

**DEPARTMENT OF MANAGED HEALTH CARE
HELP CENTER
DIVISION OF PLAN SURVEYS**

TECHNICAL ASSISTANCE GUIDE

UTILIZATION MANAGEMENT

ROUTINE DENTAL SURVEY

OF

PLAN NAME

(A Medi-Cal Dental Managed Care Plan)

DATE OF SURVEY:

PLAN COPY

Issuance of this January 15, 2016 Technical Assistance Guide renders all other versions obsolete.

DENTAL TAG

UTILIZATION MANAGEMENT REQUIREMENTS

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Requirement UM-001: UM Program Policies and Procedures

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1367.01(a)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

CA Health and Safety Code section 1367.01(b)

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

CA Health and Safety Code section 1367.01(c)

(c) A health care service plan subject to Section 1367.01, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant Section 2050 of the Business and Professions Code or pursuant to Osteopathic Act, or if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

CA Health and Safety Code section 1367.01(i)

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director and/or senior Dentist responsible for utilization management
- Utilization Management Director

DOCUMENT(S) TO BE REVIEWED

- UM policies and procedures, including org charts and committee descriptions (A UM Program Description may be substituted or in addition to policies and procedures)
- Job Description of the Dental Director responsible for ensuring the UM Process complies with Section 1367.01
- Copy of licenses of the Dental Director(s)
- UM Committee minutes
- Review licensing filing of the Plan’s UM Program and confirm submission of appropriate policies and procedures.

UM-001 - Key Element 1:

- 1. The health care service plan or the entity with which it contracts for utilization review or utilization management services complies with the requirements of Section 1367.01. CA Health and Safety Code section 1367.01(a)**

Assessment Questions	Yes	No	N/A
1.1 Has the Plan/ contracted entity identified a health care service or has a list of health care services that require review and prior authorization/ approval by the Plan as a condition of reimbursement?			
1.2 Are health care services reviewed by the Plan or contracted entity to determine whether the requested service is based in whole or in part on medical necessary?			
1.3 Do some medical necessity reviews result in a modification or denial of the requested service on the basis that the service was not medically necessary?			

UM-001 - Key Element 2:

- 2. The Plan has utilization management policies and procedures. CA Health and Safety Code section 1367.01(b)**

Assessment Questions	Yes	No	N/A
2.1 Do policies and procedures describe the process by which the Plan reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of dental care services for Plan enrollees?			

Assessment Questions	Yes	No	N/A
2.2 Do policies and procedures include utilization review processes such as prospective review, concurrent review and retrospective review?			

UM-001 - Key Element 3

**3. A designated or employed Medical Director is responsible to ensure the Plan’s UM Program complies with this section and holds an unrestricted license to practice medicine in California.
CA Health and Safety Code section 1367.01(c)**

Assessment Questions	Yes	No	N/A
3.1 Is a dentist designated or employed to provide clinical direction to the UM Program and ensure compliance with the requirements of Section 1367.01?			
3.2 Does the designated individual hold a current unrestricted license to practice dentistry in California?			

UM-001 - Key Element 4:

**4. The Plan ensures telephone access for providers to request authorizations for health care services.
CA Health and Safety Code section 1367.01(i)**

Assessment Questions	Yes	No	N/A
4.1 Do the Plan’s UM policies and procedures describe and ensure telephone access for requesting authorizations for dental care services?			
4.2 Does the Plan maintain telephone access for providers to request authorizations for dental care services?			

End of Requirement UM-001: UM Program Policies and Procedures

Requirement UM-002: UM Decision Making and Time Frames

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1367.01(a)

(a) Every health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

CA Health and Safety Code sections 1367.01(e) and (g)

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

CA Health and Safety Code sections 1367.01(h)(1) and (2)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, every health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan

to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

CA Health and Safety Code sections 1367.01(h)(3) through (5)

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved.

Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.

The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required.

The Plan shall also notify the provider and enrollee of the anticipated date on which a decision

may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- UM Director/ Managers
- Dental Director and/ or senior dentist responsible for UM

DOCUMENT(S) TO BE REVIEWED

- UM policies and procedures, including UM decision timeframe requirements
- Organization charts, committee descriptions and key staff job descriptions of staff involved in UM review
- Sample of UM denial files to be reviewed onsite

UM-002 - Key Element 1:

- 1. The Plan has written policies and procedures for review and approval, modification, delay or denial of services (medical necessity denials) and ensures they are consistently applied.
CA Health and Safety Code sections 1367.01(e) and (g)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have policies and procedures to ensure that only licensed dentists or a licensed health care professional (competent to evaluate clinical issues related to requested health care services) make decisions to deny or modify requested services on the basis of medical necessity?			
1.2 Do the Plan’s denial files validate that only licensed dentists or a licensed health care professional (competent to evaluate clinical issues related to requested health care services) make decisions to deny or modify requested services on the basis of medical necessity? (Standard UM Denials Worksheet #6)			

UM-002 - Key Element 2:

- 2. The Plan has established and implemented written policies and procedures regarding the timeliness of UM Decisions and ensures they are consistently applied.
CA Health and Safety Code sections 1367.01(h)(1) and (2)**

Assessment Questions	Yes	No	N/A
2.1 After the Plan’s receipt of the information reasonably necessary to make the determination, does the Plan make decisions to approve,			

Assessment Questions	Yes	No	N/A
<p>modify, or deny requests by providers in a timely fashion, <u>not to exceed five (5) business days</u> (This applies to requests prior to, or concurrent with the provision of health care services to enrollees.) (Standard UM Denials Worksheet #9)</p>			
<p>2.2 After the Plan’s receipt of the information reasonably necessary and requested by the Plan to make the determination, for urgent referrals and requests for other health care services, does the Plan make the decision to approve, modify, or deny requests by providers in a timely fashion, not to exceed seventy-two (72) hours (This applies to requests prior to, or concurrent with the provision of health care services to enrollees.) (Standard UM Denials Worksheet #9)</p>			
<p>2.3 Does the Plan communicate utilization review decisions to approve, deny, delay, or modify health care services to requesting providers initially by telephone, facsimile or electronic mail and then in writing within twenty-four (24) hours of making the decision? (Standard UM Denials Worksheet #14)</p>			
<p>2.4 Does the Plan communicate UM decisions to approve, deny, delay, or modify health care services to enrollees in writing within two (2) business days? (Standard UM Denials Worksheet #16)</p>			
<p>2.5 Does the Plan request information from the provider that is reasonably necessary to make a medical necessity decision in a timely fashion (appropriate for the nature of the enrollee’s condition)?</p>			
<p>2.6 Upon receipt of the requested information, does the Plan make decisions to approve, modify, or deny the request within the required timeframe? (Standard UM Denials Worksheet #9)</p>			
<p>2.7 For retrospective reviews, does the Plan make the decision to approve or deny the previous provision of health care services to enrollees, and communicate that decision within thirty (30) days after the Plan’s receipt of the information reasonably necessary and requested by the Plan to make the determination? (Standard UM Denials Worksheet #9)</p>			

End of Requirement UM-002: UM Decision Making and Time Frames

Requirement UM-003: UM Criteria Development

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code sections 1363.5(a) and (b)

(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for sub-acute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify or deny health care services shall:

- (1) Be developed with involvement from actively practicing health care providers
- (2) Be consistent with sound clinical principles and processes
- (3) Be evaluated, and updated if necessary, at least annually

CA Health and Safety Code section 1367.01(b)

These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes.

CA Health and Safety Code section 1367.01(f)

The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- UM Director
- Dental Director or designee
- Senior dental health clinical officer

DOCUMENT(S) TO BE REVIEWED

- UM policies and procedures and/or Program document outlining development and approval of UM criteria
- UM Committee minutes
- Signature page for UM program/Plan/policies and procedures

UM-003 - Key Element 1:

- 1. The Plan develops UM criteria consistent with acceptable standards and evaluates them annually.
CA Health and Safety Code sections 1363.5(a) and (b); CA Health and Safety Code section 1367.01(f)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan utilize criteria/guidelines when determining the medical necessity of requested health care services? (GMC Requirement UM-010, KE1, AQ 1.1)			
1.2 Are criteria/guidelines developed with involvement from actively practicing dental care providers? (GMC Requirement UM-010, KE1, AQ 1.3)			
1.3 Does the Plan have a mechanism to ensure that UM criteria/guidelines for making medical necessity decisions are updated annually (or more frequently if needed)? (GMC Requirement UM-010, KE1, AQ 1.4)			
1.4 Does the Plan have a mechanism to ensure that UM criteria/guidelines for making medical necessity decisions are disseminated to all UM decision-makers?			
1.5 Does the Plan distribute clinical practice guidelines to dental care and specialty care providers as appropriate?			
1.6 Is there supporting documentation to confirm the criteria/guidelines are consistent with accepted standards of practice? (For example, documented approval via minutes from discussions; criteria/guidelines have been adopted by reputable dental organizations; criteria/guidelines consistent with national standards from federal agencies.)			

End of Requirement UM-003: Criteria Development

Requirement UM-004: Communication Requirements for UM Decisions

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1363.5(b)(4)

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

CA Health and Safety Code section 1367.01(d)

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

CA Health and Safety Code section 1367.01(h)(2)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

CA Health and Safety Code sections 1367.01(h)(3) and (4)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued

until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan.

CA Health and Safety Code sections 1367.01(h)(1) and (5)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the

plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

CA Health and Safety Code section 1374.30(i)

No later than January 1, 2001, every health care service plan shall prominently display in every plan member handbook or relevant informational brochure, in every plan contract, on enrollee evidence of coverage forms, on copies of plan procedures for resolving grievances, on letters of denials issued by either the plan or its contracting organization, on the grievance forms required under Section 1368, and on all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the plan, or by one of its contracting providers.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- UM Director
- Dental Director and/or senior dentist responsible for UM decisions

DOCUMENT(S) TO BE REVIEWED

- UM policies and procedures, including UM decision communication requirements
- Sample of denial files to be reviewed on site
- Sample of extension letters (when the Plan cannot make a decision within the required timeframe)

UM-004 - Key Element 1:

1. **The Plan has established and implemented guidelines for UM-related communications to providers and enrollees (including content, form, and timeframes).**
CA Health and Safety Code section 1363.5(b)(4); CA Health and Safety Code section 1367.01(d); CA Health and Safety Code sections 1367.01(h)(3) and (4); CA Health and Safety Code section 1374.30(i)

Assessment Questions	Yes	No	N/A
1.1 For retrospective UM decisions, does the Plan communicate denials or modifications of health care services to providers in writing? (Standard UM Denials Worksheet #15)			
1.2 Do communications regarding decisions to approve requests by providers specify the specific health care service approved? (UM Approval Letter Worksheet #10, if applicable)			
1.3 Do the Plan’s denial letters provide a clear and concise explanation of the reasons for the Plan’s decision to deny, delay, or modify health care services? (Standard UM Denials Worksheet #17)			

Assessment Questions	Yes	No	N/A
1.4 Do the Plan’s denial letters specify a description of the criteria or guidelines used for the Plan’s decision to deny, delay, or modify health care services? (Standard UM Denials Worksheet #18)			
1.5 Do the Plan’s denial letters specify the clinical reasons for the Plan’s decision to deny, delay, or modify health care services? (Standard UM Denials Worksheet #19)			
1.6 Do written communications to a dentist or other health care provider of a denial, delay, or modification of a request include the name of the health care professional responsible for the denial, delay, or modification? (Standard UM Denials Worksheet #21)			
1.7 Do written communications to a dentist or other health care provider of a denial, delay, or modification of a request include the direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting dentist or health care provider to easily contact them? (Standard UM Denials Worksheet #21)			
1.8 Do written communications to an enrollee of a denial, delay, or modification of a request include information as to how he / she may file a grievance to the Plan? (Standard UM Denials Worksheet #22)			
1.9 Do written communications to an enrollee of a denial, delay, or modification of a request include information as to how he / she may request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers? (Standard UM Denials Worksheet #24)			

UM-004 - Key Element 2:

- 2. The Plan has established and implemented guidelines for communicating to the enrollee and Physician if a UM decision will not be made within 5 business days.
CA Health and Safety Code sections 1367.01(h)(1) and (5)**

Assessment Questions	Yes	No	N/A	Go to Comments
2.1 Does the Plan have guidelines for communicating with the enrollee and provider if UM decisions do not meet the required timeframes?				Click
2.2 If the Plan is unable to make a UM decision within the required timeframe, does the Plan notify the provider and enrollee of the anticipated decision date? (Standard UM Denials Worksheet #10)				Click

End of Requirement UM-004: Communications Requirements for UM Decisions

Requirement UM-005: Disclosure of UM Process to Authorize or Deny Services

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1363.5(a)

(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for sub-acute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

CA Health and Safety Code sections 1363.5(b)(4) and (5)

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

(5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

CA Health and Safety Code section 1363.5(c)

(c) The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: "The materials provided to you are guidelines used by this 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."

CA Health and Safety Code 1367.01(b)

(b) These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- UM Director
- Dental Director or designee
- Member Services staff

- Participating dentist

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures for disclosure of UM processes and criteria to providers, enrollees, and the public
- Policies and procedures for disclosure to the provider and enrollee of the specific UM criteria used in all decisions based on medical necessity to modify, delay, or deny care
- Review of disclosure documents including provider materials relating to disclosure, disclosures to provider groups and UM vendors, enrollee materials relating to disclosure, public materials relating to disclosure
- Template letter(s) with disclosure statement
- Review licensing filing of the Plan’s UM Program to confirm submission of policies and procedures, and the description of the UM process.

UM-005 KE 1 1.4

UM-005 - Key Element 1:

1. The Plan shall disclose to network providers, contractors and enrollees the process the Plan uses to authorize, modify, or deny health care services under the benefits provided by the Plan.

CA Health and Safety Code section 1363.5(a); CA Health and Safety Code sections 1363.5(b)(4) and (5); CA Health and Safety Code section 1363.5(c)

Assessment Questions	Yes	No	N/A
1.1 Do Plan policies and procedures provide for the disclosure of the process the Plan uses to authorize, modify, or deny health care services?			
1.2 Does the Plan disclose the UM process information to network providers?			
1.3 Does the Plan demonstrate that it discloses UM processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request?			
1.4 Does the Plan demonstrate that it discloses to the enrollee and provider the UM criteria used as a basis to modify, deny, or delay services in specified cases under review? (GMC Requirement UM-011, KE1, AQ 1.2B)			
1.5 Are UM Criteria available to the public upon request, which may include the availability through electronic communication means?			
1.6 Is disclosure of UM criteria to the public accompanied by the following notice: “The materials provided to you are guidelines used by this 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.”?			

End of Requirement UM-005: Disclosure of UM Process to Authorize or Deny Services

Requirement UM-006: UM Processes as Part of the QA Program

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code sections 1367.01(e), (h), and (j)

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny, or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the State Managed Care Fund.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

28 CCR 1300.70(a)(1)

(a) Intent and Regulatory Purpose.

(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.

28 CCR 1300.70(b)(2)(G)(5)

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example

- UM Director
- QM Director
- Dental Director

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures for UM
- UM or QM Annual Work Plan
- UM or QM Committee minutes
- Trending reports
- Activity summaries
- Audit Reports
- Enrollee & Provider Satisfaction Surveys (UM-related questions and results)
- Corrective action plans
- Enrollee and Provider satisfaction survey questions related to UM
- Enrollee and Provider satisfaction survey results, last two years, if applicable

UM-006 - Key Element 1:

1. The Plan has established and implemented a QA process to assess and evaluate their compliance with UM requirements.

CA Health and Safety Code sections 1367.01(e), (h), and (j)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have a process in place to evaluate complaints and assess trends to identify potential quality issues in the UM process and regularly report this information to appropriate bodies?			
1.2 Does the Plan have a process in place to monitor and assess compliance with timeliness of decision-making, timeliness of notification, and turnaround times for UM functions?			
1.3 Has the Plan established and implemented policies and procedures to monitor and assess compliance with the use of appropriate licensed health care providers in making denial decisions and the appropriate use and application of criteria in making medical necessity decisions?			
1.4 Has the Plan established and implemented policies and procedures to audit denial letters ensuring the required information is included, and communicated to the appropriate user, providers and/or enrollees?			
1.5 Does the Plan systematically and routinely analyze its evaluation of the UM process to identify any potential quality issues in the UM process? (GMC Requirement UM-013, KE1, AQ 1.1)			
1.6 Does the Plan develop, communicate, and implement corrective action plans when potential quality issues are identified in the UM process? (GMC Requirement UM-013, KE1, AQ 1.2)			
1.7 Does the Plan evaluate the effectiveness of any corrective action plan (using performance measures, for example) and make further recommendations to improve the UM process? (GMC Requirement UM-013, KE1, AQ 1.3)			
1.8 Does the Plan systemically and routinely analyze UM data to monitor for potential over- and under-utilization? (GMC Requirement UM-013, KE1, AQ 1.4)			

UM-006 - Key Element 2:

- 2. The scope of quality assurance monitoring includes assessment and evaluation of provider referral and specialist care patterns of practice.
28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(2)(G)(5)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan's quality assurance/ utilization review mechanism encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists and appropriate preventive health services based on reasonable standards established by the Plan and/or delegated providers?			
2.2 Does the Plan have a process in place to routinely monitor and assess access to specialist care and appropriate preventive health services?			
2.3 Does the Plan analyze its evaluation of access to specialist care and appropriate preventive health services?			

Assessment Questions	Yes	No	N/A
2.4 Does the Plan have a process to routinely monitor and assess access to specialist care and appropriate preventive health services for any delegated providers?			
2.5 Does the Plan identify, communicate, and implement corrective actions when potential access issues are identified in the UM process?			
2.6 Does the Plan evaluate the effectiveness of any corrective actions (using performance measures, for example) and make further recommendations to improve potential access issues?			

End of Requirement UM-006: UM Processes as Part of the QA Program

Requirement UM-007: UM Delegation Oversight

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code sections 1363.5(a)

(a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for sub-acute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

CA Health and Safety Code section 1363.5(b)

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

- (1) Be developed with involvement from actively practicing health care providers.
- (2) Be consistent with sound clinical principles and processes.
- (3) Be evaluated, and updated if necessary, at least annually.
- (4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.
- (5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

CA Health and Safety Code sections 1367.01(a) and (b)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan

reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

CA Health and Safety Code sections 1367.01(a) through (c)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) A health care service plan subject to this section shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

CA Health and Safety Code sections 1367.01(a), (b), and (f)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These

policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

CA Health and Safety Code sections 1367.01(a), (e), (h), and (j)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by

providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved.

Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.

The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request

for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

CA Health and Safety Code sections 1367.01(a) and (h)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved.

Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.

The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional

examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

CA Health and Safety Code sections 1367.01(e), (h), and (i)

(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be

made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved.

Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.

The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not

received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

CA Health and Safety Code sections 1371.4(a) through (d)

(a) A health care service plan, or its contracting medical providers, shall provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the requirements of this subdivision.

(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan

fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the plan. Payment for this care may not be denied.

28 CCR 1300.67.2(c)

Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week;

28 CCR 1300.70(b)(2)(G)(5)

(b) Quality Assurance Program Structure and Requirements.

(2) Program Requirements.

In order to meet these obligations each plan's QA program shall meet all of the following requirements:

(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees.

(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- UM or QM Director
- Director of Governmental Compliance
- Director of delegated entities (or equivalent), if necessary

DOCUMENT(S) TO BE REVIEWED

- Plan to Plan contract or Delegation Agreement
- Materials provided by the Plan to the delegate to delineate responsibilities and monitoring activities
- Delegated entity UM Program description, policies and procedures, and criteria, as applicable
- Plan audit tool and sample audits of delegated entities
- Delegate UM reports
- Minutes of meetings where Plan presents audit findings for delegated entity audit
- Corrective action plans submitted and reviewed as necessary
- Provider service agreement and amendments addenda as applicable

UM-007 - Key Element 1:

- 1. Delegation Oversight: The Plan has policies and procedures for monitoring its delegated entities including methodology and frequency of oversight. The Plan conducts regular oversight of the UM Program for each of its delegated entities for compliance with its established UM standards.
CA Health and Safety Code sections 1367.01(a) and (b)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have policies and procedures for monitoring its delegated entities including methodology and frequency of oversight?			
1.2 Does the Plan conduct regular oversight of the UM Program for each of its delegated entities for compliance with its established UM standards?			

UM-007 - Key Element 2:

- 2. UM Program: Each delegate has a written description of the UM Program that includes structure, scope, criteria, processes, and policies (as outlined in UM-001) and has a designated Dental Director who is responsible for UM Program oversight and holds an unrestricted license to practice medicine in California.
CA Health and Safety Code sections 1367.01(a), (b), and (c)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan ensure that each delegate has a written description of the UM Program that includes structure, scope, criteria, processes, and policies and is consistent with the Plan’s UM Program?			
2.2 Is there a delegation agreement between the Plan and the entity to which the Plan has delegated management (of UM, QM, GA, LAP, etc. benefits, etc.) that includes, but is not limited to, 1) A statement/description of services to be performed on the Plan’s behalf? 2) Delineation of administrative responsibilities between the Plan and the delegate?			
2.3 Is there a delegation agreement between the Plan and the entity to which the Plan has delegated management (of UM, QM, benefits, etc.) that includes, but is not limited to, a description of the delegated services and activities?			
2.4 Does the Plan ensure that each delegate has a designated Dental Director who holds an unrestricted license to practice medicine in California?			
2.5 Does the Dental Director’s position description include substantial responsibility for providing clinical direction and oversight of the UM Program?			

UM-007 - Key Element 3:

- 3. UM Decision-Making and Timeframes: Each delegate has established and implemented policies and procedures regarding approval, modification, delay, or denial of services as well as the timeliness of those decisions (within the requirements outlined in UM-002).
CA Health and Safety Code sections 1367.01(e), (h), and (i)**

Assessment Questions	Yes	No	N/A
3.1 Does the Plan ensure that the delegate has a clearly stated policy that denials of coverage for reasons of dental necessity are made by a qualified licensed dentist or health care professional as outlined in UM-002?			
3.2 Does the Plan ensure that the delegate provides telephone access for providers to request authorization for health care services?			
3.3 Does the Plan ensure that the delegate's timeframes for UM decisions are within the requirements as outlined in UM-002?			
3.4 Does the Plan ensure that the delegate ensures timely responses to provider requests for authorization?			

UM-007 - Key Element 4:

- 4. UM Criteria: There is evidence that the delegate(s) have developed written UM criteria/ guidelines consistent with acceptable standards and perform(s) an annual evaluation of the UM Program, which is reviewed by the appropriate committee(s) and updated as necessary (consistent with the requirements outlined in UM-003).
CA Health and Safety Code section 1363.5(b); CA Health and Safety Code sections 1367.01(a), (b) and (f)**

Assessment Questions	Yes	No	N/A
4.1 Does the Plan ensure that the delegate's written criteria or clinical guidelines for UM decisions meet the requirements outlined in UM-003?			
4.2 Does the Plan ensure that the delegate(s) performs an annual evaluation and update of the UM Program, which is then reviewed by the appropriate committees?			
4.3 Does the Plan ensure that the delegate(s) has written criteria or clinical guidelines for UM decisions that are clearly documented for each UM function along with the procedures for use/ application of the criteria in making medical necessity determinations?			

UM-007 - Key Element 5:

- 5. Communication Requirements for UM Decisions: Each delegate has established and implemented guidelines for UM-related communications to providers and enrollees (including content, form, and timeframes) consistent with UM-004.
CA Health and Safety Code sections 1367.01(a) and (h)**

Assessment Questions	Yes	No	N/A
5.1 Does the Plan ensure that the delegate's written notification for denials includes the name and direct contact number for the professional responsible for a denial, delay, or modification of an authorization as outlined in UM-005?			
5.2 Does the Plan ensure that the delegate's written notification for denials includes a clear explanation of the reasons for the delegate's decision, a description of the criteria used, and clinical reasons for the decision regarding medical necessity?			
5.3 Does the Plan ensure that the delegate's written notification for denials includes grievance and IMR information?			

UM-007 - Key Element 6:

- 6. Disclosure of UM Authorization Processes:** Each delegate discloses to providers, contractors, enrollees and the public the UM processes and guidelines used to authorize, modify, or deny health care services under the benefits provided by the Plan (consistent with the requirements outlined in UM-005).
CA Health and Safety Code section 1363.5(b) CA Health and Safety Code sections 1367.01(a) and (b)

Assessment Questions	Yes	No	N/A
6.1 Does the Plan ensure that the delegate's written criteria or clinical guidelines for UM decisions meet the requirements outlined in UM-003?			
6.2 Does the Plan ensure that the delegate discloses, or provides for the disclosure to its providers, enrollees, and the public, information on criteria and UM processes as outlined in UM-003?			

UM-007 - Key Element 7:

- 7. UM Processes as Part of the QA Program:** Each delegate assesses the quality of their UM Program and processes and takes appropriate action when problems are identified (consistent with requirements outlined in UM-006).
CA Health and Safety Code sections 1367.01(a), (e), (h), and (j); 28 CCR 1300.70(b)(2)(G)(5)

Assessment Questions	Yes	No	N/A
7.1 Does the Plan ensure that the delegate assesses the quality of their UM Program and processes and takes appropriate action when problems are identified? (UM-006)			
7.2 Does the Plan receive and review copies of delegate QA audits, assessments, analyses, corrective action plans, etc.?			

UM-007 - Key Element 8:

8. Access to Emergency Services: Each delegate ensures that emergency health care services are available and accessible, that providers are reimbursed for care necessary to stabilize an emergency condition, and that denials of payment for emergency care meets requirements.

CA Health and Safety Code sections 1371.4(a) through (d); 28 CCR 1300.67.2(c)

Assessment Questions	Yes	No	N/A
8.1 Does the Plan ensure that the delegate has emergency health care services available and accessible within the service area twenty-four (24) hours a day, seven (7) days a week?			
8.2 Does the Plan ensure that the delegate reimburses for emergency services provided to its enrollees until the care results in stabilization of the enrollee and the delegate shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition?			
8.3 Does the delegate apply the reasonable person standard in adjudicating emergency services claims?			
8.4 Does the Plan ensure that the delegate denies reimbursement to a provider for a medical screening examination only in cases where the enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist?			

End of Requirement UM-007: UM Delegation Oversight

DHCS REQUIREMENTS FOR GMC PROGRAMS

Introduction:

Any negative finding in Requirements UM-001 through UM-007 could potentially be a GMC finding. The GMC surveyor is instructed to confer with the Surveyor responsible for Requirements UM-001 through UM-007, especially regarding any shaded element below, to ensure uniform findings. The shaded elements indicate elements that are also included in Requirements UM-001 through UM-007.

Requirement UM-008: UM Program Policies and Procedures

Many of the elements required by the Medi-Cal Dental GMC Program are the same as required by the Act. The following elements evaluate the Plan's UM Program as it relates specifically to the Medi-Cal Dental Manual of Criteria.

CONTRACT CITATIONS

Medi-Cal Dental GMC Program Exhibit A, Attachment 7, Provision A

A. Utilization Management (UM) Program

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary dental covered services as identified in the Medi-Cal Dental Manual of Criteria.

Contractor is responsible to ensure that the UM program includes:

1. Qualified staff responsible for the UM program.
2. The separation of dental care decisions from fiscal and administrative management to assure dental care decisions will not be unduly influenced by fiscal and administrative management.
3. Allowances for a second opinion from a qualified dental professional at no cost to the Member.

4. Established criteria for approving, modifying, deferring, or denying requested services. Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

5. Communications to dental providers of the procedures and services that require prior authorization and ensure that all contracting dental providers are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

6. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals.

Contractor shall ensure that all contracted dental providers and non-contracting specialty providers are informed of the prior authorization and referral process at the time of referral.

7. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

8. Procedures for continuously reviewing the performance of dental care personnel, the utilization of services and facilities, and cost.

These activities shall be done in accordance with Health and Safety Code Section 1367.1 and 28 CCR 1300.70(a)(3) and (c).

28 CCR 1300.70(a)(3)

Health Care Service Plan Quality Assurance Program

(a) Intent and Regulatory Purpose.

(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.

28 CCR 1300.70(c)

(c) In addition to the internal quality of care review system, a plan shall design and implement reasonable procedures for continuously reviewing the performance of health care personnel, and the utilization of services and facilities, and cost. The reasonableness of the procedures and the adequacy of the implementation thereof shall be demonstrated to the Department.

CA Health and Safety Code section 1367.01(a)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

CA Health and Safety Code section 1367.01(c)

(c) A health care service plan subject to this section, except a plan that meets the requirements of Section 1351.2, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

CA Health and Safety Code section 1367.01(i) through (j)

(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- UM or QM Director
- Director of Governmental Compliance

- Network Manager or Director
- Director of delegated entities (or equivalent), if necessary

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures that reflect the specialty referral system to track and monitor referrals requiring prior authorization.
- Policies and procedures for informing all contracted dental providers and non-contracted specialty providers are informed of the prior authorization and referral process at the time of referral.
- Policies and procedures that delineate the separation of medical decisions from fiscal/ administrative decisions.
- Policies and procedures for providing materials to enrollees and providers informing them that they may get a second opinion from a qualified dental professional at no cost to the member.
- Provider and enrollee communication materials used to inform them that they may get a second opinion from a qualified dental professional at no cost to the member
- Provider communications, such as newsletters and/or other forms of provider communications.
- Provider Roster/Contracts.

UM-008 - Key Element 1:

- 1. The Plan develops, implements, continuously updates and improves a UM Program that ensures appropriate processes are used to review and approve the provision of medically necessary dental covered services.
Medi-Cal Dental GMC Program, Exhibit A, Attachment 7, Provision A; 28 CCR 1300.70(a)(3); 28 CCR 1300.70(c); CA Health and Safety Code Section 1367.01(c) and CA Health and Safety Code Section 1367.01(i) through (j).**

Assessment Questions	Yes	No	N/A
1.1 Has the Plan implemented a UM Program that is continuously updated and ensures the appropriate processes are used to review and approve the provision of medically necessary dental covered services as identified in the Medi-Cal Dental Manual of Criteria?			
1.2 Has the Plan implemented a Quality Assurance Program that addresses service elements in accordance with 28 CCR 1300.70(a)(3) and (c)?			
A. Does the Plan’s program address accessibility and availability?			
B. Does the Plan’s program address continuity of care?			
1.3 Does the Plan’s Quality Assurance Program monitor whether the provision and utilization of services meets professionally recognized standards of practice?			
1.4 Does the Plan have procedures for continuously reviewing the performance of dental care personnel?			
1.5 Does the Plan have procedures for continuously reviewing the			

Assessment Questions	Yes	No	N/A
utilization of services and facilities?			
1.6 Does the Plan have procedures for continuously reviewing the cost of utilization services by the Finance Department?			
1.7 Does the Plan ensure that only qualified staff are responsible for the UM program? (UM-001, KE 3; UM-002, KE 1)			
1.8 Are all treatment decisions rendered by appropriate clinical staff, void of any influence or oversight by the Finance Department or Administrative Department?			
1.9 Does the Plan allow for a second opinion from a qualified dental professional at no cost for the member?			
1.10 Does the Plan use established criteria for approving, modifying, deferring, or denying requested services?			
1.11 Does the Plan document the manner in which the providers are involved in the development or adoption of specific criteria used by the Plan?			
1.12 Does the Plan inform providers of the policies and procedures which require prior authorization and inform contracting providers of the procedures and timeframes necessary to obtain prior authorization for these services?			
1.13 Does the Plan have procedures in place to ensure that all contracted dental providers and non-contracted specialty providers are informed of the process for prior authorization and referral at the time of referral?			
1.14 Does the Plan have an established system to track and monitor specialty referrals requiring prior authorization?			
A. Does the system track and monitor authorized, denied, deferred, and modified referrals?			
B. Does the system track and monitor the timeliness of referrals?			
1.15 Does the Plan integrate UM activities into the Quality Improvement System?			
A. Does the Plan have a process to integrate reports to review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS Staff?			
1.16 Does the Plan maintain telephone access for providers to request authorization for health care services?			

End of Requirement UM-008: UM Program Policies and Procedures

Requirement UM-009: Decision Making and Timeframes

CONTRACT CITATION(S)

Medi-Cal Dental GMC Program Exhibit A, Attachment 7, Provision B (1)-(3) and (5)-(8)

B. Pre-Authorizations and Review Procedures

Contractor shall ensure that its pre-authorization procedures are in accordance with the Medi-Cal Dental policy and procedures as described in the Medi-Cal Dental Manual of Criteria, and meet the following minimum requirements:

1. Qualified dental professionals supervise review decisions, and a qualified dentist will review all denials.
2. There is a set of written criteria or guidelines for Utilization Review that is based on the dental standard of care, is consistently applied, regularly reviewed, and updated.
3. Reasons for decisions are clearly documented.
5. Decisions and appeals are made in a timely manner and are not unduly delayed for dental conditions requiring time sensitive services.
6. Prior Authorization requirements shall not be applied to emergency services.
7. Records, including any Notice of Action, shall meet the retention requirements described in Exhibit E, Additional Provisions, Provision 20, Audit.
8. The requesting provider is notified of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. Notification must always be sent to the provider in writing. Verbal notice may also be given to the provider, but must be followed up by the written notification. Upon request, Contractor shall provide a list of all services requiring prior authorizations.

Medi-Cal Dental GMC Program Exhibit A, Attachment 7, Provision C

C. Timeframes for Dental Authorization

1. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency. Emergency care must be readily available and accessible within the service area twenty-four (24) hours a day, seven (7) days a week.
2. Routine authorizations: Within five (5) business days from the receipt of the information that is reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network services not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than ten (10) business days from the receipt of the request. The decision may be deferred and the time limit extended an additional ten (10) business days only where the Member or the Member's provider requests an extension, or the Contractor can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
3. Expedited authorizations: For requests in which a provider indicates, or the Contractor determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than three (3) business days after receipt of the request for

services. The Contractor may extend the three (3) business days' time period by up to ten (10) calendar days if the Member requests an extension, or if the Contractor justifies, to the DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.

Medi-Cal Dental GMC Program Exhibit A, Attachment 14, Provision H

H. Denial, Deferral, or Modification of Prior Authorization Requests

1. Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a dental care service. This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

2. Contractor shall provide for a written notification to the Member and the Member's authorized representative on a standardized form, approved by DHCS, informing the Member of all the following:

a. The Member's right to, method of obtaining, and time limit for requesting a State Fair Hearing to contest the denial, deferral, or modification action and the decision the Contractor has made, the reason(s) for the action and the specific regulation(s) or plan authorization procedures supporting the action.

b. The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson.

c. The name and address of Contractor and the Department of Social Services (DSS) toll-free telephone number for obtaining information on legal service organizations for representation.

3. Contractor shall provide required notification to Members and their authorized representatives in accordance with the time frames set forth in 22 CCR 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third (3rd) business day after the decision is made, not to exceed fourteen (14) calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 7, Utilization Management, Provision C, Timeframes for Dental Authorization, Contractor shall notify the Member in writing of the deferral of the decision no later than fourteen (14) calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide written notification of the decision to Members no later than twenty-eight (28) calendar days from the receipt of the original request.

If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 7, Utilization Management, Provision C, Timeframes for Dental Authorization, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

Medi-Cal Dental GMC Program Exhibit E, Provision 20 (a)

20. Audit

In addition to Exhibit C, Provision 4, Audit, Contractor also agrees to the following:

The Contractor will maintain such books and records necessary to disclose how the Contractor discharged its obligations under this contract. These books and records will disclose the quantity of covered services provided under this contract, the quality of those services, the manner and

amount of payment made for those services, the persons eligible to receive covered services, the manner in which the Contractor administered its daily business, and the cost thereof.

a. Books and Records

These books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this contract including subcontracts, working papers; reports submitted to DHCS; financial records; all dental records, charts and prescription files; and other documentation pertaining to dental and non-dental services rendered to Members.

Medi-Cal Dental GMC Program Exhibit E, Provision 20 (b)

20. Audit

b. Records Retention

Notwithstanding any other records retention time period set forth in this contract, these books and records will be maintained for a minimum of five (5) years from the end of the current fiscal year in which the date of service occurred, unless a longer period is required by law; in which the record or data was created or applied; and for which the financial record was created or the contract is terminated, or, in the event the Contractor has been duly notified that DHCS, DHHS, Department of Justice (DOJ) or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

CA Health and Safety Code sections 1367.01(h)(3) through (5)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, every health care service plan subject to this section shall meet the following requirements:

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow

the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- UM or QM Director
- Director of Governmental Compliance

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures regarding dental care and services, including those that specifically address the Medi-Cal Dental Manual of Criteria
- Policies and Procedures related to authorizations and timeliness standards, including expedited requests.
- Utilization Management Committee Meeting minutes
- Policies and procedures regarding records retention

UM-009 - Key Element 1:

1. **Pre-Authorization and Review Procedures:** The Plan ensures that its pre-authorization procedures meet the minimum requirements as specified in the Medi-Cal Dental GMC Program Contract.
Medi-Cal Dental GMC Program, Exhibit A, Attachment 7, Provision B;
Medi-Cal Dental GMC Program Exhibit E, Provision 20 (b)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan ensure that only qualified dental professionals supervise review decisions?			

Assessment Questions	Yes	No	N/A
1.2 Does the Plan ensure that only qualified dentists review all denials?			
1.3 Does the Plan maintain a set of written criteria or guidelines for utilization review that is based on the dental standard of care?			
A. Does the Plan ensure that the guidelines are consistently applied, regularly reviewed, and updated?			
1.4 Does the Plan clearly document the reasons for decisions?			
1.5 Does the Plan ensure that decisions and appeals are made in a timely manner and not unduly delayed for dental conditions requiring time sensitive services?			
1.6 Does the Plan ensure that prior authorization requirements are not applied to emergency services?			
1.7 Does the Plan notify providers of any decisions to deny, approve, modify or delay a service authorization request?			
1.8 Does the Plan notify providers of any decisions to authorize a service in an amount, duration or scope that is less than requested?			
1.9 Does the Plan provide notice to deny, approve, modify, delay a service authorization request, or any decisions to authorize a service in an amount, duration or scope that is less than requested in writing, or if given verbally, the decision is followed up by a written notification?			
1.10 Does the Plan maintain records for a minimum of five (5) years from the end of the current fiscal year in which the date of service occurred? Or longer if a longer period is required by law or the Plan is notified of an investigation?			

UM-009 - Key Element 2:

- 2. Expedited Authorizations: The Plan has processes in place to ensure expedited requests are handled in accordance with DHCS requirements. Medi-Cal Dental GMC Program, Exhibit A, Attachment 7, Provision C (3)**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan make expedited authorization decisions when a provider indicates, or the Plan determines, that the standard timeframe could seriously jeopardize a Member's life or ability to attain, maintain, or regain maximum function?			
2.2 Does the Plan make expedited authorization decisions and provide notice as expeditiously as the Member's health condition requires but no later than three (3) business days after the receipt for request for services, when the conditions stated in 2.3 are met?			
2.3 Does the Plan ensure that an extension for a decision is processed only in the event of a Member request or if the Plan justifies, to DHCS on			

Assessment Questions	Yes	No	N/A
request, the need for additional information and how the extension is in the Member's best interest?			
2.4 Does the Plan have policies and procedures in place that state that the Plan may extend the three (3) business days' time period for expedited requests by up to ten (10) calendar days if the Member requests an extension, or if the Plan justifies to the DHCS upon request, a need for additional information and how the extension is in the Member's interest?			
2.5 Do the Plan's policies and procedures provide that any decision delayed beyond the time limit is considered a denial and must be immediately processed as such?			

UM-009 - Key Element 3:

3. Timeframe for UM Decisions: The Plan completes decisions to deny, defer, or modify requests for prior authorization within the timeframes outlined in the DHCS contract. Medi-Cal GMC Program Exhibit A, Attachment 7, Provision C (1)-(2)

Assessment Questions	Yes	No	N/A
3.1 Do the Plan's policies ensure that no prior authorization is required for an emergency? Does the policy ensure that the reasonable person standard is used to determine whether the presenting complaint is considered emergency?			
3.2 Does the Plan ensure that emergency care is available twenty-four (24) hours a day, seven (7) days a week?			
3.3 Do the Plan's policies ensure that routine authorizations are made within five (5) business days from the receipt of the information that is reasonably necessary to render a decision, but no longer than ten (10) business days from the receipt from the request?			
A. Does the Plan defer decisions (for an additional ten (10) days) only where the Member or the Member's provider requests an extension, or where the Plan has provided justification to DHCS for the need for additional information and how it is in the Member's best interest?			
B. If a decision is delayed beyond the time limits, is it processed as a denial?			

End of Requirement UM-009: Decision Making and Timeframes

Requirement UM-010: UM Criteria Development

CONTRACT CITATION(S)

Medi-Cal GMC Program Exhibit A, Attachment 7, Provision B (2)

B. Pre-Authorizations and Review Procedures

2. There is a set of written criteria or guidelines for Utilization Review that is based on the dental standard of care, is consistently applied, regularly reviewed, and updated.

Medi-Cal GMC Program Exhibit A, Attachment 7, Provision A (4)

Contractor is responsible to ensure that the UM program includes:

4. Established criteria for approving, modifying, deferring, or denying requested services.

Contractor shall utilize evaluation criteria and standards to approve, modify, defer, or deny services. Contractor shall document the manner in which providers are involved in the development and or adoption of specific criteria used by the Contractor.

These activities shall be done in accordance with Health and Safety Code Section 1367.1 and 28 CCR 1300.70(a)(3) and (c).

CA Health and Safety Code sections 1363.5 (b)

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify or deny health care services shall:

- (1) Be developed with involvement from actively practicing health care providers
- (2) Be consistent with sound clinical principles and processes
- (3) Be evaluated, and updated if necessary, at least annually

CA Health and Safety Code section 1367.01(b)

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5.

CA Health and Safety Code section 1367.01(f)

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

CA Health and Safety Code section 1367.01(a)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or

concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- UM Director
- Senior dental health clinical officer
- Director of Governmental Compliance

DOCUMENT(S) TO BE REVIEWED

- UM policies and procedures and/or Program document outlining development and approval of UM criteria
- UM Committee minutes
- Signature page for UM program/Plan/policies and procedures

UM-010 - Key Element 1:

**1. The Plan develops UM Criteria consistent with acceptable standards and evaluates them annually.
Medi-Cal GMC Program Exhibit A, Attachment 7, Provision B (2); CA Health and Safety Code sections 1363.5(a) and (b); CA Health and Safety Code section 1367.01(f)**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan, or its delegate, utilize criteria/ guidelines when determining the medical necessity of requested dental care services prospectively, retrospectively, or concurrently? (KKA Requirement UM-003, KE1, AQ 1.1)			
1.2 Is there a set of written criteria or guidelines for utilization review that is based on the dental standard of care?			
1.3 Are the criteria/ guidelines developed with involvement from actively practicing dental care providers? (KKA Requirement UM-003, KE1, AQ 1.2)			
1.4 Does the Plan, or its delegate, have a mechanism to ensure that UM criteria/ guidelines for making medical necessity decisions are reviewed and updated at least annually (or more frequently if needed)? (KKA Requirement UM-003, KE1, AQ 1.3)			
1.5 Does the Plan, or its delegate, have a mechanism to ensure that UM criteria/ guidelines are consistent with sound clinical principles and processes?			

End of Requirement UM-010: UM Criteria Development

Requirement UM-011: Communication Requirements for UM Decisions

CONTRACT CITATION(S)

Medi-Cal Dental GMC Program Exhibit A, Attachment 7, Provision B (4)

4. Notification to Members regarding denied, deferred or modified referrals is made as specified in Exhibit A, Attachment 14, Member Services. There shall be a well-publicized appeals procedure for both providers and Members.

Medi-Cal Dental GMC Program Exhibit A, Attachment 14, Provision H

H. Denial, Deferral, or Modification of Prior Authorization Requests

1. Contractor shall notify Members of a decision to deny, defer, or modify requests for prior authorization by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a dental care service. This notification must be provided as specified in 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

2. Contractor shall provide for a written notification to the Member and the Member's authorized representative on a standardized form, approved by DHCS, informing the Member of all the following:

a. The Member's right to, method of obtaining, and time limit for requesting a State Fair Hearing to contest the denial, deferral, or modification action and the decision the Contractor has made, the reason(s) for the action and the specific regulation(s) or plan authorization procedures supporting the action.

b. The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson.

c. The name and address of Contractor and the Department of Social Services (DSS) toll-free telephone number for obtaining information on legal service organizations for representation.

3. Contractor shall provide required notification to Members and their authorized representatives in accordance with the time frames set forth in 22 CCR 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third (3rd) business day after the decision is made, not to exceed fourteen (14) calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 7, Utilization Management, Provision C, Timeframes for Dental Authorization, Contractor shall notify the Member in writing of the deferral of the decision no later than fourteen (14) calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide written notification of the decision to Members no later than twenty-eight (28) calendar days from the receipt of the original request.

If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 7, Utilization Management, Provision C, Timeframes for Dental Authorization, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

CA Health and Safety Code section 1367.01(a)

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or

concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

CA Health and Safety Code section 1363.5(b)(4)

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

CA Health and Safety Code section 1367.01(d)

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider's request, pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

CA Health and Safety Code section 1367.01(h)(2)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

CA Health and Safety Code sections 1367.01(h)(3) and (4)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two

business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively or concurrent with the provision of health care service to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan.

CA Health and Safety Code sections 1367.01(h)(1) and (5)

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the

plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

22 CCR 51014.1

Fair Hearing Related to Denial, Termination or Reduction in Medical Services.

(a) In addition to any notice mailed pursuant to section 50179, 53261, 53452, 56261, or 56452, each beneficiary shall be informed in writing, at the time of application to the program and by the Department on a quarterly basis thereafter, of the right to a fair hearing upon receipt of notice of:

(1) Any action, other than approval, including but not limited to deferral or denial, taken by the Department or a Medi-Cal managed care plan on a request by a provider for any medical service.

(2) Any intended action by the Department or a Medi-Cal managed care plan to terminate or reduce any medical service.

(b) The written notice of the right to a fair hearing shall specify:

(1) The method by which a hearing may be obtained.

(2) That the beneficiary may be either:

(A) Self represented.

(B) Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(3) The circumstances under which the medical service shall be continued pending decision on the fair hearing.

(4) The time limit for requesting fair hearing.

(c) Except as provided in (d), notice of intended action to reduce or terminate authorization for a medical service prior to expiration of the period covered by the authorization shall be mailed by the Department or by the Medi-Cal managed care plan to the beneficiary at least 10 days before the effective date of action. The notice shall include:

(1) A statement of the action the Department or Medi-Cal managed care plan intends to take.

(2) The reason for the intended action.

(3) A citation of the specific regulations or Medi-Cal managed care plan authorization procedures supporting the intended action.

(4) An explanation of the beneficiary's right to request a fair hearing for the purpose of appealing the Department's or Medi-Cal managed care plan's decision.

(5) An explanation of the procedure to request a hearing.

(6) An explanation of the circumstances under which a medical service shall be continued if a hearing is requested.

(d) The Department or Medi-Cal managed care plan may dispense with the 10 day mailing requirement in (c), but shall mail the notice of action before the date of action and shall meet all other requirements, when any of the following circumstances occur:

(1) The Department or Medi-Cal managed care plan receives a clear written statement signed by the beneficiary stating that the beneficiary no longer wishes to receive continuous medical service.

(2) The beneficiary has been admitted or committed to an institution and is no longer eligible for Medi-Cal benefits or, for a Medi-Cal managed care plan member, is no longer enrolled in the Medi-Cal managed care plan.

(3) The beneficiary has been accepted for medical assistance in another state or a new jurisdiction and that fact has been established by the jurisdiction presently providing assistance.

(4) A change in level of medical care is prescribed by the beneficiary's physician.

(5) The Department, or Medi-Cal managed care plan with the concurrence of the Department, obtains facts indicating the medical service should be terminated because of the probable fraud of the beneficiary. In this case notice shall be mailed at least 5 days before the action becomes effective.

(e) Except as provided in (g), notice of a reduction or termination as defined in (e)(1) and (2) shall be mailed by the Department or Medi-Cal managed care plan to the beneficiary or to the person identified as the beneficiary's authorized representative in records submitted by the health care provider requesting the services. The notice shall contain the information required by (c), except that it shall describe the action the Department or Medi-Cal managed care plan has taken rather than an action it intends to take. It shall be deposited with the United States postal service in time for pick-up no later than the third working day after the reduction or termination.

(1) "Termination" as used in this subdivision means denial by the Department or Medi-Cal managed care plan of a request for non-acute continuing services, as defined in section 51003(c)(1).

(2) "Reduction" as used in this subdivision means approval by the Department or Medi-Cal managed care plan of a request for non-acute continuing services as defined in section 51003(c)(1), at less than the amount or frequency requested and less than the amount or frequency approved on the immediately preceding authorization. There is no reduction if a shorter time period of services than requested is approved, as long as the amount or frequency of services during that period has not been reduced from the previously approved level.

(f) Except as provided in (g), notice of a termination as defined in (f)(1), shall be personally delivered or mailed as provided below. Notice shall be personally delivered to the beneficiary in his or her hospital room unless the beneficiary's treating physician has certified in writing that such personal delivery may result in serious harm to the beneficiary. If the treating physician has so certified, notice shall be mailed to the mailing address of the beneficiary or the person, if any, identified as the beneficiary's authorized representative in hospital medical records or documents submitted by the hospital to the Department or Medi-Cal managed care plan. Notice required by this subdivision shall contain the information required by (c) except that it shall describe the action the Department or Medi-Cal managed care plan has taken rather than an action it intends to take. It shall be personally delivered or be mailed no later than the first working day after termination.

(1) "Termination" as used in this subdivision means denial by the Department or Medi-Cal managed care plan of a request by a provider for acute continuing services, as defined in section 51003(c)(2). There is no termination when the field office consultant or Medi-Cal managed care plan approves less than the full number of acute care days requested.

(g) Notice of termination or reduction as provided for in (e) and (f) is not required in any of the following circumstances:

(1) By the date that notice would otherwise be personally delivered or mailed;

(A) Non-acute services requested for a limited time period are provided in full or,

(B) In the case of acute care services, the beneficiary is discharged from the hospital.

(2) The only days of acute care denied have already been provided to the beneficiary.

(3) The Department or Medi-Cal managed care plan authorized acute care days subject to specific services being performed during a specified time, and the Department or Medi-Cal managed care plan retroactively denies these previously authorized days because such services were delayed or not performed.

(h) Notice of action taken, or intended action other than approval for either a written or verbal request by a provider for medical service, other than those specified under subdivisions (c), (e)

and (f) or sections 53261 or 56261, shall be transmitted by the Department or Medi-Cal managed care plan to the provider of service. The method of transmittal of the notice of action taken or intended action may be either written or verbal. Should the beneficiary not receive notification from the provider of the Department's or Medi-Cal managed care plan's decision, the beneficiary may contact the provider to obtain such notification.

(i) For the purposes of this section, "medical service" means those services that are subject to prior authorization pursuant to section 51003 or the Medi-Cal managed care plan's authorization procedures.

(j) For the purposes of this section, "Medi-Cal managed care plan" means a prepaid health plan as defined in section 50071.5 or a primary care case management plan as defined in section 50071.8.

(k) The provisions of this section apply to Medi-Cal managed care plans only for beneficiaries who are enrolled in the Medi-Cal managed care plan and for medical services that are covered in the contract between the Department and the Medi-Cal managed care plan. The provisions of this section do not apply to the decisions of providers serving beneficiaries enrolled in Medi-Cal managed care plans when prior authorization of the service by the Medi-Cal managed care plan's authorization procedures is not a condition of payment for the medical service.

22 CCR 51014.2

Medical Assistance Pending Fair Hearing Decision.

(a) Continued medical assistance as set forth in (b), (c), and (d) below, pending a hearing decision shall be provided only if the beneficiary appeals in writing to the Department for a hearing within 10 days of the mailing or personal delivery of the notice of action pursuant to section 51014.1(c), (e) or (f), or before the effective date of action.

(b) In the case of a termination or reduction pursuant to section 51014.1(c), authorization shall be maintained until the period covered by the existing authorization expires, the date a hearing decision is rendered, or the date on which the hearing is otherwise withdrawn or closed, whichever is earliest.

(c) In the case of a termination of acute care services pursuant to section 51014.1(f), acute care authorization pending a hearing shall begin:

(1) The first day after the previously approved length of stay for continuing acute care if the request for extension by a provider was submitted to the on-site Medi-Cal reviewer during the first on-site visit after the previously approved length of stay expired.

(2) The sixth day of hospitalization if a request for extension pursuant to section 51003(c)(2)(B)5. was submitted to the on-site Medi-Cal reviewer during the first on-site visit after the first five days of hospitalization.

(3) The day the request for extension was submitted to the Department or to the Medi-Cal managed care plan if neither (1) nor (2) apply.

(4) The date of the termination decision if a decision on the request for extension was initially deferred pending the receipt of additional information.

Authorization pending a hearing pursuant to this subdivision shall end on the date a hearing decision is rendered, the date on which the hearing appeal is withdrawn or closed, the date the treating physician documents that the beneficiary is ready for lower level of care, or the date of discharge, whichever is earliest.

(d) In the case of a termination or reduction of non-acute care services pursuant to section 51014.1(e), authorization shall begin:

- (1) Upon expiration of the previous authorization if the request by a provider for reauthorization is submitted prior to such expiration, or
 - (2) The day of receipt of a completed request for reauthorization not requiring additional information from the provider, or
 - (3) The date of deferral of a decision on a request for reauthorization, when such deferral was necessary because of an incomplete request or because additional medical information is needed. Authorization pending a hearing pursuant to this subdivision ends on the date through which services were requested by the treating physician, the date a hearing decision is rendered, or the date on which the hearing appeal is withdrawn or closed, whichever is earliest.
- (e) Notwithstanding (a), (c), and (d), continued medical assistance pursuant to (c) or (d):
- (1) is not required at a greater amount or frequency of services than approved for the immediately preceding period of authorization,
 - (2) is not required in the case of acute care services if the beneficiary has been discharged from the hospital at the time that continued authorization would otherwise be put into effect,
 - (3) is not required in the case of non-acute care services requested for a limited time period, if they have been provided in full at the time that continued authorization would otherwise be put into effect.
- (f) For the purposes of this section, “Medi-Cal managed care plan” means a prepaid health plan as defined in section 50071.5 or a primary care case management plan as defined in section 50071.8.
- (g) The provisions of this section apply to Medi-Cal managed care plans only for beneficiaries who are enrolled in the Medi-Cal managed care plan and for medical services that are covered in the contract between the Department and the Medi-Cal managed care plan.

22 CCR 53894

Notice to Members of Plan Action to Deny, Defer or Modify a Request for Medical Services.

- (a) Each plan shall provide members with a notice of an action taken by the plan to deny a request by a provider for any medical service. Notice in response to an initial request from a provider shall be provided in accordance with this section. Notice in response to a request for continuation of a medical service shall be provided in accordance with section 51014.1. Notice of denial of a medical service shall not be required in the following situations:
- (1) The denial is a denial of a request for prior authorization for coverage for treatment that has already been provided to the member.
 - (2) The denial is a non-binding verbal description to a provider of the services which may be approved by the plan.
 - (3) The denial is a denial of a request for drugs, and a drug identical in chemical composition, dosage, and bioequivalence may be obtained through prior authorization from the plan or from the list, established by the plan, of drugs available without prior authorization from the plan.
- (b) Each plan shall provide members with a notice of deferral of a request by a provider for a medical service. Notice of the deferral shall be delayed for 30 days to allow the provider of the medical services time to submit the additional information requested by the plan and to allow time for the plan to make a decision. If, after 30 days from the plan's receipt of the request for prior authorization, the provider has not complied with the plan's request for additional information, the plan shall provide the member notice of denial pursuant to subdivision (a). If, within that 30 day period, the provider does comply, the plan shall take appropriate action on the request for prior authorization as supplemented by the additional information, including providing any notice to the member.

(c) Each plan shall provide members notice of modification of a request by a provider for prior authorization. Notice in response to an initial request from a provider shall be provided in accordance with this subdivision. Notice in response to a request for continuation of a medical service shall be provided in accordance with section 51014.1. Notice of modification pursuant to this subdivision shall not be required in the following situations:

(1) Each plan may modify a request for durable equipment without notice, as long as the substituted equipment is capable of performing all medically significant functions that would have been performed by the requested equipment.

(2) Each plan may modify the duration of any approved therapy or the length of stay in an acute hospital inpatient facility without notice as long as the plan provides an opportunity for the provider to request additional therapy or inpatient days before the end of the approved duration of the therapy or length of stay.

(d) The written notice of action issued pursuant to subdivisions (a), (b), or (c) shall be deposited with the United States postal service in time for pick-up no later than the third working day after the action and shall specify:

(1) The action taken by the plan.

(2) The reason for the action taken.

(3) A citation of the specific regulations or plan authorization procedures supporting the action.

(4) The member's right to a fair hearing, including:

(A) The method by which a hearing may be obtained.

(B) That the member may be either:

1. Self represented.

2. Represented by an authorized third party such as legal counsel, relative, friend or any other person.

(C) The time limit for requesting a fair hearing.

(e) For the purposes of this section, medical services means those services that are subject to prior authorization under the plan's authorization procedures.

(f) The provisions of this section apply only to medical services that are covered in the contract between the Department and the plan.

(g) The provisions of this section do not apply to the decisions of providers serving plan members when prior authorization of the service by the plan's authorization procedures is not a condition of payment to the provider for the medical service.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- UM or QM Director
- Director of Governmental Compliance

DOCUMENT(S) TO BE REVIEWED

- UM and network management policies and procedures related to under/over utilization
- Plan provider policies and procedures related to suspension of new enrollment and reinstatement

- Reporting policies and procedures, specifically the reporting of utilization data by Primary Care Dentist service site to DHCS

UM-011 - Key Element 1:

1. Communication Requirements for UM Decisions: The Plan’s decisions to approve, deny, defer or modify requests for prior authorization are provided by communications to enrollees, and are compliant with the DHCS contract, including content, form, and timeframes.

Medi-Cal Dental GMC Program, Exhibit A, Attachment 7, Provision B (4); Attachment 14, Provision H, Health and Safety Code section 1363.5(b)(4); Health and Safety Code section 1367.01(h)(3)-(5).

Assessment Questions	Yes	No	N/A
1.1 Does the Plan, or its delegate, communicate decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees?			
A. Does the Plan specify the specific health care service approved?			
1.2 Does the Plan, or its delegate, provide written notification to Members, or their authorized representatives, of decisions to deny, delay, defer, or modify requests for approval of services, including referrals?			
A. Does the Plan communicate decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, and concurrent with the provision of health care services to enrollees communicated to the enrollee in writing?			
B. Are the decisions communicated in writing and include a clear and concise explanation of the reason for the Plan’s decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity? (KKA Requirement UM-005 KE 1 AQ 1.4)			
C. Do the decisions include information as to how to file a grievance?			
1.3 Are decisions resulting in denial, delay, or modification of all or part of the requested health care service communicated to the enrollee in writing within two (2) business days of the decision pursuant to Health and Safety Code section 1367.01 (h)(3)?			
1.4 Is the notification written on a standardized form approved by DHCS?			
1.5 Does the notification of intended action to deny, defer, or modify an initial request for service contain the required information as outlined in the DHCS contract, 22 CCR section 53894?			
A. A statement of the action the Plan intends to take?			
B. The reason for the action the Plan intends to take?			
C. A citation of the specific regulations or Medi-Cal managed care plan authorization procedures supporting the intended action?			
D. A written notice of the right to a fair hearing and the method by which a hearing may be obtained?			

Assessment Questions	Yes	No	N/A
E. That the Member may be either be self-represented or represented by an authorized third party such as legal counsel, relative, friend or any other person?			
F. The time limit for requesting a fair hearing?			
G. The name and address of the Plan and Department of Social Service (DSS) toll-free telephone number for obtaining information on legal service organizations for representation?			
1.6 Does the notification contain the required information as outlined in the DHCS contract, 22 CCR section 51014.2?			
A. That when an enrollee appeals a notice of intended action to reduce or terminate the Plan must ensure that the enrollee maintains authorization until the period covered by the existing authorization expires, the date a hearing decision is rendered, or the date on which the hearing is otherwise withdrawn or closed, whichever is earliest?			
1.7 Is the notification provided to Members in accordance with Health and Safety Code section 1367.01(h)(5)?			
A. Does the Plan notify the enrollee, in writing, if the Plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe (within five (5) days from receipt of the information reasonably necessary and requested by the Plan or within seventy-two (72) hours if an imminent threat to health, life, limb, or other major bodily function), and include in the notice and the date anticipated that a decision should be rendered, the specific information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required?			
1.8 Does the Plan provide required notification to Members and their authorized representatives of decisions to deny, defer, or modify requests for prior authorization in accordance with the timeframes set forth in 22 CCR sections 51014.1 and 53894?			
A. Does the Plan mail the intended notice of action to the beneficiary at least ten (10) days before the effective date of action?			
B. If a Plan defers a decision due to the need for additional information, is a notice sent to the Member regarding the decision to defer no later than fourteen (14) calendar days from the date of the receipt of the original request?			
C. Does the Plan provide the Member notice of denial no later than thirty (30) days if the additional information is not received?			
1.9 Is the notification deposited with the Postal Service in time for pickup no later than the third business day after the decision is made, but no later than fourteen (14) calendar days from the receipt of the original request?			

Assessment Questions	Yes	No	N/A
1.10 If the final decision is to deny or modify the request, does the Plan ensure that the notification is provided to the Member no later than twenty-eight (28) calendar days from the receipt of the original request?			
1.11 If a decision regarding a prior authorization request is not made within the timeframes indicated in the DHCS contract (no longer than ten (10) days for routine authorizations, within three (3) business days for expedited authorizations), does the Plan consider the request denied and inform the Member within two (2) business days of the decision?			
1.12 Does the Plan have a well-publicized appeals procedure for both providers and Members?			

UM-011 - Key Element 2:

2. Notice of Action for Termination or Reduction of Services: The Plan provides notices of intended action to deny, reduce or terminate services to enrollees in a manner which is compliant with the DHCS contract and 22 CCR sections 51014.1, 51014.2 and 53894. Medi-Cal Dental GMC Program, Exhibit A, Attachment 7, Provision B (4); Medi-Cal Dental GMC Program, Exhibit A, Attachment 14, Provision H (1); 22 CCR section 51014.1; 22 CCR section 51014.2; 22 CCR section 53894

Assessment Questions	Yes	No	N/A
2.1 Is the notification for the denial, deferral, reduction or termination of services written on a standardized form approved by DHCS?			
2.2 Does the notification of denial, deferral, reduction, or termination of services contain the required information as outlined in the DHCS contract, 22 CCR section 51014.1?			
A. Written notice of the right to a fair hearing and the method by which a hearing may be obtained.			
B. That the Member may be either self-represented or represented by an authorized third party such as legal counsel, relative, friend or any other person			
C. The circumstances under which the medical services shall be continued pending decision on the fair hearing.			
D. The time limit for requesting a fair hearing.			
2.3 Does the notice of intended action to reduce or terminate contain the following elements?			
A. A statement of the action the Plan took or intends to take?			
B. The reason for the action the Plan took or intends to take?			
C. A citation of the specific regulations or Medi-Cal managed care plan authorization procedures supporting the intended action?			
D. An explanation of the beneficiary's right to request a fair hearing for the purpose of appealing the decision,			

Assessment Questions	Yes	No	N/A
including:			
E. An explanation of the procedure to request a hearing.			
F. An explanation of the circumstances under which a medical service shall be continued if a hearing is requested.			
<p>G. <u>If the notice is a notice of intended action</u>, is it sent to the enrollee as applicable at least ten (10) days prior to any action other than approval?</p> <p><u>If the action has already taken effect</u>, is the notice of a denial or a reduction mailed within three (3) working days from the effective date?</p> <p>This ten (10) day requirement is not applicable under 22 CCR section 51014.1(c) if the Member provides a written statement that they do not wish to receive the care, the Member is no longer eligible, the Member is no longer enrolled in the Plan, the Member is committed to institution, the Member has been accepted for medical assistance in another state, a change in care is prescribed by the provider, or a finding of fraud by DHCS. If a finding of probable fraud then the notice should be mailed at least five (5) days before the action takes effect.</p>			
2.4 Does the notification contain the required information as outlined in the DHCS contract, 22 CCR section 51014.2?			
A. That when an enrollee appeals a notice of intended action to reduce or terminate the Plan must ensure that the enrollee maintains authorization until the period covered by the existing authorization expires, the date a hearing decision is rendered, or the date on which the hearing is otherwise withdrawn or closed, whichever is earliest?			

End of Requirement UM-011: Communication Requirements for UM Decisions

Requirement UM-012: Review of Utilization Data

CONTRACT CITATION(S)

Medi-Cal Dental GMC Program Exhibit A, Attachment 7, Provision D

D. Review of Utilization Data

Contractor shall include within the UM program mechanisms to detect both under- and over-utilization of dental services. Contractor shall suspend all new enrollments for a provider who does not meet the thresholds of utilization. Reinstatement of enrollment may proceed once thresholds are met. Contractor’s internal reporting mechanisms used to detect Member utilization patterns shall be reported to DHCS no later than thirty (30) calendar days after the beginning of each calendar year.

Contractor shall submit self-reported monthly utilization data by Primary Care Dentist service site as determined by DHCS in an All Plan Letter. The report shall be submitted thirty (30) calendar days after the end of each reporting month.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Dental Director
- UM or QM Director
- Director of Governmental Compliance

DOCUMENT(S) TO BE REVIEWED

- UM and network management policies and procedures related to under/over utilization
- Plan provider policies and procedures related to suspension of new enrollment and reinstatement
- Reporting policies and procedures, specifically the reporting of utilization data by Primary Care Dentist service site to DHCS

UM-012 - Key Element 1:

1. Suspension/Reinstatement of Under-Utilized Providers: The Plan’s UM Program includes mechanisms to detect and address both under- and over-utilization of dental services as outlined in the DHCS contract.

Medi-Cal Dental GMC Program, Exhibit A, Attachment 7, Provision D

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have mechanisms in place to detect both under- and over-utilization of dental services?			
1.2 Does the Plan define utilization thresholds for providers?			
1.3 Does the Plan suspend all new enrollments for providers who do not meet the threshold for utilization?			
1.4 Does the Plan have a policy for reinstatement of providers once they have met the utilization thresholds?			

UM-012 - Key Element 2:

- 2. Reporting of Utilization Mechanisms and Data: The Plan submits self-reported monthly utilization data by Primary Care Dentist service site to DHCS in a timely manner. Medi-Cal Dental GMC Program, Exhibit A, Attachment 7, Provision D**

Assessment Questions	Yes	No	N/A
2.1 Does the Plan report its internal reporting mechanisms for detecting Member utilization patterns to the DHCS no later than thirty (30) calendar days after the beginning of the calendar year?			
2.2 Does the Plan submit self-reported monthly utilization data by Primary Care Dentist service site?			
2.3 Does the Plan submit its monthly utilization data thirty (30) calendar days after the end of each reporting month?			

End of Requirement UM-012: Review of Utilization Data

Requirement UM-013: UM Processes as Part of the Plan's QM Program

CONTRACT CITATION(S)

Medi-Cal Dental GMC Program Exhibit A, Attachment 7, Provision A (7)

A. Utilization Management (UM) Program

Contractor shall develop, implement, and continuously update and improve, a UM program that ensures appropriate processes are used to review and approve the provision of medically necessary dental covered services as identified in the Medi-Cal Dental Manual of Criteria.

Contractor is responsible to ensure that the UM program includes:

7. The integration of UM activities into the Quality Improvement System (QIS), including a process to integrate reports on review of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff.

These activities shall be done in accordance with Health and Safety Code Section 1367.1 and 28 CCR 1300.70(a)(3) and (c).

CA Health and Safety Code section 1367.01(j)

A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

CA Health and Safety Code section 1370

Every plan shall establish procedures in accordance with department regulations for continuously reviewing the quality of care, performance of medical personnel, utilization of services and facilities, and costs.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Staff responsible for the activities described above, for example
- UM Director
- QM Director
- Dental Director

DOCUMENT(S) TO BE REVIEWED

- Policies and procedures for UM
- UM or QM Annual Work Plan
- UM or QM Committee minutes
- Trending reports
- Activity summaries

- Audit Reports
- Enrollee & Provider Satisfaction Surveys (UM-related questions and results)
- Corrective action plans
- Enrollee and Provider satisfaction survey questions related to UM
- Enrollee and Provider satisfaction survey results, last two years, if applicable

UM-013 - Key Element 1:

1. The Plan has established and implemented a QA process to assess and evaluate their compliance with UM requirements.

Medi-Cal Dental GMC Program Exhibit A, Attachment 7, Provision A (7) and CA Health and Safety Code section 1367.01(j)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan systematically and routinely analyze its evaluation of the UM process to identify any potential quality issues or trends in the UM process? (KKA Requirement UM-006, KE1, AQ 1.5)			
1.2 Does the Plan develop, communicate, and implement corrective action plans when potential quality issues are identified in the UM process? (KKA Requirement UM-006, KE1, AQ 1.6)			
1.3 Does the Plan evaluate the effectiveness of any corrective action plan (using performance measures, for example) and make further recommendations to improve the UM process? (KKA Requirement UM-006, KE1, AQ 1.7)			
1.4 Does the Plan systematically and routinely analyze UM data to monitor for potential over- and under-utilization? (KKA Requirement UM-006, KE1, AQ 1.8)			
1.5 Does the Plan have a process in place to integrate reports of the number and types of appeals, denials, deferrals, and modifications to the appropriate QIS staff?			

End of Requirement UM-013: UM Processes as part of the Quality Management Program

Requirement UM-014: UM Delegation Oversight

CONTRACT CITATION(S)

Medi-Cal Dental GMC Program Exhibit A, Attachment 7, Provision E

E. Delegating UM Activities

Contractor may delegate UM activities. If Contractor delegates these activities, Contractor shall comply with Exhibit A, Attachment 5, Quality Improvement System, Provision F, Delegation of Quality Improvement Activities.

Medi-Cal Dental GMC Program Exhibit A, Attachment 5, Provision F

Delegation of Quality Improvement Activities

1. Contractor is accountable for all quality improvement functions and responsibilities (e.g. Utilization Management, Credentialing and Site Review) that are delegated to subcontractors. If Contractor delegates quality improvement functions, Contractor and delegated entity (subcontractor) shall include in their subcontract, at minimum:
 - a. Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and subcontractor.
 - b. Contractor's oversight, monitoring, and evaluation processes and subcontractor's agreement to such processes.
 - c. Contractor's reporting requirements and approval processes. The agreement shall include subcontractor's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly.
 - d. Contractor's actions/remedies if subcontractor's obligations are not met.
2. Contractor shall maintain a system to ensure accountability for delegated quality improvement activities, that at a minimum:
 - a. Evaluates subcontractor's ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.
 - b. Ensures subcontractor meets standards set forth by the Contractor and DHCS.
 - c. Includes the continuous monitoring, evaluation and approval of the delegated functions.

INDIVIDUAL(S)/POSITION(S) TO BE INTERVIEWED

Staff responsible for the activities described above, for example:

- Delegate Dental Director
- Plan UM Manager
- Delegate UM Manager
- Plan UM coordinators that conduct audits of the delegates
- UM representatives from one or more provider delegates
- Plan staff person responsible for the delegation
- Delegate staff person responsible for the delegation
- Director of Governmental Compliance

DOCUMENT(S) TO BE REVIEWED

- Related policies and procedures, including those detailing the processes for delegation and continued oversight of delegated entities
- Pre-delegation assessments
- Delegation contracts, letters of agreements, and memoranda of understanding
- Audit tools, forms, and reports/results
- Documentation that the Plan conducts a periodic audit of delegated activities and requires a corrective action plan for deficiencies identified with documentation of appropriate follow-up
- Documentation that the Plan periodically reviews and approves Delegate’s UM Program Description and Work Plan
- Plan board or QM committee or subcommittee minutes which document review and oversight of delegated providers and organizations
- Corrective action plans for delegated providers as appropriate
- Routine and ad hoc reports from the delegated entities
- Minutes of governance committee in which Delegate reports were discussed

UM-015 - Key Element 1:

**1. Delegating UM Activities: The Plan complies with DHCS contract provisions relating to the delegation of UM Activities
Medi-Cal Dental GMC Program, Exhibit A, Attachment 7, Provision E**

Assessment Questions	Yes	No	N/A
1.1 Does the Plan maintain accountability for all UM functions and responsibilities?			
1.2 Does the Plan include the DHCS contractually required elements in the subcontracts with UM delegates?			
A. Quality improvement responsibilities, and specific delegated functions and activities of the Plan and delegate.			
B. Plan oversight, monitoring, and evaluation processes and subcontractor’s agreement to such processes.			
C. Plan reporting requirements and approval processes. The agreement includes subcontractor’s responsibility to report findings and actions taken as a result of the quality improvements activities at least quarterly.			
D. Plan’s actions/remedies if subcontractor’s obligations are not met			
1.3 Does the Plan maintain a system to ensure accountability for delegated quality improvement activities?			
A. Does the system evaluate the subcontractor’s ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities?			

Assessment Questions	Yes	No	N/A
B. Does the system ensure the subcontractor meets standards set forth by the Contractor and DHCS?			
C. Does the system include the continuous monitoring, evaluation and approval of the delegated functions?			

End of Requirement UM-014: UM Delegation Oversight