PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3041 (previously UP100341)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Treatment Authorization Request (TAR) Review Process</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: (UM-2) 04/25/1994
(Effective 06/19/2013 - TAR/RAF Review Policy split)</td><td colspan="4">Next Review Date: 06/12/2025
Last Review Date: 06/12/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<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: 06/12/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MPUP3026 – Inter-Rater Reliability Policy
C. MCUP3141 – Delegation of Inpatient Utilization Management
D. MPUD3001 – Utilization Management Program Description
E. MCRP4068 – Medical Benefit Medication TAR Policy
F. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
G. CGA024 – Medi-Cal Member Grievance System
H. CMP36 – Delegation Oversight and Monitoring
I. CMP26 – Verification of Caller Identity and Release of Information
J. CMP30 – Records Retention and Access Requirements

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity: Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
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. Cosmetic Surgery: Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
D. Urgent Request: A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:
   1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, ***or***

2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

E. Non-urgent Request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the Member or the Member's ability to regain maximum function and would not subject the Member to severe pain.

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

G. Pre-service Request: A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.

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

IV. ATTACHMENTS:

A. Partnership TAR Requirements list (including Outpatient Surgical Procedures CPTs Requiring TAR list and Pain Management CPTs Requiring TAR list

V. PURPOSE:

To describe the procedures used by the Partnership HealthPlan of California (Partnership) Utilization Management (UM) Department to process Referral Authorization Forms (RAFs) and Treatment Authorization Requests (TARs) based upon the medical necessity of the request.

VI. POLICY / PROCEDURE:

A. GENERAL PROCEDURES

1. Partnership pays for authorized services according to the specific terms of each physician, hospital, or other provider contract. Partnership will reimburse only if individuals are eligible at the time the service is rendered.
2. Resources necessary to help in determining review decisions, include, but are not limited to the published, current, InterQual® criteria; Medi-Cal (State of California) criteria, Medicare criteria, and Partnership internally developed and approved guidelines. Determinations also take into account individual member needs and characteristics of the local delivery system.
   a. The Provider of service must verify eligibility of the Member via Partnership systems at the time of service. This verification is necessary for all service authorizations.
   b. Partnership's Online Services (OLS) portal https://provider.partnershiphp.org/UI/Login.aspx is available to verify eligibility and determine the Member's assigned primary care provider (PCP). Information required to verify the eligibility of an individual is as follows:
      1) Provider NPI (National Provider Identifier)
      2) Member Social Security number or Partnership Member ID number
      3) Date of Service
3. TARs are not processed by Partnership until the TAR form is complete and includes all member information and all attachments noted on the TAR are received. When completing information fields for the provider of service and service(s) being requested, the correct and valid codes must be utilized.
4. Authorizations are only valid for the timeframe approved by Partnership. If the timeframe is exceeded due to an unforeseen delay, the Provider may submit a request for an extension of the time period, noting the reason for the delay.

5. Since 2014, all TARs and related materials including worksheets, letters, and other documentation, are scanned and stored electronically. Electronic files are maintained and archived with appropriate backup both on and off-site. Paper records prior to 2014 are archived and stored offsite. Records are maintained as noted:
    a. For Members age twenty-one (21) and over, archived materials are kept for a minimum of 10 years.
    b. For Members under the age of twenty-one (21), archived materials are kept until the Member reaches the age of twenty-one (21) or for ten (10) years, whichever is longer.

B. SERVICES REQUIRING TREATMENT AUTHORIZATION

1. Certain procedures, services, and medications require prior authorization from Partnership before reimbursement is made. Those services requiring a Treatment Authorization Request (TAR) are listed as attachments to this policy. The attachment consists of:
    a. Partnership TAR Requirements List
    b. HCPCS Codes Requiring a TAR
    c. Outpatient Surgical Procedures Requiring TAR
    d. Pain Management CPTs Requiring TAR
2. For those providers contracting with Partnership, if a Member has primary coverage through Medicare Part A, a TAR is not required until the Member exhausts the benefits available under Medicare. Once benefits have been exhausted, the TAR must be submitted along with written verification from Medicare that the benefits have been exhausted. The TAR must be submitted within 15 business days of the date the benefits exhausted or within 60 calendar days of retrospective eligibility.
    a. Exception: If the provider receives a denial from Medicare or any other primary payor source, they must submit a TAR to Partnership's Health Services Department, along with a copy of the Medicare denial and the medical record documentation. The TAR must be received by Partnership within 60 calendar days of the issue date of the denial from Medicare or the other payor source.
3. TARs are not required for services related to emergency services, minor consent, family planning and preventive services, basic prenatal care, sexually transmitted disease services and human immunodeficiency virus (HIV) testing.
4. Authorizations granted for single-encounter, outpatient medical services (diagnostic imaging, dental anesthesia, sleep studies, surgical procedures, interventional pain management procedures, genetic testing, and laboratory studies) will be limited to a 6-month authorization period. Services excluded from this limit will include: Transplants, Dialysis, Palliative Care, Cardiac Rehabilitation, and Pulmonary Rehabilitation. Please note this limit is only applicable to single-encounter, outpatient medical services requiring a TAR. Requests for extension of authorization when a service is not rendered within the authorization period should continue to be submitted as a correction (as described in VI.C.8 below) and will be reviewed on a case by case basis.

C. TAR SUBMISSION PROCESS

TARs for Members who require services should be submitted electronically via Partnership's Online Services (OLS) portal https://provider.partnershiphp.org/UI/Login.aspx. TARs must be received by Partnership within fifteen (15) business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.) Electronic submission will allow for more expedient processing. If online submission is not possible, the TAR may be submitted via fax (707) 863 - 4118 or mail to Partnership's Health Services Department for review.

1. Urgent TAR Requests

Urgent TAR submission is available for requests in which the provider indicates, or Partnership determines, that the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function. Requests for an urgent determination should be submitted by the provider and clearly marked "Urgent" or "Expedited" and should indicate reason there is an urgent need for authorization. A TAR for an elective (non-emergent) surgery submitted urgently due only to an imminent date of service is NOT considered to be urgent. TARs submitted under these circumstances will be reviewed as a non-urgent pre-service request.

2. Non-urgent Elective Requests
   a. All elective inpatient hospital admissions require prior authorization EXCEPT anticipated two (2) day post vaginal delivery stays and four (4) day post C-Section stay. Obstetrical admissions do not require a TAR prior to admission, for obstetrical delivery. The hospital must notify Partnership if the mother and/or baby require additional days of acute care. The Nurse Coordinator concurrently reviews the case within 24 hours (1 calendar day) of receipt of clinical information.
   b. A service being provided that is not pregnancy related requires the admitting physician to submit the TAR for the elective procedure prior to the actual hospital admission. Although an approved TAR will assign a specified number of initial days approved, the hospital is required to notify Partnership within one business day of the actual date of admission. Please note that Partnership will assign a number of initially approved days, however, it is the hospital's responsibility to notify Partnership within one business day of the date of the actual admission. If the patient's condition necessitates hospitalization beyond the pre-approved timeframe, Partnership will perform concurrent review on the remainder of the stay.
   c. Authorization for non-obstetric elective hospital admissions must be submitted by the admitting physician and include the following:
      1) Procedure code or service being performed
      2) Facility where procedure will be performed
      3) Anticipated date of procedure
      4) Number of days being requested if inpatient admission
      5) Diagnosis
   d. Managed care plans are not required to cover cosmetic surgery (see definition in III.C).
3. Emergency Admissions
   a. For all emergency and obstetrical admissions, the hospital or long term care (LTC) facility must notify Partnership and the Member's PCP of the admission as soon as possible, but not later than the first business day following the date of admission.
   b. The case is reviewed by the Nurse Coordinator and a decision on length of stay is authorized based on Partnership established criteria within 24 hours (1 calendar day).
4. Dialysis Services
   a. Initial TAR requests for Dialysis services for Members who have no other insurance will be authorized for a 90 calendar day period only.
   b. Per CCR Title 22 section 50763, "Medi-Cal beneficiaries must apply for any available health care coverage when no cost is involved." All Members receiving dialysis must submit an application to Social Security for Medicare benefits.
   c. The provider must submit a denial from Medicare for Partnership to approve services beyond the initial 90 calendar days.
   d. Once a Medicare determination of denial of coverage is received, Partnership will issue a TAR that will remain valid for the Member's lifetime or until the Member receives a kidney transplant.
5. Hospice Services

Hospice services require a TAR ONLY for inpatient services (i.e. acute or skilled nursing facility [SNF]/LTC facility.) However, a Hospice election form signed by the Member or their legal representative must accompany any initial claim for hospice services (all outpatient and inpatient services).

6. Long Term Care/Skilled Nursing Services
   All Skilled Nursing or Long Term Care facility admissions require approval prior to the admission, and throughout the length of stay.
   a. When a Member is admitted for custodial care, a TAR submission may be approved for an initial six (6) month period and the Member's condition will be re-evaluated at six (6) month increments.
   b. For continued custodial care, a new TAR must be submitted within 15 calendar days of the expiration date of the original TAR.
7. Post-service (Retrospective) Requests
   Retrospective (Retro) TARs must be received by Partnership within fifteen (15) business days of the date of service or within 60 calendar days of a denial from the primary insurance carrier. (Note that if a provider incorrectly submits a TAR for a Partnership member to the State Medi-Cal field office, Partnership will apply these timeliness requirements beginning on the date the request is received in our office.) Retro TARs received after that timeframe are considered for review only under the following conditions:
   a. When a Member does not identify theirself to the provider as a Partnership Member by deliberate concealment or because of physical or mental incapacity to so identify theirself.
   b. If a Member has obtained retroactive eligibility. The TAR must be received by Partnership within 60 calendar days of the Member having obtained Medi-Cal eligibility.
8. Correction TAR Requests
   a. The provider has up to 12 months from the approved date of the ORIGINAL authorized TAR to submit modifications of approved services. A new TAR must be submitted with the requested modifications and MUST reference the ORIGINAL TAR number and code(s) or date(s) to be modified. Modifications will be accepted or made only on approved TARS for the following:
      1) Types of service. For example, only similar items or procedures may be modified (e.g. micropore tape versus paper tape, right wheels versus left wheels, etc.).
      2) Minor extension or change of dates may be requested (e.g. start of service May 15 versus May 20).
      3) Units of service (e.g. 9 visits versus 6 visits). This usually coincides with a change of, or extension of, dates of service requested.
9. Note that if a provider incorrectly submits a TAR for a Partnership Member to the State Medi-Cal field office, Partnership applies timeliness requirements to that request. If the Member was eligible with Partnership at the time of the request, TARs submitted beyond the 15 business day requirement are considered late but will still be reviewed for medical necessity.

D. UM REVIEW PROCESS

1. Nurse Coordinator Review
   A Nurse Coordinator can approve, modify, defer (pend) or deny the TAR for non-medical necessity determinations. The Nurse Coordinator reviews the information received from the provider utilizing Partnership approved review guidelines. The Nurse Coordinator approves the request if it meets medical necessity criteria. Requests that do not meet review guidelines and require clinician review due to questions of medical necessity are referred to the Chief Medical Officer (CMO) or Physician Designee for further evaluation. The Nurse Coordinator attaches all relevant documentation, InterQual® criteria and the Medical Director Worksheet. ONLY the Chief Medical Officer or Physician Designee can deny TARs for reasons of medical necessity.

2. Chief Medical Officer / Physician Designee Review
    a. The Chief Medical Officer or Physician Designee must be available physically or by telephone during business hours to assist with evaluating TAR requests.
    b. The Chief Medical Officer or Physician Designee review is done in all cases of potential denial due to medical necessity, interpretation issues, or other issues as requested by the UM staff. Partnership's Chief Medical Officer or Physician Designee reviews all TARs referred to him/her, taking the action deemed appropriate.
    c. The Chief Medical Officer or Physician Designee may contact involved providers or consultants for additional information as required to assist them in rendering a decision about the case. They may contact the requesting provider for further information. The Chief Medical Officer or Physician Designee documents the rationale for any decision on the Medical Director Worksheet. Once the Chief Medical Officer or Physician Designee approves or modifies the request, the TAR will be returned to the Nurse Coordinator for completion.
    d. The Chief Medical Officer or Physician Designee is the only person authorized to sign denials for medical necessity or to make any exceptions or modifications to the established Partnership medical criteria. Denials for medical necessity are made only by the Chief Medical Officer or Physician Designee.
    e. Partnership makes a physician reviewer available (Chief Medical Officer or Physician Designee) to discuss medical necessity determinations with providers by telephone (peer to peer review).
    f. For information on the process for a Member, Member's authorized representative, or a provider on behalf of a Member, to appeal Partnership UM decisions, see Partnership policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.
3. Delegated Entity Review
    a. Partnership uses delegated entities to perform some aspects of utilization management. They make determinations on service requests for their assigned Members. All delegates will follow the decision making and notification timeframes set out below in section VI.D.6. for medical and behavioral health services.
    b. Partnership's Associate Director of UM Regulations is responsible for monitoring the Utilization Management activities of delegated entities. On a daily basis (during business days), the UM Associate Director of UM Regulations and the Delegation Program Manager monitor authorizations performed by delegated entities through Partnership's electronic authorization system. On a weekly basis, they generate timeliness reports for all delegated entities and analyze trends. Delegated entities are notified immediately of any areas of concern. On a quarterly basis, timeliness data reports are prepared for review and audit with each delegated entity. Reports are also reviewed by the CMO or physician designee at least annually or more often as needed if areas of concern are noted.
    c. Multi-specialty medical groups do not require pre-authorization from Partnership for services for which they are delegated. All elective hospital admissions must be pre-authorized by the medical group and reported to Partnership at the time of admission.
4. Non-Contracted Hospital Review
    a. Elective admissions to non-contracted hospitals require approval of a TAR, which is subject to Partnership's timeline policies. When the admission is elective and has been given prior authorization, no further communication is required until the approved number of days is nearing expiration and the Member is expected to remain hospitalized beyond the days previously approved. The facility is required to provide to the Nurse Coordinator appropriate clinical information supporting the medical necessity of continued stay.
    b. As most admissions to non-contracted hospitals are for emergency conditions, the procedure for non-contracting hospital review is as follows:

1) If the admission does not meet admission criteria, it is referred to the Chief Medical Officer (CMO) or Physician Designee for review. The Nurse Coordinator notifies the non-contracting hospital of the Chief Medical Officer or Physician Designee's decision and provides the process for appeal or the opportunity to discuss the determination with the CMO/Physician Designee (peer to peer review).
2) Until the Member is medically stable for discharge or transfer to a lower level of care, clinical review should be sent to Partnership's Nurse Coordinator.
3) For a Member capitated to an in-plan hospital who is admitted to a non-capitated hospital, please refer to policy MCUP3141 Delegation of Inpatient Utilization Management.

5. Post Stabilization Services
   Upon receipt of an authorization request from an emergency services provider, UM shall render a decision within 30 minutes or the request is deemed approved, pursuant to Title 42 CFR section 438.114 and Title 28 CCR Section 1300.71.4.
6. UM Decision and Notification Timelines
   a. Urgent Concurrent Review
      1) For urgent concurrent review, Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours.
      2) If the request to extend urgent concurrent care was not made prior to 24 hours before the expiration of the authorized period of time or number of treatments, the request will be reviewed as an urgent pre-service and a decision will be rendered within 72 hours from the original date of receipt.
      3) If the request to approve additional days for urgent concurrent care is related to care not approved by Partnership previously, Partnership will attempt to obtain necessary information related to the request within 24 hours. The decision will be rendered no later than 72 hours from the original date of receipt of the request. For urgent concurrent denials, Partnership may inform the hospital Utilization Review (UR) department staff of the decision, with the understanding that staff will inform the attending/treating prescriber.
      4) If it is determined that additional information is required, or if a Member requests an extension, Partnership will extend the time frame one time by up to 14 calendar days. Partnership will document the specific reason for the extension in Partnership's electronic authorization system. The provider is then notified immediately in writing of the extension and what specific additional information is required to complete the review.
      5) Electronic or written notification of the decision is communicated to the provider within 24 hours of the decision, and no later than 72 hours after receipt of the request. If the time frame was extended, the provider will be notified at the time of decision, but no longer than 72 hours from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request. Partnership is not required to notify the Member of an urgent concurrent decision as the Member is not at financial risk for the services being requested.
   b. Urgent Pre-service Review
      1) For urgent pre-service review, Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours.
      2) If it is determined that additional information is required, or if a Member requests an extension, Partnership will extend the time frame one time by up to 14 calendar days. Partnership will document the specific reason for the extension in Partnership's electronic authorization system. The Member and the provider are then notified immediately in writing of the extension and what specific additional information is required to complete the review. Any decision delayed beyond the time limits will be escalated to a Physician Designee for

review of medical necessity. Partnership will re-review the request if the clinical information requested is received after a decision has been made.

3) Electronic or written notification of the decision and how to initiate a routine or expedited appeal, if applicable, is communicated to the provider within 24 hours of the decision and no later than 72 hours from the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision. If the time frame was extended, the notification is communicated at the time of decision, but no later than 72 hours from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request.

c. Non-urgent Pre-service Review and Non-urgent Concurrent and Review

1) For non-urgent pre-service review, Partnership will render a decision (approve, modify, defer/pend, deny) within five (5) business days from the receipt of the request, but no later than 14 calendar days from the receipt of the request.
2) For non-urgent concurrent review (inpatient care e.g. LTC/SNF), Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours of receipt of the request and will continue concurrently reviewing the authorization within one (1) business day of receipt each time clinical information is received.
3) If the request is received during non-business hours, Partnership will process the request the next business day.
4) If the TAR lacks clinical information necessary to render a decision, the TAR may be deferred/pended up to 14 calendar days from the date of the original receipt of the request. Partnership will document the specific reason for the extension in Partnership's electronic authorization system. The Member and the Provider are then notified immediately in writing of the extension and what specific additional information is required to complete the review. In addition to electronic or written notification, the UM Staff will contact the Provider and/or designated office staff member to remind them of the specific information requested and the regulatory timeframe for submission. In the event that a Member requests an extension on a deferred/pended TAR with Partnership's grievance department, or if Partnership determines an extension of the pended request is in the best interest of the Member after the initial 14 calendar days are exhausted, Partnership may extend the deferred/pended period up to an additional 14 calendar days, for a total of 28 calendar days from the original date of receipt of the request. Any decision delayed beyond the time limits will be escalated to a Physician Designee for review of medical necessity. Partnership will re-review the request if the specified clinical information requested is received after a decision has been made.
5) Notification of Decision:
    a) Non-urgent pre-service review: Electronic or written notification of the decision and how to initiate a routine or expedited appeal, if applicable, is communicated to the provider within 24 hours of the decision and written notification is mailed to the Member within two (2) business days of the decision. If the time frame for the review was extended, the notification will be provided at the time of decision, but no longer than five (5) business days from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request or 28 calendar days if a second extension is applied.
    b) For a non-urgent concurrent review, electronic or written notification of the decision is communicated to the provider within 24 hours of the decision and no later than 72 hours after receipt of the request. Partnership is not required to notify Members of non-urgent concurrent review decisions as the Member is not at financial risk for the

services being requested.

d. Post-service (Retrospective) Review
   1) For post-service review, Partnership will render a decision (approve, modify, defer/pend, deny) no longer than 30 calendar days from the receipt of the request.
   2) Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable, is communicated to the provider within 24 hours of decision, but no longer than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision.

E. MONITORING OF THE TAR PROCESS
1. Aggregate TAR data is subject to retrospective analysis by Partnership's UM Department. This review is designed to:
   a. Identify individual provider practice patterns relative to standards of medical practice.
   b. Evaluate over and under-utilization of services.
2. Partnership monitors turnaround times of internal processing for compliance with standards.
3. Denials or modifications for medical necessity are monitored weekly to ensure accuracy in regulatory requirements, review processes, and correspondence.
4. Partnership performs inter-rater reliability audits as outlined in policy MPUP3026 Inter-Rater Reliability Policy, at least biannually on both physician and nurse reviewers.
5. Member & provider grievances, as well as Partnership's member and provider satisfaction survey responses, serve as an evaluation tool.
6. Administrative denials (as defined in policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions) are reviewed monthly by the Chief Medical Officer. A summary is presented to the Internal Quality Improvement Committee (IQI) at least annually or more often as needed.
7. 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:
   a. Consistent with sound clinical principles and processes
   b. Evaluated and updated at least annually
   c. 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
   d. 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.
   e. Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

F. COMMUNICATION SERVICES
1. Partnership provides access to staff for members and practitioners seeking information about the UM process and the authorization of care in the following ways:
   a. Calls from Members are triaged through Member Services staff who are accessible to practitioners and Members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
   b. Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
   c. After normal business hours, Members may contact the advice nurse line at (866) 778-8873 for clinical concerns.

d. Practitioners both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
   1) Partnership has a dedicated after-hours local phone number (707) 430-4808 or toll free number (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Officer or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a Member whose emergency medical condition is stabilized.
   2) For information on utilization management procedures (prior authorization requirements, Clinical Protocols and Practice Guidelines) refer to Partnership's Provider Manual, Section 5: Health Services at www.partnershiphp.org. For information on how to submit claims, refer to Partnership's Provider Manual, Section 3: Claims at www.partnershiphp.org.

e. Partnership has a toll free number (800) 863-4155 that is available to either members or practitioners.

f. UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues. For a list of UM Program Staff and Assigned Responsibilities, please refer to policy MPUD3001 Utilization Management Program Description.

2. Linguistic services to discuss UM issues are provided by Partnership to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries for population groups as determined by contract. These services include the following:
   a. No cost linguistic services
      1) Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
      2) Written informing materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated into threshold languages in accordance with regulatory timeframes and into other languages or alternative formats as indicated in the Member's record or upon request. Material formats include audio, large print and electronically for Members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
      3) Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711] .
3. Partnership regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 5 Utilization Management
B. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights"

Templates (08/31/2021)

C. DHCS All Plan Letter (APL) 22-012 *Revised* Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (12/30/2022)
D. California Health and Safety Code (HSC) Sections 1363.5 and 1367.01(h)(3)
E. Title 42 Code of Federal Regulations (CFR) section 438.114 and Title 28 California Code of Regulations (CCR) Section 1300.71.4
F. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2024) UM 5 Timeliness of UM Decisions Elements A and E

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: TAR Procedure [UM-2]: 11/19/96; 12/15/99; 01/12/00 – RAF Procedure [UM-1]: 12/27/95; 05/27/99); (TAR/RAF [UP100341] - 06/21/00; 04/18/01; 03/20/02, 05/21/03 attachments revised 10/01/03; 04/21/04; 01/19/05; 04/20/05; 09/21/05, 10/18/06, 08/20/08, 07/15/09; 05/19/10; 07/20/11); 06/19/13; 06/17/15; 09/16/15; 05/18/16; 04/19/17; *06/13/18; 02/13/19; 05/08/19; 09/11/19; 04/08/20; 09/09/20; 04/14/21; 08/11/21; 05/11/22; 06/14/23; 06/12/24

*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: N/A

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Administrative denials are reviewed monthly by the Chief Medical Officer and monitored quarterly to identify trends and/or the need for additional provider education, outreach, or other intervention. A summary is presented to the Internal Quality Improvement Committee every six months. 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.