ASTRANA HEALTH and their HCSP (include HCSP name, address, telephone). Copies of all denials are sent to the member's HCSP. (Refer to policy and procedure UM 006.)

6. In cases where a member's benefits have been exhausted but the member still requires care, the UM staff, in coordination with the HCSP, will assist the member, if necessary, in obtaining other care. This may mean informing the members about ways to obtain continued care through other sources such as community resources.

7. In cases where services requested are not available in-network for the member, the UM nurse will refer the case to ASTRANA HEALTH Physician Medical Director or designee for review for an out-of-network Provider or Facility. A request for a Letter of Agreement will be initiated.

a. DHCS, Medi-Cal APLs or CMS directives in response to current crises including but not limited to COVID 19 pandemic, California Wildfires and or a Federal Disaster or other Public Health State of Emergency will be released without an LOA. If the members identify themselves as being impacted by the disaster, pre-authorizations will be waived.

8. As part of the review process, the UM nurse will identify and forward any quality related issues to the QI Department for review, if delegated. If not delegated refer

to the specific HCSP. Case Management and concurrent review cases are referred to the appropriate UM staff for follow-up.

9. A medical necessity decision may be deferred for any of the following reasons:
   - Additional information is required to make medical necessity determination.
   - Clinical information has been sent to an expert reviewer for consultation.
   - The Medical Director or other licensed physician reviewer has requested further testing and/or second opinion.

Auto Approval Process

Auto Approval logic is based on current state and federal regulations, provider contracts and health plan contracts, IPA contracts for contracted providers only. The auto approval turnaround times will follow the regular referrals process based on urgency. IPA rule logic is posted on T:\Everyone Share\Divya. Senior Medical Leadership will review the logic on at minimum quarterly basis.

Documentation of attempts:

- ASTRANA HEALTH will make an initial outreach attempt, recommended within a few hours of receiving the request. For expedited organization determination request, ASTRANA HEALTH must make an outreach attempt within 24 hours of receipt of the request.
- ASTRANA HEALTH will notify provider what information is missing; be specific about what is needed to approve coverage.
- ASTRANA HEALTH will document how outreach was conducted (e.g., phone, fax) and what was requested.
- ASTRANA HEALTH will document the date and time of all outreach attempts and whether the outreach was successful (all missing information requested is obtained).

Additional Attempts:

- When feasible, ASTRANA HEALTH will make outreach attempts only during business hours.
- If not within business hours, ASTRANA HEALTH will follow the after-hours instructions, if any, on the provider's voicemail or answering service.
- ASTRANA HEALTH will leave at least a few hours between attempts for the provider to respond.
- ASTRANA HEALTH will notify the provider what information, if any, is missing.

- ASTRANA HEALTH will clearly document all outreach attempts; note method, date, and time.
- ASTRANA HEALTH will leave at least a few hours from your final outreach attempt prior to issuing a decision.

10. Timeliness standards developed by the HICE or by Federal or state regulatory agencies (CMS, DHS, and DMHC) shall be followed as outlined on attached timeliness documents.

Best Practice Recommendations for Medicare Advantage Organizations

Applicable to both Contracted and non-contracted providers

	Adjudication Timeframe	Number of Outreach Attempts	Timing of Outreach Attempts
Standard Organization Determinations -	30 days	3	During business hours in the provider's time zone
Standard Organization Determinations – Pre-Service	14 days	3	• Initial attempt within 2 calendar days of receipt of request • When possible, during business hours in the provider's time zone
Expedited Organization Determinations	72 hours	3	• Initial attempt upon receipt of request • When possible, during business
Standard Reconsiderations	30 days (pre-service) 60 days (payment)oral	3	• Initial attempt within 4 calendar days of receipt of request • When possible, during business hours in the provider's time zone
Expedited Reconsiderations	72 hours	3	• Initial attempt upon receipt of request • When possible, during business

Redirection (Out of Network)

Request for an out of network provider should be reviewed based on medical necessity. When medical necessity is established, the request can be approved if one of the criteria below is met:

- You have a medical problem that needs urgent or emergency attention.
- You have special needs or medical problems such as provider in network cannot care for you.
- Providers in your network are not available to care for you.

Out of Network Referrals

If ASTRANA HEALTH/IPA network is unable to provide the requested service within the contracted Provider Network, the PCP may request a referral to an outside provider.

1. The PCP must follow this policy when a member requires a non-contracted provider referral.

2. ASTRANA HEALTH UM department and/or the ASTRANA HEALTH Medical Director or designee will establish the presence of medical necessity
3. When medical necessity is established and the service cannot be provided within the ASTRANA HEALTH Provider network, the referral will be approved as medically indicated.
4. The contracting department will be notified and establish a Memorandum of Understanding (MOU) with the non-contracted practitioner/provider. The Memorandum of Understanding is in effect for as long as the member is receiving care from the non-contracted practitioner/provider.
5. In the event a member requires medical services beyond the scope of the medical expertise available, ASTRANA HEALTH may coordinate with the Health Plan, may consider possible reciprocity with another medical group/IPA to provide services
6. Out or area pre-service requests must be referred to the respective Health Plan's Case Management Department
7. Use of out of network practitioner, if no in network practitioner is an option or if no in network practitioner has appropriate clinical expertise, because ASTRANA HEALTH is deciding if it is or is not medically necessary for the member to receive care out of network. The IPA/Medical Group provides adequate and timely coverage of these services out of network and does not need to arrange or schedule out-of-network services but will provide necessary information for members to be able to arrange them.
8. If the IPA/Medical Group approves a member to go out of network because it is unable to provide a necessary and covered service in-network, the IPA/Medical Group will coordinates payment with the out-of-network practitioner and ensures that the cost to the member is no greater than it would be if the service was provided in-network. Services provided by out of network providers are at no cost to Medi-Cal members.
9. DHCS, Medi-Cal APLs or CMS directives in response to current crises including but not limited to COVID 19 pandemic, California Wildfires and or a Federal Disaster or other Public Health State of Emergency, the member may be allowed to receive care from a non-contracted provider of service if they identify themselves as being impacted by the disaster.

ASTRANA HEALTH ensures redirection of members to an in-network provider meet accessibility and availability requirements if an out-of-network provider UM request is denied. A general rule of thumb is the 30-30 rule this asserts that services be available either within 30 miles of a member's residence or within 30 minutes of travel time.

Appointment availability with in-network provider will be documented by UM staff. For urgent request, the appointment will be available within 7 calendar days. Non urgent request will be available within 14 calendar days for routine request or based on Health Plan's specific access standards.

ASTRANA HEALTH collects data for needed individual case review for evaluation of availability and accessibility of services provided or arranged for the member. Come evaluated factors include but not limited to:

- Waiting times
- Member complaints
- Emergency and urgent care
- Requests for changes of primary care physicians
- Referrals and
- Back up arrangements

Availability / Disclosure of Criteria

Members, providers, and the public may request specific criteria. ASTRANA HEALTH UM makes this available to them. This offer is made available to members and providers on the ASTRANA HEALTH website, in New Member materials / newsletters and new Provider Orientation Materials.

1. Requests may be made in person, in writing or via phone.

2. The request is forwarded to the Utilization Management (UM) Department.

3. The Utilization Management Coordinator (UMC) personally hands the request to the UM Director / Manager and enters the request in the Request for Criteria log.

4. The UM Director / Manager obtains a copy of the requested criteria. S/he drafts a cover letter with the following notice:
   "The materials provided to you are guidelines used by INSERT HEALTH PLAN to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

5. The letter is given to the UMC to send:
   a. Via certified mail for urgent Medicare
   b. All other letters will be sent via standard mail

6. The signed receipt is filed with the request and the Request for Criteria log.

Referral Tracking

1. All PCPs must maintain a referral log that contains the following information:
   - Date referral sent to ASTRANA HEALTH
   - Member name
   - Member social security number
   - Referral acuity (routine, urgent, etc.)
   - Diagnosis, referral reason

- Service/activity requested
- Date referral returned from ASTRANA HEALTH
- Referral decision (approved, modified, denied)
- Date patient notified
- Date of appointment or service
- Date consultation or other report received

2. PCPs may use the HMO form or another system that contains all the above-required information.
3. Referral logs must be available at all times at the PCP site.
4. Copies of referrals and any received consultation or service reports must be filed in the member's medical record.
5. Once an authorization has been used by a provider, our Claims Department will enter an encounter for payment in the EZ Cap claims payment module. The authorization status in the authorization module will change for status 1- open authorization to status 3 – closed for any used authorization. All unused authorizations will automatically be changed to status 5 - expired in EZ Cap.
6. PCPs have access to the web portal and are able to view list of patients whose authorizations are going to expire within 30 days.
    a. Unused reports are posted on the provider portal for PCPs to review.
    b. PCPs must contact their affected members to assess the need for use of referral.
    c. PCPs with access to our web-portal are allowed to perform a one- time extension via UM portal for an additional 30 days. For providers that do not have a web portal account, cases must be faxed to ASTRANA HEALTH's UM Department.
    d. If member is still not seen after initial 30- day extension, PCP must re-evaluate member for further treatment and next steps.

Medicare

In accordance with CMS' policy under the scope that significant communication and significant publications under the Section 1557 regulation as applied to the programs addressed include but are not limited to:

- All marketing material
- Ad hoc enrollee communications that include information related to health coverage, benefits, and prescription drug coverage
- Part C and Part D Explanation of Benefits (EOB)
- Annual Notice of Change (ANOC)/Evidence of Coverage (EOC),
- Provider/pharmacy directories,
- Formularies
- Enrollment forms,
- Summary of Benefits
- Appeal and grievance notices

In addition, ASTRANA HEALTH will include the approved Non-discrimination notices and taglines such as ACA 1557 requirements-Notice of availability of language assistance or auxiliary aids on the significant communications sent to enrollees.

These significant communications include notices, newsletters, brochures and letters such as approval, Integrated Denial Notice (IDN), Notice of Medicare Non-Coverage, DNOD, DENC, or member welcome letter, etc.

ASTRANA HEALTH will include the approved 1557 notice and tagline based on the following:

- For letters one or two pages in length: Use the “short form” notice and two taglines.
- For letters three pages or more in length: Use the “long form” notice and taglines.
- The notice and taglines do not have to be added into the body of the letter but may be included as a separate sheet in the mailing envelope.
- Include only a single tagline sheet in every mailing, even if the envelope contains multiple communications.

ASTRANA HEALTH conducts a full and meaningful review of an organization determination or reconsideration request. ASTRANA HEALTH makes reasonable efforts to gather all of the information needed to make substantive and accurate decisions as early in the coverage process as possible. ASTRANA HEALTH will document all requests for information and maintain that documentation within the case file. ASTRANA HEALTH clearly identify the records, information, and documents needed when requesting information from a provider. If the coverage request is made by a contracted provider on behalf of the enrollee, and the provider does not respond to ASTRANA HEALTH requests for information, an ASTRANA HEALTH physician will conduct the outreach to both the contracted provider and non-contracted providers. Documentation should include the following:

- A specific description of the required information
- The name, phone number, fax number, e-mail, and/or mailing address, as applicable, for the point of contact at the plan; and
- The date and time of each request, documented by date and time stamps on copies of a written request, call record, facsimile transmission, or e-mail. Call records should include specific information about who was contacted, what was discussed/requested, and what information was obtained by the plan.

If ASTRANA HEALTH does not obtain the requested information, we must make a decision within the applicable timeframe based on the available clinical information. Extensions to the applicable adjudication timeframe are permitted, as long as the extension meets the requirements at 42 CFR §§422.568(b)(1), 422.572(b)(1), and 422.590(e)(1), as appropriate. Unless the extension has been requested by the enrollee, the extension must be in the enrollee’s interest and either for purposes of requesting information from a non-contract provider that is necessary to approve the request, or because of extraordinary or exigent circumstances. If the plan issues an

adverse decision due to the inability to obtain the information needed to approve coverage, the plan should clearly identify that basis and the necessary information in the written denial notice

Standard Organization Determinations

For all standard organization determination requests, reasonable and diligent efforts to obtain missing information include a minimum of three attempts with requests made, when possible, during normal business hours in the provider's time zone. The first attempt is made within two (2) calendar days of receipt of request

Methods for requesting information can include:

- Telephone;
- Fax;
- E-mail; and/or
- Standard or overnight mail with certified return receipt.

Recordkeeping is essential for demonstrating ASTRANA HEALTH's compliance with procedures for making coverage decisions. The date/time of the postmark or timestamp on e-mails and faxes are considered the date/time of the request to the provider for the information. Requests made by telephone will be documented with the date and time of the call.

If the requested information is not received, the decision is made within the applicable timeframe based on the available clinical information

Expedited Organization Determinations

For expedited organization determination requests, reasonable and diligent efforts to obtain information include a minimum of three attempts. When possible, attempts should be made during normal business hours in the provider's time zone. Reasonable and diligent attempts to meet the 72-hour decision-making timeframe on an expedited organization determination begin with making the first outreach attempt to the treating provider upon receipt of the coverage request.

ASTRANA HEALTH is subject to the expedited timeframe when the enrollee has not yet obtained the item or service and (1) the plan agrees to the enrollee's request to expedite the determination, or (2) the provider has indicated that applying the standard timeframe could seriously jeopardize the enrollee's life or health.
What is reasonable will be based upon the facts and circumstances of the case, including the day/time the plan received the expedited request. If the sufficiency of the plan's outreach efforts in a given case is subject to review, consideration will also be given to whether the plan used multiple means of communication (e.g., phone, fax, e-mail) in an effort to obtain the information. If a request is from a contracted provider and there is no response, our medical director will conduct phone outreach to the contracted provider and non-contracted providers.

Methods of outreach can include:

- Telephone;
- Fax;
- E-mail; and/or
- Overnight mail with certified return receipt.

Recordkeeping is essential for demonstrating MAO compliance with procedures for making coverage decisions. The date/time of the postmark or timestamp on e-mails and faxes are considered the date/time of the request to the provider for the information. Requests made by telephone should be documented with the date and time of the call.

If the requested information is not received, the decision is made within the applicable timeframe based on the available clinical. If a denial is made due to inability to obtain the needed information, ASTRANA HEALTH will clearly state the basis and necessary information in the written denial notice.

Standard Reconsiderations

For all standard reconsideration requests, reasonable and diligent efforts to obtain information include a minimum of three attempts with requests made during normal business hours in the provider's time zone.

Methods for requesting information can include:

- Telephone;
- Fax;
- E-mail, and/or
- Standard or overnight mail with certified return receipt.

Recordkeeping is essential for demonstrating ASTRANA HEALTH's compliance with procedures for making coverage decisions. The date/time of the postmark or timestamp on e-mails and faxes are considered the date/time of the request to the provider for the information. Requests made by telephone should be documented with the date and time of the call.

The first request for information should be made within four (2) calendar days of receipt of the appeal request. If the sufficiency of ASTRANA HEALTH's outreach efforts in a given case are subject to review, consideration will also be given to whether the plan used multiple means of communication (e.g., phone, fax, e-mail) in an effort to obtain the information. Based on the contractual relationship between a ASTRANA HEALTH and its contracted providers, ASTRANA HEALTH will be able to obtain requested documentation from contracted providers in a reliable and timely manner. If a request is from a contracted provider and there is no response, our medical director will conduct phone outreach to the contracted provider and non-contracted provider.

When adjudicating reconsiderations, if ASTRANA HEALTH expects to uphold its initial adverse determination based on lack of medical necessity because the plan needs clinical information from the provider to approve coverage, the physician making the reconsideration should attempt to communicate with the requesting provider about the request before the plan issues its decision.

If the requested information is not received, the decision is made within the applicable timeframe based on the available clinical. If a denial is made due to inability to obtain the needed information, ASTRANA HEALTH will clearly state the basis and necessary information in the written denial notice.

Initial Denial Notification

Initial Denial Written Notice with peer-to-peer notification is sent to the requesting practitioner within 24 hours (1 calendar day) of decision via fax and simultaneously posted on the provider web portal. Practitioners are given the opportunity to discuss any (non-behavioral and behavior) adverse or partial approval, determination or potential adverse determination with the qualified health care professional that performed the initial review by calling peer to peer line. When original peer reviewer is not available, UM denial team will forward the request to the senior Medical Director or on-call Medical Director for review.

Peer to peer info is available on Initial Denial Notification & ASTRANA HEALTH's website under Provider Resource.

Discrimination Notice:

Discrimination Notice and Limited English Proficiency is to be added to member letters such as but not limited to:

- Approval
- Denials
- Pended UM decisions

The Discrimination Notice can be in a long or short form and the LEP statement translated in the top fifteen (15) languages of California.

Oral notifications:

- IVR Calls are initiated once a determination has been made for Urgent referrals and for routine J codes.
- ASTRANA HEALTH provides initial oral notification of a denial decision within 24 hours of an urgent concurrent request or within 72 hours of an urgent preservice request, ASTRANA HEALTH has an additional three (3) calendar days following oral notification to provide written or electronic notification. ASTRANA HEALTH will record the time and date of notification and the staff member who spoke with the practitioner or member. Oral notification must

involve communication with a live person; ASTRANA HEALTH cannot leave a voicemail at any time.

- The following are considered valid oral notification attempts:
  1. Speaking with the Member or Representative directly
  2. Attempting to contact the Member or Representative and leaving a HIPPA approved voicemail on the Member's or Representative's preferred phone number. Dates and time of attempts will be documented in EZ CAP

Monitoring

ASTRANA HEALTH are required to show self-monitoring for non-behavioral and behavioral health decision and notification timeliness as required by respective plan partners and based on ASTRANA HEALTH's contract. Reporting guidelines will include but not limited to:

- At a minimum, review the percentage of timeliness adherence to timeframe for each request category (urgent concurrent, urgent, preservice, and non-urgent and post service) and by product lines.
- Report types:
  1. Non behavioral UM decision making
  2. Notification of non-behavioral UM decisions
  3. Behavioral UM decision making
  4. Notification of behavioral UM decisions
  5. Pharmacy UM decision making
  6. Notification of pharmacy UM decisions

Use of Provider Web portals

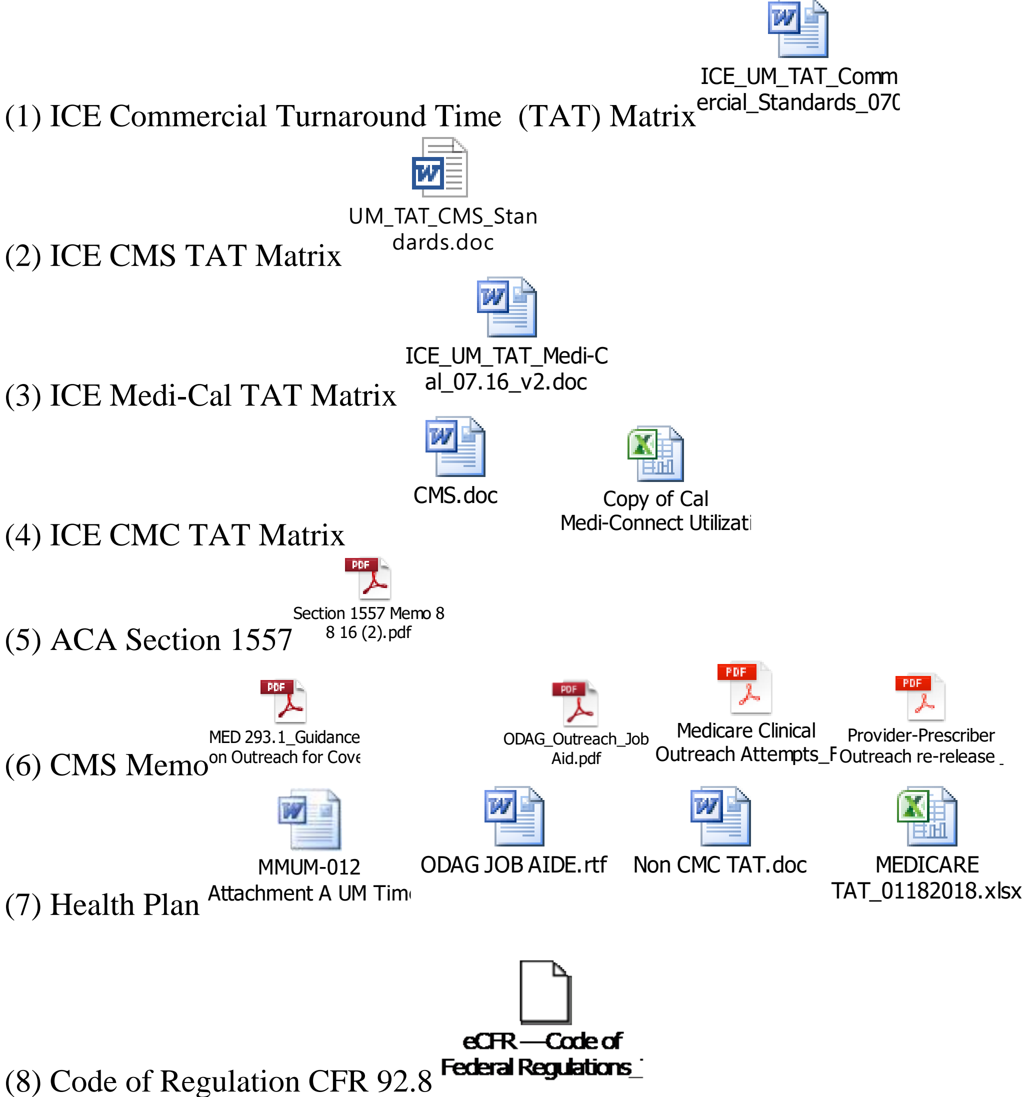
ASTRANA HEALTH may provide electronic decision notifications to practitioners through a web portal and informs practitioners of the notification mechanism and their responsibility to check the portal regularly. In addition, ASTRANA HEALTH will documents the date and time when the information was posted in the portal, and the information posted in the portal meets the requirements of written notification. When logging in to Provider web portal account, the provider is prompt to acknowledge the decision notifications. The read receipt of the authorization letters will be written back to EZCAP system to indicate the date and time of acknowledgement received. ASTRANA HEALTH has an alternative notification method for practitioners who do not have access to the web portal, including fax communications.

FORMS:

REFERENCE:

NCQA UM Standards and Elements
California Health and Safety Code 1367.01 (c) (e)
Senate Bill 59 - ftp://www.leginfo.ca.gov/pub/99-00/bill/sen/sb_0051-0100/sb_59_cfa_19990712_150518_asm_comm.html
Knox Keene Act – Commercial Referral Guidelines
https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/ProgramAudits.html
Chapter 13, sections 40.1, 50.1, 70.7 and 80.1 in the Medicare Managed Care Manual
Section 1367.02 of the Health and Safety Code

ATTACHMENTS:



(1) ICE Commercial Turnaround Time (TAT) Matrix
(2) ICE CMS TAT Matrix
(3) ICE Medi-Cal TAT Matrix
(4) ICE CMC TAT Matrix
(5) ACA Section 1557
(6) CMS Memo
(7) Health Plan
(8) Code of Regulation CFR 92.8

(9) APL Emergency Guidance

APL 20-004 Emergency Guidanc

APL 21-011 - New Federal Guidance Re

7-16-21-SOE-California.pdf

(10) Level 1 and 2 Review -internal guidelines.

Level 1 and 2 Review 10-2021.doc