PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

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<tr><td colspan="3">Guideline/Procedure Number: MCUG3007 (previously UG100307)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Authorization of Ambulatory Procedures and Services</td><td colspan="3">☒ External Policy
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td>☒ QUAC</td><td></td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 08/12/2026</td></tr>
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I. RELATED POLICIES:

A. MPUP3139 – Criteria and Guidelines for Utilization Management
B. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
C. MCUP3041 – Treatment Authorization Request (TAR) Review Process
D. MCUP3049 – Pain Management Specialty Services
E. MCUG3024 – Inpatient Utilization Management
F. CMP26 – Verification of Caller Identity and Release of Information

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Adverse Benefit Determination (ABD): The definition of an Adverse Benefit Determination encompasses all previously existing elements of an "Action" as defined under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An ABD is defined to mean any of the following actions taken by a Managed Care Plan (i.e. Partnership HealthPlan of California):
   1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   2. The reduction, suspension, or termination of a previously authorized service.
   3. The denial, in whole or in part, of payment for a service.
   4. The failure to provide services in a timely manner.
   5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
   6. The denial of the Member's request to obtain services outside the network.
   7. The denial of a Member's request to dispute financial liability.

B. Authorized Representative: An adult Member has the right to designate a friend, family Member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California (Partnership) for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business

day. The Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.

C. NC: Nurse Coordinator

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To provide guidelines for certification of ambulatory procedures and services. Certain outpatient procedures and tests must be prior authorized to evaluate and confirm the appropriateness of the proposed treatment plan along with the appropriateness of the location and level of care prior to the delivery of care. The process also allows the health plan to determine that the requested service is a covered benefit and that the patient is an eligible Member.

VI. GUIDELINE / PROCEDURE:

A. Outpatient services which require authorization are defined in policy MCUP3041 Treatment Authorization Request (TAR) Review Process.

B. Review Objectives
   1. Medical necessity
   2. Appropriate level of care
   3. Network eligibility of provider(s)
   4. Referral from primary care provider
   5. Member eligibility
   6. Covered Benefit

C. Criteria used in medical necessity determinations
   1. The Nurse Coordinator (NC) compares the medical information against the criteria and guidelines described in policy MPUP3139 Criteria and Guidelines for Utilization Management to evaluate the appropriate use of services, matching medical needs and treatment plans.
   2. If a request is received for authorization of services for which review criteria are not available, the NC, in conjunction with the Chief Medical Officer (CMO) or Physician Designee, uses clinical judgment and noted documentation from authorized medical references, journals, and articles to make a determination regarding the request. (See MPUP3139 Criteria and Guidelines for Utilization Management)

D. Authorization Process
   1. The provider of the service completes a Treatment Authorization Request (TAR) and submits it to Partnership's Health Services Department. This process should be initiated by the ordering provider a minimum of five business days prior to the procedure or test.
   2. The NC reviews the information received from the provider utilizing Partnership approved review guidelines. The NC approves the request if it meets medical necessity criteria. Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process for a full description of the process. A determination decision is based upon:
      a. The appropriateness of the proposed place of treatment
      b. The number of treatments or services
      c. The treatment plan
      d. The appropriateness of the proposed treatment
   3. The provider should verify that the TAR has been approved prior to rendering services.
   4. Confirmation documents and/or telephone confirmation will be provided to any of the following depending on the service request (i.e. inpatient or outpatient)
      a. Requesting provider
      b. Facility
      c. Member

5. Adverse Benefit Determinations
   a. If a request for treatment does not meet established criteria, the NC may request more information or refer the request for review to the CMO/Physician Designee. The CMO/ Physician Designee may consult with the requesting provider to evaluate the request.
   b. If the CMO/Physician Designee determines the requested service is not medically necessary, the CMO/Physician Designee or NC will:
      1) Notify the requesting provider and Member
      2) Provide objective criteria for the decision
      3) Document reasons for the decision
      4) Notify the requesting provider and Member of rights to an appeal
   c. A Notice of Action (NOA) letter from the Physician Designee and/or telephone confirmation will be forwarded to any of the following listed below depending on the service request (i.e. inpatient or outpatient).
      1) Requesting provider
      2) Provider of service
      3) Member
   d. The NOA letter will clearly state the reason for the denial or modification in terms specific to the Member's condition and in language that a layperson would understand.
6. Appeals
   a. A Member, a Member's authorized representative, or a provider acting on behalf of a Member may appeal an adverse benefit decision as described in Partnership's policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.
7. Reauthorization
   a. All authorizations which may recur are subject to the following requirements:
      1) Assessment and demonstration of continued need for treatment/service
      2) Reevaluation of plan of treatment, appropriateness of level of care and physician orders
      3) Documentation of patient compliance with treatment/service

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines
B. Current InterQual® Criteria
C. DHCS All Plan Letter (APL) 21-011 *Revised* Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022)
D. National Committee for Quality Assurance (NCQA) Guidelines UM 7 Denial Notices Element B

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer

X. REVISION DATES: 06/01/00; 09/19/01; 10/20/04; 10/19/05; 10/17/07; 08/20/08; 05/19/10; 05/16/12; 10/15/14; 05/20/15; 03/16/16; 04/19/17; *06/13/18; 05/08/19; 09/11/19; 09/09/20; 08/11/21; 08/10/22; 09/13/23; 09/11/24; 10/08/25; 08/12/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

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In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- Consistent with sound clinical principles and processes
- Evaluated and updated at least annually
- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.