DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF PLAN MONITORING
DIVISION OF PLAN SURVEYS

TECHNICAL ASSISTANCE GUIDE

UTILIZATION MANAGEMENT

ROUTINE MEDICAL SURVEY

OF

PLAN NAME

DATE OF SURVEY:

PLAN COPY

Issuance of this July 6, 2026 Technical Assistance Guide renders all other versions obsolete.

FULL SERVICE TAG

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This Technical Assistance Guide (TAG) serves as a guide for medical surveys which are conducted under the Health and Safety Code medical survey statutes and regulations. This TAG may be revised as appropriate, to incorporate new or updated relevant legal requirements as they impact the surveys, or for any other reason as determined by the Department. Health plans are responsible for complying with applicable statutes and regulations upon their effective dates and, therefore, are deemed to have prior notice of all statutes and regulations effective during the medical survey period. Health plans may be assessed for compliance with those requirements even when they have not yet been added to the TAG. The Department's medical survey authority is broad, and includes, but is not limited to, reviewing books and records, conducting interviews, making site visits, and making telephone calls to verify information as part of the survey assessment of any Key Element question in this TAG. The recipients of these telephone calls may include, but not be limited to, health plan and delegate physicians/medical directors, plan customer service representatives, triage nurses, and/or network/contracted providers.

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Requirement UM-001: UM Program Policies and Procedures

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

Staff responsible for the activities described above, for example:

- Medical Director and/or senior physician responsible for UM
- UM Director

DOCUMENTS TO BE REVIEWED

- UM policies and procedures, including organization charts and committee descriptions (A UM program description may be substituted or in addition to policies and procedures).
- Job description of the Medical Director responsible for ensuring the UM process complies with Section 1367.01.
- Copy of licenses of the Medical Directors.
- UM committee reports and meeting 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 Plan has compliant utilization management policies and procedures. CA Health and Safety Code section 1367.01(b).**

Assessment Questions
1.1 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 health care services for Plan enrollees? **Section 1367.01(b)**
1.1 Comments
1.2 Do policies and procedures include utilization review processes such as prospective review, concurrent review, and retrospective review? **Section 1367.01(b)**
1.2 Comments
1.3 Have the Plan's UM policies and procedures been filed with the Director for review and approval? **Section 1367.01(b)**
1.3 Comments

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UM-001 - Key Element 2:

2. **A designated Medical Director is responsible for ensuring medical necessity decision making compliance and holds an unrestricted license to practice medicine in California.**
   CA Health and Safety Code section 1367.01(c).

Assessment Questions	
2.1	Does the designated Medical Director ensure the process by which the Plan reviews medical necessity decisions complies with the requirements of Section 1367.01? **Section 1367.01(c)**
2.1 Comments	
2.2	Does the designated individual hold a current unrestricted license to practice medicine in California? **Section 1367.01(c)**
2.2 Comments	

UM-001 - Key Element 3:

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

Assessment Questions	
3.1	Does the Plan maintain telephone access for providers to request authorizations for health care services? **Section 1367.01(i)**
3.1 Comment	

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

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Requirement UM-002: UM Decision Making and Timeframes

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

Staff responsible for the activities described above, for example:

- UM Director/Managers
- Medical Director and/or senior physician responsible for UM

DOCUMENTS 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.
- UM denial and modification files.

UM-002 - Key Element 1:

1. **Only licensed physicians, or appropriately licensed health care professionals, make decisions to deny or modify requested services on the basis of medical necessity - and the Plan requests only information reasonably necessary to make determinations.**
   CA Health and Safety Code sections 1367.01(e) and (g).

Assessment Questions	
1.1	Does the Plan ensure that only licensed physicians 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? **Section 1367.01(e)**
1.1 Comments	
1.2	Do the Plan's UM files show that if additional medical information from providers is needed in order to determine whether to approve, modify, or deny requests for authorization, the Plan requests only information reasonably necessary to make the determination? **Section 1367.01(g)**
1.2 Comments	

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UM-002 - Key Element 2:

2. The Plan communicates decisions to approve, modify, or deny requests within the appropriate timeliness requirements.
CA Health and Safety Code sections 1367.01(h)(1), (2), (3), and (5).

Assessment Questions
2.1 Does the Plan make decisions to approve, modify, or deny requests by providers in a timely fashion, 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? (This applies to requests prior to, or concurrent with the provision of health care services to enrollees.) **Section 1367.01(h)(1)**
2.1 Comments
2.2 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 72 hours after the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination? (This applies to requests prior to, or concurrent with the provision of health care services to enrollees.) **Section 1367.01(h)(2)**
2.2 Comments
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 within 24 hours of the decision and then in writing? **Section 1367.01(h)(3)**
2.3 Comments
2.4 Does the Plan communicate UM decisions to approve, deny, delay, or modify health care services to enrollees in writing within 2 business days of the decision? **Section 1367.01(h)(3)**
2.4 Comments
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.) **Section 1367.01(h)(5)**
2.5 Comments

2.6	Upon receipt of the requested information, does the Plan make decisions to approve, modify, or deny the request within the required timeframe? **Section 1367.01(h)(5)**
2.6 Comments	
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 30 days after the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination? **Section 1367.01(h)(1)**
2.7 Comments	

UM-002 - Key Element 3:

3. In cases of concurrent review, care shall not be discontinued until a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.
CA Health and Safety Code section 1367.01(h)(3), (4).

Assessment Questions	
3.1	Does the Plan demonstrate treating providers can easily contact the Plan physician that made the adverse decision? **Section 1367.01(h)(4)**
3.1 Comments	
3.2	Does the plan demonstrate concurrent review decisions, pertaining to care that is underway, are communicated to the enrollee's treating provider within 24 hours of the Plan's decision to deny, delay, or modify all or part of the requested health care service? **Section 1367.01(h)(3)**
3.2 Comments	
3.3	Does the Plan demonstrate in concurrent review cases, care is not discontinued until, (1) the treating provider been notified of the Plan's decision AND (2) a care plan been agreed upon by the treating provider that is appropriate for the medical needs of the patient? **Section 1367.01(h)(3)**
3.3 Comments	

End of Requirement UM-002: UM Decision Making and Timeframes

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Requirement UM-003: UM Criteria Development

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

Staff responsible for the activities described above, for example:

- UM Director
- Medical Director or designee
- Senior mental health clinical officer

DOCUMENTS TO BE REVIEWED

- UM policies and procedures and/or program document outlining development and approval of UM criteria.
- UM review 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 Section 1363.5(b)(1)-(3) and (5) requirements.

CA Health and Safety Code section 1363.5 (b); CA Health and Safety Code section 1367.01(f); Assessment Questions
1.1 Does the Plan utilize criteria/guidelines when determining the medical necessity of requested health care services? **Section 1363.5(b)**
1.1 Comments
1.2 Are criteria/guidelines developed with involvement from actively practicing health care providers? **Section 1363.5(b)(1)**
1.2 Comments
1.3 Is there supporting documentation to confirm the criteria/guidelines are consistent with sound clinical principles and processes? **Section 1363.5(b)(2); Section 1367.01(f)**
1.3 Comments
1.4 Are the UM criteria/guidelines for making medical necessity decisions evaluated at least annually, and updated if necessary? **Section 1363.5(b)(3)**
1.4 Comments

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1.5	Are the Plan's criteria/guidelines used during utilization management functions available to the public upon request? **Section 1363.5(b)(5)**
1.5 Comments	

End of Requirement UM-003: Criteria Development

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Requirement UM-004: Communication Requirements for UM Decisions

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

Staff responsible for the activities described above, for example:

- UM Director
- Medical Director and/or senior physician responsible for UM decisions

DOCUMENTS 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 (h)(4); CA Health and Safety Code section 1374.30(i).

Assessment Questions
1.1 Does the Plan communicate denials or modifications of health care services to enrollees and providers in writing? **Section 1367.01(h)(4)**
1.1 Comments
1.2 Do written communications regarding decisions to deny, delay, or modify health care services provide a clear and concise explanation of the reasons for the Plan's decision? **Section 1367.01(h)(4)**
1.2 Comments
1.3 Do written communications regarding decisions to deny, delay, or modify health care services specify a description of the criteria or guidelines used for the Plan's decision? **Section 1367.01(h)(4); Section 1363.5(b)(4)**
1.3 Comments

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1.4	Do written communications regarding decisions to deny, delay, or modify specify the clinical reasons for the Plan's decision? **Section 1367.01(h)(4)**
1.4 Comments	
1.5	Do written communications to the requesting provider include the name of the health care professional responsible for the denial, delay, or modification? **Section 1367.01(h)(4)**
1.5 Comments	
1.6	Do written communications to the requesting provider include the direct telephone number or extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them? **Section 1367.01(h)(4)**
1.6 Comments	
1.7	Do written communications to an enrollee of a denial, delay, or modification of a request include information as to how the enrollee may file a grievance with the Plan? **Section 1367.01(h)(4)**
1.7 Comments	
1.8	Do written communications to the enrollee include information as to how the enrollee may request an independent medical review in cases where the enrollee believes health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers? **Section 1374.30(i)**
1.8 Comments	
1.9	Does the Plan prominently display in every: member handbook or relevant informational brochure, Plan contract, enrollee evidence of coverage forms, copies of Plan procedures for resolving grievances, letters of denials issued by either the Plan or its contracting organization, grievance forms required under Section 1368, and all written responses to grievances, information concerning the right of an enrollee to request an independent medical review in cases where the enrollee believes health care services have been improperly denied, modified, or delayed by the Plan? **Section 1374.30(i)**
1.9 Comments	

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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 required timeframes.
CA Health and Safety Code section 1367.01(h)(5).

Assessment Questions
2.1 If the Plan cannot make a decision to approve, modify, or deny the requested authorization within the timeframes specified in Section 1367.01(h)(1) and (2), is it because (1) the Plan is not in receipt of all of the information reasonably necessary and requested, or (2) because the Plan requires consultation by an expert reviewer, or (3) 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? **Section 1367.01(h)(5)**
2.1 Comments
2.2 If the Plan cannot make a decision with the required timeframe, does the plan, immediately upon the expiration of the timeframe specified in Section 1367.01(h)(1) and (2) or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, it notifies the provider and the enrollee in writing that the Plan cannot make a decision for the request for authorization within the required timeframe? **Section 1367.01(h)(5)**
2.2 Comments
2.3 Does the notification to the provider and enrollee (described in 2.2) also specify the information requested but not received, or the expert reviewer to be consulted, or the additional examination or tests required? **Section 1367.01(h)(5)**
2.3 Comments
2.4 If the Plan is unable to make a decision within the required timeframe, does the Plan notify the provider and enrollee of the anticipated decision date? **Section 1367.01(h)(5)**
2.4 Comments
2.5 If the Plan is unable to make a decision within the required timeframe because additional information reasonably necessary was requested, upon receipt of all information reasonably necessary and requested, it makes a decision within the required timeframes of Section 1367.01(h)(1) or (2), whichever applies? **Section 1367.01(h)(5)**

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2.5 Comments

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

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

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

Staff responsible for the activities described above, for example:

- UM Director
- Medical Director or designee
- Member Services staff
- Participating physician

DOCUMENTS TO BE REVIEWED

- Policies and procedures for disclosure of UM processes and criteria to providers, enrollees, and the public.
- Review policies and procedures for obtaining a second opinion.
- Review EOCs to verify inclusion of procedures for obtaining a second opinion
- 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 - Key Element 1:

1. **The Plan shall disclose to applicable required parties 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) and (c).

Assessment Questions	
1.1	Does the Plan disclose the UM process information to the Director and to network providers the Plan uses to authorize, modify, or deny health care services under the benefits provided by the Plan? **Section 1363.5(a)**
1.1 Comments	

1.2 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? **Section 1363.5(a)**
1.2 Comments
1.3 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."? **Section 1363.5(c)**
1.3 Comments

UM-005 - Key Element 2:

2. The Plan's Evidence of Coverage (EOC) provides notice of policy and information regarding the manner in which an enrollee may receive a second medical opinion.
CA Health and Safety Code section 1383.1(a).

Assessment Questions
2.1 Does the Plan's EOC provide all enrollees notice of the policy and information regarding the manner in which an enrollee may receive a second medical opinion? **Section 1383.1(a)**
2.1 Comments
2.2 Does the Plan's written policy describe how the Plan reviews requests for a second medical opinion? **Section 1383.1(a)**
2.2 Comments

UM-005 - Key Element 3:

3. The Plan provides or authorizes second opinions by a qualified health care professional if requested by an enrollee or a participating health professional within required timeframes and allows for non-medically necessary second opinions when applicable. The Plan ensures denials of requests for second opinions are communicated to enrollees in writing and include required grievance notices.
CA Health and Safety Code section 1383.15(a), (b), (c), (f), and (i).

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Assessment Questions
3.1 Does the Plan provide or authorize a second opinion by an appropriately qualified health care professional, if requested by an enrollee or participating health professional? **Section 1383.15(a)**
3.1 Comments
3.2 Does the Plan allow for non-medically necessary second opinions for any of the following reasons? (List is non-inclusive): **(1)** The enrollee questions the reasonableness or necessity of recommended surgical procedures. **Section 1383.15(a)(1)** **(2)** The enrollee questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition. **Section 1383.15(a)(2)** **(3)** The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis. **Section 1383.15(a)(3)** **(4)** The treatment plan in progress is not improving the enrollee's medical condition within an appropriate period of time given the diagnosis and plan of care, and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment. **Section 1383.15(a)(4)** **(5)** The enrollee has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care. **Section 1383.15(a)(5)**
3.2 Comments
3.3 When the enrollee faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the enrollee's ability to regain maximum function, does the Plan authorize or deny second opinion requests within 72 hours (or in a timely fashion appropriate for the nature of the enrollee's condition)? **Section 1383.15(c)**
3.3 Comments

3.4	When the enrollee's condition is non-urgent, does the Plan authorize or deny second opinion requests in an expeditious manner? **Section 1383.15(c)**
3.4 Comments	
3.5	If the enrollee requests a second opinion about care from a specialist, then does the Plan allow the enrollee to choose from any provider from any independent practice association or medical group within the network of the same or equivalent specialty to provide that opinion? **Section 1383.15(f)**
3.5 Comments	
3.6	If the enrollee requests a second opinion from an out of network specialist, then does the Plan incur the cost or negotiate the fee arrangement for the second opinion, beyond the applicable copayments paid by the enrollee? **Section 1383.15(f)**
3.6 Comments	
3.7	If the Plan denies the request for a second opinion, then are additional medical opinions not within the original physician organization the enrollee's responsibility? **Section 1383.15(f)**
3.7 Comments	
3.8	If the Plan denies an enrollee's request for a second opinion, then does the Plan notify the enrollee in writing of the reasons for the denial? **Section 1383.15(i)**
3.8 Comments	
3.9	If the Plan denies an enrollee's request for a second opinion, then does the Plan notify the enrollee in writing of his or her right to file a grievance with the Plan? **Section 1383.15(i)**
3.9 Comments	
3.10	If the Plan denies an enrollee's request for a second opinion, then does the Plan's written denial notice to the enrollee comply with CA Health and Safety Code section 1368.02(b)? **Section 1383.15(i)**
3.10 Comments	

End of Requirement UM-005:

Disclosure of UM Process to Authorize or Deny Services

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

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

Staff responsible for the activities described above, for example:

- UM Director
- QM Director
- Grievance Officer
- Medical Director

DOCUMENTS TO BE REVIEWED

- UM, Quality Assurance, Grievance and Appeals policies and procedures (related to utilization management/review decision-making and medical necessity appeals).
- Annual Work Plan(s), Committee minutes, trending reports, summaries, data analysis findings, and audit reports.
- Enrollee & Provider Satisfaction Surveys.
- Corrective action plans (internal and external) and evidence of implemented actions taken related to utilization management.
- Corrective action plans (internal and external) and evidence of implemented actions taken related to utilization review including the assessment of trends and evaluations of complaints.
- UM system review, demonstration, and workflows.
- Responsibilities and job/performance expectations, templates, job aids, for staff responsible for denying or modifying requests.

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(j), 1368.04(a), 1370, Rule 1300.68(b)(1), Rule 1300.70(b)(1)(D), (c).

Assessment Questions
1.1 As part of its QA program, has the Plan established and implemented a process to assess and evaluate its compliance with Section 1367.01, including (1) evaluation of complaints, (2) assessment of trends, (3) implementation of actions to correct identified problems, (4) 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 measurement of performance? **Section 1367.01(j), 1370**
1.1 Comments

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1.2	Does the Plan evaluate complaints related to UM? **Section 1367.01(j), 1368.04(a), Rule 1300.68(b)(1)**
1.2 Comments	
1.3	Does the Plan assess UM trends? **Section 1367.01(j), 1368.04(a), Rule 1300.68(b)(1)**
1.3 Comments	
1.4	Does the Plan implement corrective actions to correct identified UM problems? **Section 1367.01(j), 1368.04(a), Rule 1300.68(b)(1)**
1.4 Comments	
1.5	Does the Plan communicate actions and results, related to identified UM problems, to the appropriate health plan employees and contracting providers? **Section 1367.01(j), 1368.04(a), Rule 1300.68(b)(1)**
1.5 Comments	
1.6	Does the Plan evaluate UM related corrective action plans and measurements of performance? **Section 1367.01(j)**
1.6 Comments	
1.7	Is the Plan's assessment and evaluation of compliance with Section 1367.01 reasonable and adequately implemented and does it ensure appropriate care, consistent with professionally recognized standards of practice is not withheld or delayed for any reason? **Section 1367.01(j), 1370, Rule 1300.70(b)(1)(D), (c)**
1.7 Comments	

UM-006 - Key Element 2:

2. **The Plan has the organizational and administrative capacity to provide services to subscribers and enrollees, where medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management. CA Health and Safety Code section 1367 (g)**

Assessment Questions	
2.1	Does the Plan have the organizational and administrative capacity to provide services to subscribers and enrollees? **Section 1367(g)**
2.1 Comments	

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2.2	Does the Plan demonstrate medical decisions are unhindered by fiscal and administrative management? **Section 1367(g)**
2.2 Comments	

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

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Requirement UM-007: Terminal Illness Requirements and Compliance

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

Staff responsible for the activities described above, for example:

- UM Director
- Medical Director
- Officer or designee responsible for the grievance system
- Member Services Manager

DOCUMENTS TO BE REVIEWED

- Policies and procedures for denials involving services requested for an enrollee with a terminal illness.
- Policies and procedures regarding treatment, services, or supplies recommended by a participating Plan provider, but deemed experimental by the Plan.
- Standard complaint form.
- Sample of denial files to be reviewed onsite.
- Denial template letters for enrollees with a terminal illness.
- Delegated entity oversight reports, include oversight of standards in handling investigational/experimental denials.

UM-007 - Key Element 1:

**1. The Plan has established and implemented guidelines for identifying terminally ill patients and communicating UM decisions.
CA Health and Safety Code section 1368.1(a)(1)-(3) and (b).**

Assessment Questions	
1.1	Does the Plan have a process for identifying a terminally ill patient entitled to special handling? **Section 1368.1(a)**
1.1 Comments	
1.2	Does the Plan's definition of terminal illness conform to the Section 1368.1(a) definition of terminal illness: "an incurable or irreversible condition that has a high probability of causing death within one year or less"? **Section 1368.1(a)**
1.2 Comments	
1.3	Does the Plan's denial follow-up communication provide the enrollee a statement that includes the specific medical and scientific reasons for denying coverage? **Section 1368.1(a)(1)**
1.3 Comments	

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1.4 Does the Plan's denial follow-up communication include a description of alternative treatment, service, or supply covered by the Plan, if any? **Section 1368.1(a)(2)**
1.4 Comments
1.4 Does the Plan's denial follow-up communication include copies of the Plan's grievance procedures? **Section 1368.1(a)(3)**
1.5 Comments
1.6 Is the Plan's denial follow-up communication provided to the enrollee within 5 business days of receiving the request? **Section 1368.1(b)**
1.6 Comments
1.7 Does the complaint form provide an opportunity for the enrollee to request a conference as part of the grievance system? **Section 1368.1(b)**
1.7 Comments

End of Requirement UM-007: Terminal Illness Requirements and Compliance

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Requirement UM-008: UM Delegation Oversight

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

Staff responsible for the activities described above, for example:

- Plan Medical Director or designated QA physician
- Plan staff person responsible for the delegation
- Delegate staff person responsible for the delegation
- Delegate Medical Director
- Plan QA Manager
- Delegate QA Manager
- Plan QA coordinators that conduct audits of the delegates
- QA representatives from one or more provider delegates

DOCUMENTS 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 QA Program Description and Work Plan.
- Plan board or QA Committee or Subcommittee minutes which document review and oversight of delegated functions, 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-008 – Key Element 1:

1. The Plan has an oversight mechanism to ensure delegates are performing all delegated functions.
28 CCR 1300.70(b)(2)(B).

Assessment Questions	
1.1	To the extent the Plan delegates functions, do the Plan's documents show the Plan has an oversight mechanism to ensure its delegates adequately perform those functions? **Rule 1300.70(b)(2)(B)**

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1.1 Comments

End of Requirement UM-008: UM Delegation Oversight

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Requirement UM-009: Standing Referrals

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

Staff responsible for the activities described above, for example:

- Medical Director
- Director of Provider Relations
- UM Director

DOCUMENTS TO BE REVIEWED

- Policies and procedures for standing referrals of enrollees.
- Plan reports on monitoring of standing referrals.
- Plan reports on monitoring of standing referrals at UM delegated entities.
- Policies and procedures regarding identifying appropriate specialists and specialty care centers for standing referrals.
- Corrective action plans.

UM-009 - Key Element 1:

1. **The Plan has established an established procedure for (a) standing referrals of enrollees who need continuing care from a specialist, and (b) referrals of enrollees who require specialized care over a prolonged period of time for the purpose of having the specialist coordinate the enrollee's health care.**
   CA Health and Safety Code section 1374.16(a), (b), and (f)

Assessment Questions	
1.1	Does the Plan have an established procedure for standing referrals for enrollees who need continuing care from a specialist? **Section 1374.16(a); Section 1374.16(f)**
1.1 Comments	
1.2	Does the Plan have an established procedure for referrals to specialists or specialty care centers that have expertise in treating enrollees with a condition or disease that requires specialized medical care over a prolonged period of time and is life threatening, degenerative, or disabling? **Section 1374.16(b)**
1.2 Comments	

UM-009 - Key Element 2:

2. **The Plan makes referrals to a specialist or specialty care center that has demonstrated sufficient expertise in treating the condition or disease.**

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CA Health and Safety Code section 1374.16(b) and (e); 28 CCR 1300.74.16(e) and (f).

Assessment Questions	
2.1	Does the Plan have a process for validating specialists and specialty care centers are accredited or designated as having special expertise? **Section 1374.16(e)**
2.1 Comments	
2.2	Does the Plan have a definition of and credentialing process for HIV/AIDS specialists? **Rule 1300.74.16(e)(1)-(4)**
2.2 Comments	
2.3	Does the Plan refer to a specialist or specialty care center that has demonstrated expertise in treating the condition or disease? **Section 1374.16(b) and (e); Section 1300.74.16(f)**
2.3 Comments	

UM-009 - Key Element 3:

3. When a specialist or specialty care center has been approved to coordinate the enrollee's health care, the Plan approves the specialist to provide health care services within the specialist's area of expertise and training in the same manner as it approves the enrollee's primary care physician's services, subject to the terms of the treatment plan.
CA Health and Safety Code section 1374.16(b).

Assessment Question	
3.1	Does the Plan demonstrate that it complies with Section 1374.16(b) and approves the specialist to provide health care services within the specialist's area of expertise and training in the same manner as it approves the enrollee's primary care physician's services, subject to the terms of the treatment plan? **Section 1374.16(b)**
3.1 Comments	

End of Requirement UM-009: Standing Referrals

FULL SERVICE TAG

Requirement UM-010: Post-Stabilization

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

Staff responsible for the activities described above, for example:

- UM Director/Managers
- Medical Director and/or senior physician responsible for UM
- Staff member who receives and or responds to provider requests for post-stabilization care

DOCUMENTS TO BE REVIEWED

- UM policies and procedures, including UM decision timeframe requirements.
- Policies and procedures regarding responses to, authorization of, or payment for post-stabilization claims.
- Organization charts, committee descriptions and key staff job descriptions of staff involved in UM review.
- Sample UM denial template letters.
- Sample of UM denial files to be reviewed onsite.

UM-010 - Key Element 1:

1. The Plan arranges for post-stabilization care after the enrollee has been stabilized following an emergency condition, but the provider believes further medically necessary health care treatment is required, and the enrollee cannot be safely discharged.

CA Health and Safety Code section 1262.8; CA Health and Safety Code section 1317.1(a)(2)(A), (b), (j), (k)(1) and (2); CA Health and Safety Code section 1317.4a.(a) and (c) through (f); CA Health and Safety Code section 1371.4; 28 CCR 1300.71.4(b)(1),(2) and (d).

Assessment Questions
1.1 Does the Plan fully document all requests for authorizations and responses to such requests for post stabilization medically necessary care? **Rule 1300.71.4(d)**
1.1 Comments
1.2 Does the Plan's documentation include the date and time of the provider's request? **Rule 1300.71.4(d)**
1.2 Comments

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1.3 Does the Plan's documentation include the name of the health care provider making the request? **Rule 1300.71.4(d)**
1.3 Comments
1.4 Does the Plan's documentation include the name of the Plan representative responding to the request? **Rule 1300.71.4(d)**
1.4 Comments
1.5 Does the Plan require prior authorization for post-stabilization care? If no, do not answer Assessment Questions 1.6-1.8. **Section 1371.4(a)**
1.5 Comments
1.5 Does the Plan provide 24-hour access for patients and providers, including non-contracting hospitals, to obtain timely authorization for medically necessary post-stabilization care? **Section 1371.4(a)**
1.6 Comments
1.7 If post-stabilization request was denied, was the decision made within one half hour of the request? **Rule 1300.71.4(b)(1)**
1.7 Comments
1.8 If the Plan does not respond to a post stabilization request within 30 minutes, does it pay any claims submitted by the provider for the post stabilization care rendered? **Rule 1300.71.4(b)(2)**
1.8 Comments
1.9 Does the Plan provide all non-contracting hospitals with a contact number at which the hospital can obtain authorization from the Plan? **Section 1262.8(j)**
1.9 Comments
1.10 Does the Plan respond to a non-contracting hospital after the first call such that the non-contracting hospital does not have to make more than one call before it gets an initial response from the Plan? **Section 1262.8(b)(2)(B); Section 1371.4(j)(3)**
1.10 Comments

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1.11	Does the Plan ensure that a patient is not transferred to a contracting facility unless the provider determines no material deterioration of the patient is likely to occur upon transfer? **Section 1317.1(j)**
1.11 Comments	
1.12	Does the Plan ensure that prior authorization is not required for the provision of emergency services and care to a patient with a psychiatric emergency? **Section 1317.4a.(f)**
1.12 Comments	

End of Requirement UM-010: Post-Stabilization

Statutory/Regulatory Citations

CA Health and Safety Code section 1262.8

M-010 **KE1**

(a) A noncontracting hospital shall not bill a patient who is an enrollee of a health care service plan for poststabilization care, except for applicable copayments, coinsurance, and deductibles, unless one of the following conditions are met:
(1) The patient or the patient's spouse or legal guardian refuses to consent, pursuant to subdivision (f), for the patient to be transferred to the contracting hospital as requested and arranged for by the patient's health care service plan.
(2) The hospital is unable to obtain the name and contact information of the patient's health care service plan as provided in subdivision (c).
(b) If a patient with an emergency medical condition, as defined by Section 1317.1, is covered by a health care service plan that requires prior authorization for poststabilization care, a noncontracting hospital, except as provided in subdivision (n), shall, prior to providing poststabilization care, do all of the following once the emergency medical condition has been stabilized, as defined by Section 1317.1:
(1) Seek to obtain the name and contact information of the patient's health care service plan. The hospital shall document its attempt to ascertain this information in the patient's medical record, which shall include requesting the patient's health care service plan member card or asking the patient, or a family member or other person accompanying the patient, if he or she can identify the patient's health care service plan, or any other means known to the hospital for accurately identifying the patient's health care service plan.
(2) Contact the patient's health care service plan, or the health plan's contracting medical provider, for authorization to provide poststabilization care, if identification of the plan was obtained pursuant to paragraph (1).
(A) The hospital shall make the contact described in this subparagraph by either following the instructions on the patient's health care service plan member card or using the contact information provided by the patient's health care service plan pursuant to subdivision (j) or (k).
(B) A representative of the hospital shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the hospital upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the hospital who makes the telephone call may be, but is not required to be, a physician and surgeon.
(3) Upon request of the patient's health care service plan, or the health plan's contracting medical provider, provide to the plan, or its contracting medical provider, the treating physician and surgeon's diagnosis and any other relevant information reasonably necessary for the health care service plan or the plan's contracting medical provider to make a decision to authorize poststabilization care or to assume management of the patient's care by prompt transfer.

(c) A noncontracting hospital that is not able to obtain the name and contact information of the patient's health care service plan pursuant to subdivision (b) is not subject to the requirements of this section.
(d)(1) A health care service plan, or its contracting medical provider, that is contacted by a noncontracting hospital pursuant to paragraph (2) of subdivision (b), shall, within 30 minutes from the time the noncontracting hospital makes the initial contact, do either of the following:
(A) Authorize post-stabilization care.
(B) Inform the noncontracting hospital that it will arrange for the prompt transfer of the enrollee to another hospital.
(2) If the health care service plan, or its contracting medical provider, does not notify the noncontracting hospital of its decision pursuant to paragraph (1) within 30 minutes, the post-stabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges for the care, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2) and any regulation adopted thereunder.
(3) If the health care service plan, or its contracting medical provider, notified the noncontracting hospital that it would assume management of the patient's care by prompt transfer, but either the health care service plan or its contracting medical provider fails to transfer the patient within a reasonable time, the post-stabilization care shall be deemed authorized, and the health care service plan, or its contracting medical provider, shall pay charges, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and any regulation adopted thereunder, for the care until the enrollee is transferred.
(4) If the health care service plan, or its contracting medical provider, provides authorization to the noncontracting hospital for specified post-stabilization care and services, the health care service plan, or its contracting medical provider, shall be responsible to pay for that authorized care.
(e) If a health care service plan, or its contracting medical provider, decides to assume management of the patient's care by prompt transfer, the health care service plan, or its contracting medical provider, shall do all of the following:
(1) Arrange and pay the reasonable charges associated with the transfer of the patient.
(2) Pay for all of the immediately required medically necessary care rendered to the patient prior to the transfer in order to maintain the patient's clinical stability.
(3) Be responsible for making all arrangements for the patient's transfer, including, but not limited to, finding a contracted facility available for the transfer of the patient.
(f)(1) If the patient, or the patient's spouse or legal guardian refuses to consent to the patient's transfer under subdivision (e), the noncontracting hospital shall promptly provide a written notice to the patient or the patient's spouse or legal guardian indicating that the patient will be financially responsible for any further post-stabilization care provided by the hospital.
(2) For patients whose primary language is one of the Medi-Cal threshold languages, the notice shall be delivered to them in their primary language.

(3) The Department of Managed Health Care shall translate the notice required by this subdivision in all Medi-Cal threshold languages and make the translations available to the hospitals subject to this section.
(4) The written notice provided pursuant to this subdivision shall include the following statement:
THIS NOTICE MUST BE PROVIDED TO YOU UNDER CALIFORNIA LAW
“You have received emergency care at a hospital that is not a part of your health plan's provider network. Under state law, emergency care must be paid by your health plan no matter where you get that care. The doctor who is caring for you has decided that you may be safely moved to another hospital for the additional care you need. Because you no longer need emergency care, your health plan has not authorized further care at this hospital. Your health plan has arranged for you to be moved to a hospital that is in your health plan's provider network.
If you agree to be moved, your health plan will pay for your care at that hospital. You will only have to pay for your deductible, copayments, or coinsurance for care. You will not have to pay for your deductible, copayments, or coinsurance for transportation costs to another hospital that is covered by your health plan.
IF YOU CHOOSE TO STAY AT THIS HOSPITAL FOR YOUR ADDITIONAL CARE, YOU WILL HAVE TO PAY THE FULL COST OF CARE NOW THAT YOU NO LONGER NEED EMERGENCY CARE. This cost may include the cost of the doctor or doctors, the hospital, and any laboratory, radiology, or other services that you receive.
If you do not think you can be safely moved, talk to the doctor about your concerns. If you would like additional help, you may contact:
Your health plan member services department. Look on your health plan member card for that phone number. You can file a grievance with your plan.
The HMO Helpline at 888-HMO-2219. The HMO Helpline is available 24 hours a day, 7 days a week. The HMO Helpline can work with your health plan to address your concerns, but you may still have to pay the full cost of care at this hospital if you stay.”
(5) The hospital shall give one copy of the written notice required by this subdivision to the patient, or the patient's spouse or legal guardian, for signature and may retain a copy in the patient's medical record.
(6) The hospital shall ensure prompt delivery of the notice to the patient or his or her spouse or legal guardian. The hospital shall obtain signed acceptance of the written notice required by this subdivision, and signed acceptance of any other documents the hospital requires for any further poststabilization care, from the patient or the patient's spouse or legal guardian, and shall provide the health care service plan, or its contracting medical provider, with confirmation of the patient's, or his or her spouse or legal guardian's, receipt of the written notice.
(7) If the noncontracting hospital fails to meet the requirements of this subdivision, the hospital shall not bill the patient or the patient's health care service plan, or its contracting medical provider, for post-stabilization care provided to the patient.
(8) If the patient, or the patient's spouse or legal guardian, refuses to sign the notice, the noncontracting hospital shall document in the patient's medical record that the notice was provided and signature was refused. Upon the patient's refusal to sign, the patient shall assume financial responsibility for any further post-stabilization care provided by the hospital.

(9) The Department of Managed Health Care may, by regulation, modify the wording of the notice required under this subdivision for clarity, readability, and accuracy of the information provided.
(10) The Department of Managed Health Care may, in conjunction with consumer groups, health care service plans, and hospitals, modify the wording of the notice to include language regarding Medicare beneficiaries, if appropriate under Medicare rules. The initial modification shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340, et. seq.) of Part 1 of Division 3 of Title 2 of the Government Code).
(g) If post-stabilization care has been authorized by the health care service plan, the noncontracting hospital shall request the patient's medical record from the patient's health care service plan or its contracting medical provider.
(h) The health care service plan, or its contracting medical provider, shall, upon conferring with the noncontracting hospital, transmit any appropriate portion of the patient's medical record, if the records are in the plan's possession, via facsimile transmission or electronic mail, whichever method is requested by the noncontracting hospital's representative or the noncontracting physician and surgeon. The health care service plan, or its contracting medical provider, shall transmit the patient's medical record in a manner that complies with all legal requirements to protect the patient's privacy.
(i) A health care service plan, or its contracting medical provider, that requires prior authorization for post-stabilization care shall provide 24-hour access for patients and providers, including noncontracting hospitals, to obtain timely authorization for medically necessary post-stabilization care.
(j) A health care service plan shall provide all noncontracting hospitals in the state with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.
(k) In addition to meeting the requirements of subdivision (j), a health care service plan shall provide the contact information described in subdivision (j) to the Department of Managed Health Care. The contact information provided pursuant to this subdivision shall be updated as necessary, but no less than once a year. The receiving department shall post this contact information on its Internet Web site no later than January 1 of each calendar year.
(*l*) This section shall only apply to a noncontracting hospital.
(m) For purposes of this section, the following definitions shall apply:
(1) “Health care service plan” means a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 that covers hospital, medical, or surgical expenses.
(2) “Noncontracting hospital” means a general acute care hospital, as defined in subdivision (a) of Section 1250 or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that does not have a written contract with the patient's health care service plan to provide health care services to the patient.
(3) “Post-stabilization care” means medically necessary care provided after an emergency medical condition has been stabilized, as defined by subdivision (j) of Section 1317.1.

(4) “Contracting medical provider” means a medical group, independent practice association, or any other similar organization that, pursuant to a signed written contract, has agreed to accept responsibility for provision or reimbursement of a noncontracting hospital for emergency and post-stabilization services provided to a health plan's enrollees.
(n) Subdivisions (b) to (h), inclusive, shall not apply to minor treatment procedures, if all of the following apply:
(1) The procedure is provided in the treatment area of the emergency department.
(2) The procedure concludes the treatment of the presenting emergency medical condition of a patient and is related to that condition, even though the treatment may not resolve the underlying medical condition.
(3) The procedure is performed according to accepted standards of practice.
(4) The procedure would result in the direct discharge or release of the patient from the emergency department following this care.
(*o*) Nothing in this section is intended to prevent a health care service plan or its contracting medical provider from assuming management of the patient's care at any time after the initial provision of post-stabilization care by the noncontracting hospital before the patient has been discharged. Upon the request of the health care service plan or its contracting medical provider, the noncontracting hospital shall provide the health care service plan or its contracting medical provider with any information specified in paragraph (3) of subdivision (b).
(p) Nothing in this section shall authorize a provider of health care services to bill a Medi-Cal beneficiary enrolled in a Medi-Cal managed care plan or otherwise alter the provisions of subdivision (a) of Section 14019.3 of the Welfare and Institutions Code.

CA Health and Safety Code section 1317.1.
UM-010 KE1 (a)(2)(A), (b), (j), (k)(1), and (2).
Unless the context otherwise requires, the following definitions shall control the construction of this article and Section 1371.4:
(a)(2)(A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.
(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
(1) Placing the patient's health in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.
(j) A patient is “stabilized” or “stabilization” has occurred when, in the opinion of the treating physician and surgeon, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and surgeon, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during,

the release or transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.
(k)(1) “Psychiatric emergency medical condition” means a mental health disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following, regardless of whether the patient is voluntary or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code):
(A) An immediate danger to themselves or to others.
(B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental health disorder.
(2) This subdivision does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or medical personnel.

CA Health and Safety Code section 1317.4a.
UM-010 KE1 (a) and (c) through (f).
(a)(1) Notwithstanding subdivision (j) of Section 1317.1, a patient may be transferred for admission to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, for care and treatment that is solely necessary to relieve or eliminate a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1, provided that, in the opinion of the treating provider, the patient's psychiatric emergency medical condition is such that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency medical condition is likely to result from, or occur during, a transfer of the patient.
(2) A provider shall notify the patient's health care service plan, or the health plan's contracting medical provider of the need for the transfer if identification of the plan is obtained pursuant to paragraph (1) of subdivision (b).
(c)(1) A hospital shall make the notification described in paragraph (2) of subdivision (b) by either following the instructions on the patient's health care service plan member card or by using the contact information provided by the patient's health care service plan. A health care service plan shall provide all noncontracting hospitals in the state to which one of its members would be transferred pursuant to paragraph (1) of subdivision (b) with specific contact information needed to make the contact required by this section. The contact information provided to hospitals shall be updated as necessary, but no less than once a year.
(2) A hospital making the transfer pursuant to subdivision (a) shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the provider upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the hospital who makes the telephone call may be, but is not required to be, a physician and surgeon.
(d) If a transfer made pursuant to subdivision (a) is made to a facility that does not have a contract with the patient's health care service plan, the plan may subsequently require and make provision for the transfer of the patient receiving services pursuant to this section and subdivision (a) of Section 1317.1 from the noncontracting facility to

a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, that has a contract with the plan or its delegated payer, provided that in the opinion of the treating provider the patient's psychiatric emergency medical condition is such that, within reasonable medical probability, no material deterioration of the patient's psychiatric emergency medical condition is likely to result from, or occur during, the transfer of the patient.
(e) Upon admission, the hospital to which the patient was transferred shall notify the health care service plan of the transfer, provided that the facility has the name and contact information of the patient's health care service plan. The facility shall not be required to make more than one telephone call to the health care service plan, or its contracting medical provider, provided that in all cases the health care service plan, or its contracting medical provider, shall be able to reach a representative of the facility upon returning the call, should the plan, or its contracting medical provider, need to call back. The representative of the facility who makes the telephone call may be, but is not required to be, a physician and surgeon.
(f) A provider is not required to seek prior authorization to provide emergency services and care, as defined in paragraph (2) of subdivision (a) of Section 1317.1, or to make a transfer pursuant to subdivision (a) for a patient who has a psychiatric emergency medical condition, as defined in subdivision (k) of Section 1317.1, that is not otherwise required by law.

CA Health and Safety Code sections 1363.5
UM-003 KE1 (b)(1)-(3) and (5); UM-004 KE1 (b)(4); UM-005 KE1 (a) and (c).
(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
(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.
(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 section 1367
UM-006 KE2 (g)
(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

CA Health and Safety Code section 1367.01
UM-001 KE1 (b); KE2 (c); KE3 (i); UM-002 KE1 (e) and (g); KE2 (h)(1), (2), (3) and (5); KE3 (h)(3), (4); UM-003 KE1 (f); UM-004 KE1 (h)(4); KE2 (h)(5); UM-006 KE1 (j).
(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, 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.
(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).
(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.
(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.
(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 the enrollee's 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.
(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.

CA Health and Safety Code section 1368.1
UM-007 KE1 (a)(1)-(3) and (b).
(a) A plan that denies coverage to an enrollee with a terminal illness, which for the purposes of this section refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, shall provide to the enrollee within five business days all of the following information:
(1) A statement setting forth the specific medical and scientific reasons for denying coverage.
(2) A description of alternative treatment, services, or supplies covered by the plan, if any. Compliance with this subdivision by a plan shall not be construed to mean that the plan is engaging in the unlawful practice of medicine.
(3) Copies of the plan's grievance procedures or complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference as part of the plan's grievance system provided under Section 1368.
(b) Upon receiving a complaint form requesting a conference pursuant to paragraph (3) of subdivision (a), the plan shall provide the enrollee, within 30 calendar days, an opportunity to attend a conference, to review the information provided to the enrollee pursuant to paragraphs (1) and (2) of subdivision (a), conducted by a plan representative having authority to determine the disposition of the complaint. The plan shall allow attendance, in person, at the conference, by an enrollee, a designee of the enrollee, or both, or, if the enrollee is a minor or incompetent, the parent, guardian, or conservator of the enrollee, as appropriate. However, the conference required by this subdivision shall be held within five business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies covered by the plan, would be materially reduced if not provided at the earliest possible date.

CA Health and Safety Code section 1368.04
UM-006 KE1 (a)
(a)The director shall investigate and take enforcement action against plans regarding grievances reviewed and found by the department to involve noncompliance with the requirements of this chapter, including grievances that have been reviewed pursuant to the independent medical review system established pursuant to Article 5.55 (commencing with Section 1374.30). Where substantial harm to an enrollee has occurred as a result of plan noncompliance, the director shall, by order, assess administrative penalties subject to appropriate notice of, and the opportunity for, a hearing with regard to the person affected in accordance with Section 1397. The

administrative penalties shall not be deemed an exclusive remedy available to 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. The director shall periodically evaluate grievances to determine if any audit, investigative, or enforcement actions should be undertaken by the department.

CA Health and Safety Code section 1370
UM-006 KE 1
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. Notwithstanding any other provision of law, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person who participates in plan or provider quality of care or utilization reviews by peer review committees which are composed chiefly of physicians and surgeons or dentists, psychologists, or optometrists, or any of the above, for any act performed during the reviews if the person acts without malice, has made a reasonable effort to obtain the facts of the matter, and believes that the action taken is warranted by the facts, and neither the proceedings nor the records of the reviews shall be subject to discovery, nor shall any person in attendance at the reviews be required to testify as to what transpired thereat. Disclosure of the proceedings or records to the governing body of a plan or to any person or entity designated by the plan to review activities of the plan or provider committees shall not alter the status of the records or of the proceedings as privileged communications.
The above prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at a review who is a party to an action or proceeding the subject matter of which was reviewed, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits, or to the director in conducting surveys pursuant to Section 1380.
This section shall not be construed to confer immunity from liability on any health care service plan. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a health care service plan, the cause of action shall exist notwithstanding the provisions of this section.

CA Health and Safety Code Section 1371.4
UM-010 KE1
(a) A health care service plan that covers hospital, medical, or surgical expenses, or its contracting medical providers, shall provide 24-hour access for enrollees and providers, including, but not limited to, noncontracting hospitals, 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, or its contracting medical providers, 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, or its contracting medical providers, reasonably determines that the emergency services and care were never performed; provided that a health care service plan, or its contracting medical providers, 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.
(e) A health care service plan may delegate the responsibilities enumerated in this section to the plan's contracting medical providers.
(f) Subdivisions (b), (c), (d), (g), and (h) shall not apply with respect to a nonprofit health care service plan that has 3,500,000 enrollees and maintains a prior authorization system that includes the availability by telephone within 30 minutes of a practicing emergency department physician.
(g) The Department of Managed Health Care shall adopt by July 1, 1995, on an emergency basis, regulations governing instances when an enrollee requires medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to requests for treatment authorization.
(h) The Department of Managed Health Care shall adopt, by July 1, 1999, on an emergency basis, regulations governing instances when an enrollee in the opinion of the treating provider requires necessary medical care following stabilization of an emergency medical condition, including appropriate timeframes for a health care service plan to respond to a request for treatment authorization from a treating provider who has a contract with a plan.
(i) The definitions set forth in Section 1317.1 shall control the construction of this section.

(j)(1) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall, within 30 minutes of the time the hospital makes the initial telephone call requesting information, either authorize poststabilization care or inform the hospital that it will arrange for the prompt transfer of the enrollee to another hospital.
(2) A health care service plan that is contacted by a hospital pursuant to Section 1262.8 shall reimburse the hospital for poststabilization care rendered to the enrollee if any of the following occur:
(A) The health care service plan authorizes the hospital to provide poststabilization care.
(B) The health care service plan does not respond to the hospital's initial contact or does not make a decision regarding whether to authorize poststabilization care or to promptly transfer the enrollee within the timeframe set forth in paragraph (1).
(C) There is an unreasonable delay in the transfer of the enrollee, and the noncontracting physician and surgeon determines that the enrollee requires poststabilization care.
(3) A health care service plan shall not require a hospital representative or a noncontracting physician and surgeon to make more than one telephone call pursuant to Section 1262.8 to the number provided in advance by the health care service plan. The representative of the hospital that makes the telephone call may be, but is not required to be, a physician and surgeon.
(4) An enrollee who is billed by a hospital in violation of Section 1262.8 may report receipt of the bill to the health care service plan and the department. The department shall forward that report to the State Department of Public Health.
(5) For purposes of this section, “poststabilization care” means medically necessary care provided after an emergency medical condition has been stabilized.

CA Health and Safety Code section 1374.16
UM-009 KE1(a), (b), and (f). KE2 (b) and (e)
(a) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, and the plan medical director or his or her designee, that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee, if a treatment plan is deemed necessary to describe the course of the care. A treatment plan may be deemed to be not necessary provided that a current standing referral to a specialist is approved by the plan or its contracting provider, medical group, or independent practice association. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.
(b) Every health care service plan, except a specialized health care service plan, shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist or specialty care center that has expertise in treating the condition or disease for the purpose of

having the specialist coordinate the enrollee's health care. The referral shall be made if the primary care physician, in consultation with the specialist or specialty care center if any, and the plan medical director or his or her designee determines that this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist or specialty care center, and enrollee, if a treatment plan is deemed necessary to describe the course of care. A treatment plan may be deemed to be not necessary provided that the appropriate referral to a specialist or specialty care center is approved by the plan or its contracting provider, medical group, or independent practice association. After the referral is made, the specialist shall be authorized to provide health care services that are within the specialist's area of expertise and training to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.
(e) For the purposes of this section, "specialty care center" means a center that is accredited or designated by an agency of the state or federal government or by a voluntary national health organization as having special expertise in treating the life-threatening disease or condition or degenerative and disabling disease or condition for which it is accredited or designated.
(f) As used in this section, a "standing referral" means a referral by a primary care physician to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the primary care physician having to provide a specific referral for each visit.

CA Health and Safety Code section 1374.30
UM-004 KE1 (i).
(i) 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.

CA Health and Safety Code section 1383.1
UM-005 KE2 (a)
(a) On or before July 1, 1997, every health care service plan shall file with the department a written policy, which is not subject to approval or disapproval by the department, describing the manner in which the plan determines if a second medical opinion is medically necessary and appropriate. Notice of the policy and information regarding the manner in which an enrollee may receive a second medical opinion shall be provided to all enrollees in the plan's evidence of coverage. The written policy shall describe the manner in which requests for a second medical opinion are reviewed by the plan.

CA Health and Safety Code section 1383.15

UM-005 KE3 (a), (b), (c), (f) and (i).

(a) When requested by an enrollee or participating health professional who is treating an enrollee, a health care service plan shall provide or authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If the enrollee questions the reasonableness or necessity of recommended surgical procedures.

(2) If the enrollee questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis.

(4) If the treatment plan in progress is not improving the medical condition of the enrollee within an appropriate period of time given the diagnosis and plan of care, and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment.

(5) If the enrollee has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

(b) For purposes of this section, an appropriately qualified health care professional is a primary care physician or specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion. For purposes of a specialized health care service plan, an appropriately qualified health care professional is a licensed health care provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

(c) If an enrollee or participating health professional who is treating an enrollee requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. 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 lack of timeliness that would be detrimental to the enrollee's ability to regain maximum function, the second opinion shall be authorized or denied 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 request, whenever possible. Each plan shall file with the Department of Managed Health Care timelines for responding to requests for second opinions for cases involving emergency needs, urgent care, and other requests by July 1, 2000, and within 30 days of any amendment to the timelines. The timelines shall be made available to the public upon request.

(f) If the enrollee is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of the enrollee’s choice from any independent practice association or medical group within the network of the same or equivalent specialty. If the specialist is not within the same physician organization, the plan shall incur the cost or negotiate the fee arrangements of that second opinion,

beyond the applicable copayments which shall be paid by the enrollee. If not authorized by the plan, additional medical opinions not within the original physician organization shall be the responsibility of the enrollee.
(i) If the health care service plan denies a request by an enrollee for a second opinion, it shall notify the enrollee in writing of the reasons for the denial and shall inform the enrollee of the right to file a grievance with the plan.

28 CCR 1300.68
UM-006 KE1 (b)(1)
(b) The plan's grievance system shall include the following:
(1) An officer of the plan shall be designated as having primary responsibility for the plan's grievance system whether administered directly by the plan or delegated to another entity. The officer shall continuously review the operation of the grievance system to identify any emergent patterns of grievances. The system shall include the reporting procedures in order to improve plan policies and procedures.

28 CCR 1300.70
UM-006 (b)(1)(D), (c) UM-008 KE 1 (b)(2)(B)
(b) Quality Assurance Program Structure and Requirements.
(1) Program Structure.
To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:
(D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others;
(b) Program Requirements.
(2)In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(B) Written documents shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.
(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 to the Department.

28 CCR 1300.71.4
UM-010 (b)(1), (2) and (d). The following rules set forth emergency medical condition and post-stabilization responsibilities for medically necessary health care services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred. These rules do not apply to a specialized health care service plan

contract that does not provide for medically necessary health care services following stabilization of an emergency condition.
(b) In the case when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and may not be discharged safely, the following applies:
(1) A health care service plan shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request.
(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the health care service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided, that the health care service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care (taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.
(d) All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically necessary health care services shall be fully documented. All provision of medically necessary health care services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the health care provider making the request, and the name of the plan representative responding to the request.

28 CCR 1300.74.16
UM-009 KE2(e) and (f).
(e) For the purposes of this section an "HIV/AIDS specialist" means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California who meets any one of the following four criteria:
(1) Is credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; or
(2) Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or
(3) Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
(A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
(B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or
(4) Meets the following qualifications:

(A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
(B) Has completed any of the following:
1. In the immediately preceding 12 months has obtained board certification or recertification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or
2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.
(f) When authorizing a standing referral to a specialist pursuant to Section 1374.16(a) of the Act for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, a health care service plan must refer the enrollee to an HIV/AIDS specialist. When authorizing a standing referral to a specialist for purposes of having that specialist coordinate the enrollee's health care pursuant to Section 1374.16(b) of the Act for an enrollee who is infected with HIV, a health care service plan must refer the enrollee to an HIV/AIDS specialist. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:
(1) The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
(2) The nurse practitioner or physician assistant meets the qualifications specified in subsection (e)(4); and
(3) The nurse practitioner or physician assistant and that provider's supervising HIV/AIDS specialist have the capacity to see an additional patient.