PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="4">Policy/Procedure Number: MCUP3037 (previously UP100337 and MCUP3057)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Appeals of Utilization Management/ Pharmacy Decisions</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="4">Original Date: 04/25/1994</td><td colspan="3">Next Review Date: 06/11/2026
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH. MBA</td><td colspan="3">Approval Date: 06/11/2025</td></tr>
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I. RELATED POLICIES:

A. MPPRGR210 – Provider Grievance
B. CGA024 – Medi-Cal Member Grievance System
C. MCUP3041 – Treatment Authorization Request (TAR) Review Process
D. MCRP4068 – Medical Benefit Medication TAR Policy
E. MCUP3124 – Referral to Specialists (RAF) Policy
F. CMP36 – Delegation Oversight and Monitoring
G. CMP26 – Verification of Caller Identity and Release of Information

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Grievance
E. Provider Relations

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 (MCP) (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. Administrative Denial – Any denial of services that does not qualify as an Adverse Benefit Determination (ABD). An Administrative Denial is not subject to the appeal process and notification is only communicated to the provider.

C. Appeal – is a Member or provider request to Partnership HealthPlan of California (Partnership) for reconsideration of an adverse benefit determination resulting in the delay, modification, or denial of a service, benefit or claim based on medical necessity, or a determination that the requested service was not a covered benefit.

D. 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 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.

E. Deemed Exhaustion: In the event that the MCP fails to adhere to the state and federal notice and timeframe requirements for either a NOA or a NAR, including the MCP's failure to provide a fully translated notice, the Member is deemed to have exhausted the MCP's internal appeal process and may initiate a state hearing.

F. Notice of Action (NOA): – A formal letter informing a Member of an Adverse Benefit Determination.

G. Notice of Appeal Resolution (NAR): A formal letter informing a Member that an Adverse Benefit Determination has been overturned or upheld.

IV. ATTACHMENTS:

A. Request for Appeal/Expedited Appeal of UM or Pharmacy Decision
B. Member Authorization for Provider Appeal
C. UM and Pharmacy Appeal Acknowledgement Letter

V. PURPOSE:

To describe the process for a Partnership Medi-Cal Member, a Member's authorized representative, or a provider acting on behalf of a Member, to appeal Utilization Management (UM) or Pharmacy decisions determined by Partnership HealthPlan of California.

VI. POLICY / PROCEDURE:

A. General Appeal Rights

1. Members and providers are provided fair and solution-oriented means to address perceived problems in exercising rights as a Medi-Cal Member or provider, in accordance with requirements of Partnership's contract with the Department of Health Care Services (DHCS). This process is entirely separate from that of State Fair Hearings, to which Members retain their access.
2. Pursuant to 42 CFR 438.408 (f)(1), Partnership may only offer a single appeal of an Adverse Benefit Determination (ABD) for a Member, a Member's authorized representative, or a provider acting on behalf of a Member. This requirement of a single appeal stands whether the Member or authorized representative files an appeal directly with Partnership's Grievances and Appeals department (Member would be directed there after calling into the Member Services Department) or the provider files the appeal through Partnership's Utilization Management or Pharmacy departments. Upon notification of the plan's decision to uphold the original ABD or in instances of deemed exhaustion, the Member, the Member's authorized representative, or a provider acting on behalf of a Member, has the right to request a State Fair Hearing
3. Partnership ensures all Members have access to and can fully participate in the Grievance and Appeal System by assisting those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of Member informing materials e.g. Grievance and Appeal procedures, forms, and Partnership

responses to Grievance and Appeals, as well as access to qualified oral interpreters, Video Remote Interpreters (VRI), telephone relay systems and other devices that aid individuals with hearing and/or visual disabilities.

4. Upon request from the Member, Partnership shall provide the Member or Member's authorized representative the opportunity to review the Member's case file including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Partnership in connection with any standard or expedited Appeal of a Notice of Action. This information will be provided free of charge and sufficiently in advance of the resolution.

B. Appeals of Adverse Benefit Determinations

1. The Member, the Member's authorized representative, or the provider acting on behalf of the Member, has 60 calendar days from the date of determination to submit an appeal request in response to a Notice of Action (NOA) letter.
2. A Member or a Member's authorized representative may initiate an appeal by contacting Partnership's Member Services department. An appeal initiated in this way is considered a Member Appeal and will be referred to the Partnership Grievance and Appeals department for processing. A provider may request an appeal on behalf of a Member, with written consent from that Member, by faxing or writing Partnership's UM or Pharmacy Department. An appeal initiated in this way will also be considered a Member Appeal but will be processed by the UM or Pharmacy department as applicable. The Member or provider may use the "Request for Appeal/ Expedited Appeal of UM or Pharmacy Decision" form if desired (See Attachment A). After receipt of the request for appeal, Partnership will provide written acknowledgement to the Member and provider that is dated and postmarked within five (5) calendar days of receipt of the appeal. If the request for appeal from a provider is not accompanied by written consent from the Member, Partnership will provide the "Member Authorization for Provider Appeal" form with the written acknowledgement and proceed with the request.
3. Partnership has 30 calendar days from the receipt of the appeal request to render a determination.
4. The Chief Medical Officer or physician designee reviews the request for appeal if the determination was based on medical necessity.
5. The following types of appeal requests do not require physician review (but will be processed by UM or Pharmacy licensed clinical staff) as the determinations are not based on medical necessity criteria:
   a. Member not eligible with Partnership on date of service
   b. Member has other insurance
   c. Share of Cost (SOC) - It is the provider's responsibility to update the Member's share of cost in the State's Medi-Cal Eligibility Verification System. Members have no eligibility with Partnership, nor can claims be paid, until their SOC has been satisfied each month.
6. If Partnership's determination specifies the requested service is not a covered benefit, Partnership shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the provider and Member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applies to the specific health care service or benefit request.
7. When a decision has been made, the provider and/or Member, if applicable, are notified in writing within 5 business days with a Notice of Appeal Resolution (NAR) letter. Partnership is not required to notify the Member of a decision when the Member is not at financial risk for the services being requested (e.g. acute concurrent reviews).
8. Providers who disagree with the appeal resolution may file a grievance with Partnership by the process described in the Provider Grievance policy MPPRGR210.

C. Expedited Appeals of ABD Determinations

1. Expedited appeals may be initiated by the Member, the Member's authorized representative, or the provider acting on behalf of the Member. A Member may initiate an expedited appeal by calling the Member Services Department. A provider may initiate an expedited appeal on behalf of a Member with the Member's written consent by faxing or writing the Partnership UM or Pharmacy Department. If the request for expedited appeal is not accompanied by written consent from the Member, the Plan will proceed with the request. Expedited appeals are performed by Partnership only when, in the judgment of the Chief Medical Director (CMO) or Physician Designee, a delay in decision-making may seriously jeopardize the life or health of the Member. If the CMO or Physician Designee determines that the appeal does not meet criteria to be expedited, the appeal will be reviewed according to the standard timeframe described in VI.B.
2. Partnership refers the expedited appeal request to the Chief Medical Officer or Physician Designee for decision on the appeal. The Chief Medical Officer or Physician Designee is expected to make a decision as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after the receipt of the request for an expedited appeal. Expedited reviews are also granted to all requests concerning admissions, continued stay or other health care services for a Member who has received emergency services but has not been discharged from a facility. Partnership provides verbal confirmation of its decisions concurrent with mailing of written notification no later than seventy-two (72) hours after receipt of an expedited appeal.
3. If the expedited appeal involves a concurrent review determination, the Member continues to receive services until a decision is made and written notification is sent to the provider. Partnership is not required to notify the Member of a concurrent decision as the Member is not at financial risk for the services being requested.

D. UM or Pharmacy Administrative Denials (Not Subject to the Appeal Process)
1. UM or Pharmacy licensed clinical staff may process the following list of administrative denials for determinations based on administrative criteria only (determinations not based on medical necessity criteria).
   a. A TAR is not required
   b. Duplicate request
   c. TAR or service line not accepted due to invalid procedure code (CPT or HCPCS)
2. Administrative denials are not subject to the appeal process.
3. Each month a report of all administrative denials is reviewed and signed by the Chief Medical Officer or Physician Designee.
4. If a provider has received an administrative denial and believes the decision was based on incorrect information, the provider should submit a NEW Treatment Authorization Request (TAR) to the Health Services Department with the required documentation, within the timeframes defined for submission, so that the TAR may be processed. [See policy MCUP3041 Treatment Authorization Request (TAR) Review Process.]

VII. REFERENCES:

A. In compliance with the California Department of Health Care Services (DHCS) contract, specifically Exhibit A, Attachment III. 2.3 Utilization Management Program and Exhibit A, Attachment III. 4.6 Member Grievance and Appeal System
B. California Health and Safety Code (HSC) 1367.01(h)(3)
C. Title 42 Code of Federal Regulations (CFR) Section 438.408 (f)(1)
D. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (*Revised* 08/31/2022)
E. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2025) UM 7 Denial Notices

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Policy/Procedure Title: Appeals of Utilization Management/ Pharmacy Decisions			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994		**Next Review Date: 06/11/2026** **Last Review Date: 06/11/2025**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

VIII. DISTRIBUTION:
A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 10/10/97 (name change only); 05/17/00, 09/20/00; 04/18/01; 01/16/02; 08/20/03; 10/20/04; 10/19/05; 10/17/07; 10/15/08; 04/21/10; 08/15/12; 01/20/16; 10/19/16; 04/19/17; 08/16/17; *09/12/18; 08/14/19; 08/12/20; 08/11/21; 11/10/21; 05/11/22; 05/10/23; 05/08/24; 06/11/25

*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.

PREVIOUSLY APPLIED TO:
MCUP3057 - Provider Appeals of Health Services Administrative Denials was archived 08/14/2019

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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.