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(b) These benefits shall include the following:
(1) Outpatient services.
(2) Inpatient hospital services.
(3) Partial hospital services.
(4) Prescription drugs, if the plan contract includes coverage for prescription drugs.
(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:
(1) Maximum lifetime benefits.
(2) Co-payments.
(3) Individual and family deductibles.
(d) For the purposes of this section, "severe mental illnesses" shall include:
(1) Schizophrenia.
(2) Schizoaffective disorder.
(3) Bipolar disorder (manic-depressive illness).
(4) Major depressive disorders.
(5) Panic disorder.
(6) Obsessive-compulsive disorder.
(7) Pervasive developmental disorder or autism.
(8) Anorexia nervosa.
(9) Bulimia nervosa.
(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.
(f) This section shall not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Division 9 of Part 3 of the Welfare and Institutions Code, between the State Department of Health Services and a health care service plan for enrolled Medi-Cal beneficiaries.
(g)(1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.
(2) A plan shall provide the mental health coverage required by this section in its entire service area and in emergency situations as may be required by applicable laws and regulations. For purposes of this section, health care service plan contracts that provide benefits to enrollees through preferred provider contracting arrangements are not precluded from requiring enrollees who reside or work in geographic areas served by specialized health care service plans or mental health plans to secure all or part of their mental health services within those geographic areas served by specialized health care service plans or mental health plans.

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Assessment Questions	Yes	No	N/A
1.2 Does the Plan have written UM criteria that are consistent with accepted standards of practice for one or more of the following mental health parity conditions? • Schizophrenia • Schizoaffective disorder • Bipolar disorder (manic depressive illness) • Major Depressive disorders • Panic disorder • Obsessive-compulsive disorder • Pervasive developmental disorder or autism • Anorexia Nervosa • Bulimia Nervosa • Severe Emotional Disturbances of Children			
1.3 Are criteria/guidelines developed with involvement from actively practicing health care providers?			
1.4 Does the Plan have a mechanism to ensure that UM criteria/guidelines for making medical necessity decisions are updated annually? (Or more frequently if needed.)			
1.5 Does the Plan have a mechanism to ensure that UM criteria/guidelines for making medical necessity decisions are disseminated to all UM decision-makers?			
1.6 Does the Plan distribute clinical practice guidelines to primary care, specialty, and mental health providers as appropriate?			
1.7 Is there supporting documentation to confirm the criteria/guidelines are consistent with accepted standards of practice? (For example, documented approval via minutes from Physician discussions; criteria/guidelines have been adopted by reputable Physician organizations; criteria/guidelines consistent with national standards from federal agencies.)			

End of Requirement UM-003: Criteria Development

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.

CA Health and Safety Code section 1367.01(h)(1) and (5)
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service Plan subject to this section shall meet the following requirements:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the Plan's receipt of the information reasonably necessary and requested by the Plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.
5) If the health care service Plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the Plan is not in receipt of all of the information reasonably necessary and requested, or because the Plan requires consultation by an expert reviewer, or because the Plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the Plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the Plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the Plan, the Plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

CA Health and Safety Code section 1374.30(i)
(i) No later than January 1, 2001, every health care service Plan shall prominently display in every Plan member handbook or relevant informational brochure, in every

describe the manner in which requests for a second medical opinion are reviewed by the plan.

CA Health and Safety Code section 1383.15(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

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Assessment Questions	Yes	No	N/A
4.3 When 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, 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)?			
4.4 When the enrollee's condition is non-urgent, does the Plan authorize or deny second opinion requests in an expeditious manner?			
4.5 If the enrollee requests a second opinion, 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?			
4.6 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?			
4.7 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?			
4.8 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?			
4.9 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?			
4.10 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)?			

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

denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the Plan's decision and a care Plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.
(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the Plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the Plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.
(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the Plan is not in receipt of all of the information reasonably necessary and requested, or because the Plan requires consultation by an expert reviewer, or because the Plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the Plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the Plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the Plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The Plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the Plan, the Plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.
(6) If the director determines that a health care service Plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be

subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the State Managed Care Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.
(j) A health care service Plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the Plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health Plan employees and contracting providers, and provisions for evaluation of any corrective action Plan and measurements of performance.

28 CCR 1300.80(b)(5)(H)
(b) The onsite medical survey of a plan shall include, but not be limited to, the following procedures to the extent considered necessary based upon prior experience with the plan and in accordance with the procedures and standards developed by the Department.
(5) Review of the overall performance of the plan in providing health care benefits, by consideration of the following:
(H) The adequacy and utilization of pathology and other laboratory facilities, including the quality, efficiency and appropriateness of laboratory procedures and records and quality control procedures.

28 CCR 1300.70(a)(1)
(a) Intent and Regulatory Purpose.
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is Planned where indicated.

28 CCR 1300.70(b)(2)(G)(5)
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements. In order to meet these obligations each plan's QA program shall meet all of the following requirements:
(G) Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:
(5) Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an

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Assessment Questions	Yes	No	N/A
2.2 Does the Plan have a process in place to routinely monitor and assess access to specialist care, ancillary support services (e.g., laboratory, radiology, pharmacy, physical therapy services) and appropriate preventive health services?			
2.3 Does the Plan analyze its evaluation of access to specialist care, ancillary support services (e.g., laboratory, radiology, pharmacy, physical therapy services), and appropriate preventive health services?			
2.4 Does the Plan have a process to routinely monitor and assess access to specialist care, ancillary support services(e.g., laboratory, radiology, pharmacy, physical therapy services), and appropriate preventive health services for any delegated providers?			
2.5 Does the Plan identify, communicate, and implement corrective actions when potential access issues are identified in the UM process?			
2.6 Does the Plan evaluate the effectiveness of any corrective actions (using performance measures, for example) and make further recommendations to improve potential access issues?			

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

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Assessment Questions	Yes	No	N/A
2.3 Does the Plan's denial follow-up communication include copies of the Plan's grievance procedures?			
2.4 Is the Plan's denial follow-up communication provided to the enrollee within 5 business days of receiving the request?			
2.5 Does the complaint form provide an opportunity for the enrollee to request a conference as part of the grievance system?			

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

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

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

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

(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.
(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.
(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent

with, the provision of health care services to enrollees shall be consistent with clinical principles and processes. These criteria and guidelines shall be developed pursuant to the requirements of Section 1363.5.

CA Health and Safety Code sections 1367.01(a), (e), (h), and (i)
(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.
(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.
(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision-making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall

be applicable to all health plans and other entities conducting utilization review or utilization management.

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

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

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

necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.
(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.
(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

CA Health and Safety Code sections 1367.01(a), (e), (h), and (j)
(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.
(e) No individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:
(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

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(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.
(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.
(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.
(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and

requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.
(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.
(j) A health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan's compliance with this section is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

CA Health and Safety Code sections 1367.01(a) and (h)
(a) A health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively or concurrent with the provision of health care services to enrollees, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:

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(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed five business days from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.
(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.
(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.
(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees shall be communicated to the enrollee in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health

care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.
(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.
(6) If the director determines that a health care service plan has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the Managed Care Administrative Fines and Penalties Fund and shall be used for the purposes specified in Section 1341.45.

CA Health and Safety Code sections 1371.4(a) through (d)
(a) A health care service plan, or its contracting medical providers, shall provide 24-hour access for enrollees and providers to obtain timely authorization for medically necessary care, for circumstances where the enrollee has received emergency services and care is stabilized, but the treating provider believes that the enrollee may not be discharged safely. A physician and surgeon shall be available for consultation and for resolving disputed requests for authorizations. A health care service plan that does not require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition or active labor need not satisfy the

requirements of this subdivision.
(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.
(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.
(d) If there is a disagreement between the health care service plan and the provider regarding the need for necessary medical care, following stabilization of the enrollee, the plan shall assume responsibility for the care of the patient either by having medical personnel contracting with the plan personally take over the care of the patient within a reasonable amount of time after the disagreement, or by having another general acute care hospital under contract with the plan agree to accept the transfer of the patient as provided in Section 1317.2, Section 1317.2a, or other pertinent statute. However, this requirement shall not apply to necessary medical care provided in hospitals outside the service area of the health care service plan. If the health care service plan fails to satisfy the requirements of this subdivision, further necessary care shall be deemed to have been authorized by the Plan. Payment for this care may not be denied.

CA Health and Safety Code section 1374.72(g)(1)
(g)(1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

28 CCR 1300.67.2(c)
Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;
(c) Emergency health care services shall be available and accessible within the service area twenty-four hours a day, seven days a week;

28 CCR 1300.70(b)(2)(G)(5)
(b) Quality Assurance Program Structure and Requirements.
(2) Program Requirements.
In order to meet these obligations each plan's QA program shall meet all of the following requirements:

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Assessment Questions	Yes	No	N/A
3.3 Does the Plan ensure that the delegate's timeframes for UM decisions are within the requirements as outlined in UM-002?			
3.4 Does the Plan ensure that the delegate ensures timely responses to provider requests for authorization?			

UM-008 - Key Element 4:

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

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

UM-008 - Key Element 5:

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

Assessment Questions	Yes	No	N/A
5.1 Does the Plan ensure that the delegate's written notification for denials includes the name and direct contact number for the professional responsible for a denial, delay, or modification of an authorization as outlined in UM-005?			

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Assessment Questions	Yes	No	N/A
5.2 Does the Plan ensure that the delegate's written notification for denials includes a clear explanation of the reasons for the delegate's decision, a description of the criteria used, and clinical reasons for the decision regarding medical necessity?			
5.3 Does the Plan ensure that the delegate's written notification for denials includes grievance and IMR information?			

UM-008 - Key Element 6:

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

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

UM-008 - Key Element 7:

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

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

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UM-008 - Key Element 8:

8. Access to Emergency Services: Each delegate ensures that emergency health care services are available and accessible, that providers are reimbursed for care necessary to stabilize an emergency condition, and that denials of payment for emergency care meet requirements. (Consistent with ER-001)
CA Health and Safety Code sections 1371.4(a) through (d); 28 CCR 1300.67.2(c)

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

End of Requirement UM-008: UM Delegation Oversight

FULL SERVICE TAG

Requirement UM-009: Mental Health Parity Coverage & Claims Administration

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code sections 1374.72(a), (c), and (e)
(a) Every health care service Plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).
(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the Plan contract, shall include, but not be limited to, the following:
(1) Maximum lifetime benefits.
(2) Copayments.
(3) Individual and family deductibles.
(e) For the purposes of this section, a child suffering from, "serious emotional disturbances of a child" shall be defined as a child who (1) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria in paragraph (2) or subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

CA Health and Safety Code sections 1374.72(a) and (c)
(a) Every health care service plan contract issued, amended, or renewed on or after July 1, 2000, that provides hospital, medical, or surgical coverage shall provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, as specified in subdivisions (d) and (e), under the same terms and conditions applied to other medical conditions as specified in subdivision (c).
(c) The terms and conditions applied to the benefits required by this section, that shall be applied equally to all benefits under the plan contract, shall include, but not be limited to, the following:
(1) Maximum lifetime benefits.
(2) Copayments.
(3) Individual and family deductibles.

CA Health and Safety Code section 1374.72(g)(1)
(g)(1) For the purpose of compliance with this section, a plan may provide coverage for all or part of the mental health services required by this section through a separate

specialized health care service plan or mental health plan, and shall not be required to obtain an additional or specialized license for this purpose.

28 CCR 1300.74.72(f) and (g)
(f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.
(g) If a plan contracts with a specialized health care service plan for the purpose of providing Health and Safety Code section 1374.72 services, the following requirements shall apply:
(1) the specialized health care service plan shall maintain a telephone number that an enrollee may call during normal business hours to obtain information about benefits, providers, coverage and any other relevant information concerning an enrollee's mental health services;
(2) if the plan issues identification cards to enrollees, the identification cards shall include the telephone number required to be maintained above and a brief statement indicating that enrollees may call the telephone number for assistance about mental health services and coverage;
(3) the plan shall monitor the continuity and coordination of care that enrollees receive, and take action, when necessary, to assure continuity and coordination of care, in a manner consistent with professionally recognized evidence-based standards of practice, across the health care network;
(4) the plan shall monitor, as often as necessary, but not less frequently than once every year, the collaboration between medical and mental health providers including, but not limited to, the following:
(A) exchange of information,
(B) appropriate diagnosis, treatment and referral, and
(C) access to treatment and follow-up for enrollees with co-existing medical and mental health disorders;
(5) the plan shall retain full responsibility for assuring continuity and coordination of care, in accordance with the requirements of this subsection, notwithstanding that, by contract, it has obligated a specialized health care service plan to perform some or all of these activities

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

Staff responsible for the activities described above, for example:

- Mental health claims director/manager
- Senior mental health clinician responsible for mental health

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DOCUMENT(S) TO BE REVIEWED

- Policies and procedures, protocols documents relating any application of limits on the number of services inconsistent with those for medical or surgical services
- Member materials regarding benefit limits (including limits for parity diagnoses)
- Customer Service staff materials used to quote member benefits

UM-009 - Key Element 1:

1. Limits on annual/lifetime maximum benefits, co-payments, individual and family deductibles for mental health services are consistent with, or no more stringent than, any limits placed on medical or surgical services.
CA Health and Safety Code sections 1374.72(a), (c), and (e)

Assessment Question	Yes	No	N/A
1.1 Does the Plan provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions, including but not, limited to: 1) Maximum lifetime benefits; 2) Copayments; 3) Individual and family deductibles?			

UM-009 - Key Element 2:

2. The full service plan coordinates with the mental health plan to ensure that mental health parity benefits are being provided to its enrollees.
CA Health and Safety Code sections 1374.72(a) and (c); CA Health and Safety Code section 1374.72(g)(1); 28 CCR 1300.74.72(f) and (g)

Assessment Questions	Yes	No	N/A
2.1 Does the agreement between the full service health care plan and the carve-out mental health plan delegate mental health parity responsibilities to the mental health plan?			
2.2 Does the agreement include a description of how the mental health plan and full service health care plan coordinate the development of benefit design? (i.e., development of prescription formulary)			
2.3 Does the agreement include a description of the collaboration between the mental health care plan and the full service health care plan for the timely exchange of information between medical and mental health providers?			

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Assessment Questions	Yes	No	N/A
2.4 Does the agreement include a description of the collaboration between the mental health care plan and the full service health care plan for improving access to treatment and follow-up for enrollees with co-existing medical and mental health disorders?			

End of Requirement UM-009: Mental Health Parity & Claims Administration

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Requirement UM-010: Mental Health Triage and Referral

STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1363.5(b)
The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify or deny health care services shall:
(1) Be developed with involvement from actively practicing health care providers
(2) Be consistent with sound clinical principles and processes
(3) Be evaluated, and updated if necessary, at least annually

CA Health and Safety Code section 1367(d)
(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

CA Health and Safety Code section 1367.01(i)
(i) A health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

CA Health and Safety Code section 1367.01(j)
(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 1367.01(e)
(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).

28 CCR 1300.74.72(d) and (f)
(d) A preliminary or initial diagnosis made by a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above, that an enrollee has one or more conditions set forth in Health and Safety Code section

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1374.72, shall constitute the diagnosis for the length of time necessary to make a final diagnosis, whether or not the final diagnosis confirms the preliminary or initial diagnosis. (f) A plan's referral system shall provide enrollees timely access and ready referral, in a manner consistent with good professional practice, to mental health services for the purpose of diagnosis and medically necessary treatment of conditions set forth in Health and Safety Code section 1374.72 and for related health care services as appropriate upon referral from a primary care physician, mental health provider or pediatrician meeting the requirements of subsection (b) above.

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

Staff responsible for the activities described above, for example:

- Senior mental health clinician responsible for triage and referral
- Mental Health Medical Director
- Triage Center Manager and personnel

DOCUMENT(S) TO BE REVIEWED

- Triage Policies and Procedures
- Utilization Management Committee and/or work group meeting minutes
- Job descriptions of call center clinical and non-clinical personnel
- Record of periodic review and Plan assessment to ensure timely access and ready referral in accordance with 1300.74.72(f).
- Review of cases from the Triage Center's telephone log, including cases in which the enrollee required emergent care or urgent care.

UM-010 - Key Element 1:

1. The Plan maintains a telephone intake system for enrollees, which is staffed by trained personnel who are either individually licensed mental health professionals, or supervised by a licensed mental health professional, and which provides for appropriate crisis intervention and initial referrals to mental health providers.
CA Health and Safety Code section 1367.01(i); 28 CCR 1300.74.72(d) and (f)

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have an enrollee telephone intake system that is staffed by trained personnel who are individually licensed or are supervised by a licensed mental health professional?			
1.2 Does the Plan have policies and procedures and/or training that define protocols for initial referrals to mental health providers?			

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UM-010 - Key Element 2:

2. If the Plan requires that an enrollee access the mental health delivery system through a centralized triage and referral system, the Plan's protocols for mental health triage and referral address the level of urgency and appropriate level of care relative to the enrollee's mental status and level of functioning.
CA Health and Safety Code section 1367(d); 28 CCR 1300.67(a)(1); 28 CCR 1300.74.72(d) and (f)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan require that enrollee's access the mental health delivery system through a centralized triage and referral system?			
2.2 Do the Plan's protocols for mental health triage and referral address the level of urgency relative to the enrollee's mental status and level of functioning?			
2.3 Do the Plan's protocols for mental health triage and referral address the appropriate level of care relative to the enrollee's mental status and level of functioning			

UM-010 - Key Element 3:

3. The Plan has established standards and goals for the timeliness of response to its triage and referral telephone lines and measures performance against those standards.
CA Health and Safety Code section 1367.01(j); 28 CCR 1300.74.72(d) and (f)

Assessment Questions	Yes	No	N/A
3.1 Does the Plan have established standards and goals for timeliness of response to triage and referral telephone lines?			
3.2 Does the Plan measure performance against standards at least quarterly?			
3.3 If the Plan does not meet its goals, does it take corrective action?			
3.4 Does the Plan re-measure results after corrective action has been implemented?			

UM-010 - Key Element 4:

4. The Plan reviews and updates protocols on parity conditions, when appropriate, on a regular basis.
CA Health and Safety Code section 1363.5(b)

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Assessment Question	Yes	No	N/A
4.1 Does the Plan review and update triage protocols on parity conditions on a regular basis?			

UM-010 - Key Element 5:

5. Licensed clinical staff members make decisions about the type and level of care to which enrollees are referred.
CA Health and Safety Code section 1367.01(e)

Assessment Question	Yes	No	N/A
5.1 Do licensed clinical staff make decisions about the type and level of care to which enrollees are referred?			

End of Requirement UM-010: Mental Health Triage and Referral

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Requirement UM-011: Standing Referrals

STATUTORY/REGULATORY CITATIONS

CA Health and Safety Code section 1367.01(h)(4)
(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medical necessity, a health care service plan subject to this section shall meet the following requirements:
(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.

CA Health and Safety Code sections 1374.16(a) and (b)
(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.

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(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.

CA Health and Safety Code section 1374.16(b)

(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.

CA Health and Safety Code sections 1374.16(a), (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.

CA Health and Safety Code section 1374.16(c)
(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the determination is made by the enrollee or the enrollee's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.

CA Health and Safety Code sections 1374.16(a) through (f)
(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.
(c) The determinations described in subdivisions (a) and (b) shall be made within three business days of the date the request for the determination is made by the enrollee or the enrollee's shall be made within four business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or his or her designee.(d) Subdivisions (a) and (b) do not require a health care service plan to refer to a specialist who, or to a specialty care center that, is not employed by or under contract with the health care service plan to provide health care services to its enrollees, unless there is no specialist within the plan network that is appropriate to provide treatment to the enrollee, as determined by the primary care physician in consultation with the plan medical director as documented in the treatment plan developed pursuant to subdivision (a) or (b).primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral (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.

28 CCR 1300.74.16(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

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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.

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
- Sample of standing referral files to be reviewed on site
- Corrective Action Plans

UM-011 - Key Element 1:

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

Assessment Questions	Yes	No	N/A
1.1 Does the Plan have established policies and procedures for standing referrals?			
1.2 Does the Plan disseminate those policies to primary care providers? (e.g., via provider manual)			

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UM-011 - Key Element 2:

2. The Plan makes determinations <u>within three (3) business days</u> of the date a request for standing referral is made and all appropriate information necessary to make the determination is provided. When approved, the Plan makes the referral <u>within four (4) business days</u> of the date the proposed treatment plan, if any, is submitted to the Plan Medical Director or his/her designee.
CA Health and Safety Code section 1367.01(h)(4); CA Health and Safety Code section 1374.16(c)

Assessment Questions	Yes	No	N/A
2.1 Does the Plan make a determination regarding requests for standing referrals within three (3) business days?			
2.2 Once approved, does the Plan make the referral in 4 (four) business days of the proposed treatment plan?			
2.3 Do communications to approve standard referrals specify the specific services approved?			
2.4 Do denial letters provide a clear and concise explanation of the reasons for the denial?			
2.5 Do the Plan's denial letters specify the clinical reasons for the Plan's decision to deny, delay, or modify health care services?			
2.6 Do written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the following information: The name of the health care professional responsible for the denial, delay, or modification?			
2.7 Do written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the following information: The direct telephone number or an 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?			
2.8 Do written communications to an enrollee of a denial, delay or modification of a request include information as to how he / she may: File a grievance to the Plan?			
2.9 Do written communications to an enrollee of a denial, delay or modification of a request include information as to how he / she may: Request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers?			

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UM-011 - Key Element 3:

3. The Plan appropriately approves the treatment plan or a current standing referral to a specialist or specialty care center when an enrollee requires specialized medically necessary care over a long period of time.
CA Health and Safety Code sections 1374.16(a) and (b)

Assessment Question	Yes	No	N/A
3.1 Does the Plan approve a treatment plan or a current standing referral to a specialist or specialty care center when an enrollee requires specialized medically necessary care over a long period of time?			

UM-011 - Key Element 4:

4. The Plan makes referrals to a specialist or specialty care center that has demonstrated sufficient expertise in treating the condition or disease. Specifically, when authorizing a standing referral for a condition requiring care by a Physician with a specialized knowledge of HIV medicine, the Plan refers the enrollee to an HIV/AIDS specialist.
CA Health and Safety Code sections 1374.16(a), (b), and (e); 28 CCR 1300.74.16(e) and (f)

Assessment Questions	Yes	No	N/A
4.1 Does the Plan have a process for validating specialists and specialty care centers are accredited or designated as having special expertise?			
4.2 Does the Plan have a definition of and credentialing process for HIV/AIDS specialists?			
4.3 Does the Plan make listings of specialists and specialty care centers, including HIV/AIDS specialists available to PCPs to assist in the referral process?			
4.4 Does the Plan refer to a specialist or specialty care center that has demonstrated expertise in treating the condition or disease?			

UM-011 - Key Element 5:

5. 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)

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Assessment Question	Yes	No	N/A
5.1 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?			

End of Requirement UM-011: Standing Referrals

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STATUTORY/REGULATORY CITATION(S)

CA Health and Safety Code section 1262.8(i)
(i) A health care service plan, or its contracting medical provider, that requires prior authorization for poststabilization care shall provide 24-hour access for patients and providers, including noncontracting hospitals, to obtain timely authorization for medically necessary poststabilization care.

CA Health and Safety Code sections 1317.1.(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 provider, 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 disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:
(A) An immediate danger to himself or herself or to others.
(B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental 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.(a), (c) through (e)
(a) 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. 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 [notify the health plan of a transfer to a psychiatric unit within a general acute care hospital] 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 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.

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28 CCR 1300.71.4

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.

(a) Prior to stabilization of an enrollee's emergency medical condition, or during periods of destabilization (after stabilization of an enrollee's emergency medical condition) when an enrollee requires immediate medically necessary health care services, a health care service plan shall pay for all medically necessary health care services rendered to an enrollee.
(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.
(3) Notwithstanding the provisions of Subsection (b) of this rule, a health care service plan shall pay for all medically necessary health care services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.
(c) In the case where a plan denies the request for authorization of post-stabilization medical care and elects to transfer an enrollee to another health care provider, the following applies:
(1) When a health care service plan responds to a health care provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another health care provider, the plan shall effectuate the transfer of the enrollee as soon as possible,

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(2) A health care service plan shall pay for all medically necessary health care services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer.
(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.

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

DOCUMENT(S) TO BE REVIEWED

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

UM-012 - Key Element 1:

1. The Plan properly arranges for the transfer of enrollees after the enrollee has been stabilized subsequent to an emergency psychiatric or medical 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 sections 1317.1(a)(2)(A), (b), (j), (k)(1), and (2); CA Health and Safety Code sections 1317.4a.(a) and (c) through (e); 28 CCR 1300.71.4

Assessment Questions	Yes	No	N/A
1.1 Does the Plan fully document all requests for authorizations and responses to such requests for post stabilization medically necessary care?			
1.2 Does the Plan's documentation include the date and time of the provider's request?			
1.3 Does the Plan's documentation include the name of the health care provider making the request?			
1.4 Does the Plan's documentation include the name of the Plan representative responding to the request?			

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1.5 Does the Plan require prior authorization for post-stabilization care? If no, do not answer Assessment Questions 1.6-1.8.			
1.6 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?			
1.7 If post-stabilization request was denied, was the decision made within one half hour of the request?			
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?			
1.9 Does the Plan provide all non-contracting hospitals with a contact number at which the hospital can obtain authorization from the Plan?			
1.10 Does the Plan respond to a transferring hospital after the first call such that the transferring hospital does not have to make more than one call before it gets an initial response from the Plan?			
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?			
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?			

End of Requirement UM-012: Post-Stabilization