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	Approved By: Darla Bernstein

Procedure

Authorizations required for case review:

1. Clinical criteria that support rationale for denial including any reference to CMS guidance, Federal Regulations, clinical criteria, peer reviewed literature and sponsoring organization documents or any other documentation used when considering the request.
2. Name and title of final reviewer

UM Criteria Selection: Criteria are selected based on the regulatory requirements per the line of business (Medicare, Commercial, Medi-Cal, Special Needs Plan/Duals). The group will follow the criteria hierarchy that the Health Plan provided per LOB. If there are no available criteria based on the hierarchy, the group may develop its own criteria that is approved by the UM Committee (UMC) and/or the Health Plan. UM Criteria should be objective and based on medical evidence and current standards of practice.

Criteria Review, Update and Modification: The UM criteria will be reviewed by the group on UMC Meeting at least on an annual basis. The UMC will review if criteria and the hierarchy will need to be updated based on regulatory changes (Federal, State, Plan or NCQA). UMC may invite appropriate practitioners/providers as appropriate to give feedback based on current standards of care/practice. The UMC will adopt and approved the criteria and the hierarchy that the PA team will use for their review.

If there are no Health Plan specified hierarchy the group will follow the standard criteria hierarchy below.

Medicare Hierarchy:

- Eligibility
- Benefit document: Evidence of Coverage (EOC)
- Medicare Coverage Database: National Coverage Determinations (NCD)
- Medicare Coverage Database: Local Coverage Determinations (LCD)
- Medicare Coverage Database: Local Coverage Articles (LCA's)
- Medicare Benefit Policy Manual

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- CMS Drug Compendia (For Pharmacy Review) and/or relevant guidance from the FDA according to the rules in the Medicare Benefit Policy Manual Chapter 15, Section 50.4 and sub-chapters, paying special attention to the distinctions for anti-cancer chemotherapy regimen drugs (50.4.5) and immunosuppressive drugs (50.5.1)
- UHC, Humana or other applicable Health plan criteria (e.g. Coverage Summary, Medical Policy)

Nationally Recognized Clinical Criteria (MCG Guidelines)

Other evidenced-based criteria, such as:

- NCCN (National Comprehensive Cancer Network) Guidelines
- Up-To-Date
- ASAM for Behavioral Health

Per the Medicare 2024 Final Rule, Plans may only use the Prior Authorization Process for the following:

1. Confirm the presence of diagnoses or other medical criteria that are the basis for coverage determinations for the specific item or service.
2. For basic benefits, to ensure basic benefits are medically necessary based on standards specified in § 422.101(c)(1).
3. For supplemental benefits, to ensure that the furnishing of supplemental benefits is clinically appropriate

For Anthem Only:

Organization Specific Guidelines for Part B Drug Step Therapy or organization Specific Guidelines for Device Preferred Products. Step therapy guidelines can only be applied to drugs not used within the last 365 days

Medicare guidance (such as Local Coverage Determinations) from jurisdictions outside the service location as an indication of what Medicare considers reasonable and necessary. An LCDs Summary of Evidence and Analysis of Evidence sections as well as Coverage Indications, Limitations, and/or Medical Necessity sections can be utilized to determine what Medicare considers to be reasonable and necessary for coverage of a particular service request. The applicable literature within the policy should be used as the citation as this is the true basis of the reasonable and necessary determination within the policy.

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If there is insufficient guidance based on the above then, consistent with the Medicare Managed Care Manual Chapter 4, Section 90.5, the Medical Director will make the decision based on authoritative evidence such as:

1. Studies from government agencies (e.g., the FDA)
2. Evaluations performed by independent technology assessment groups (e.g., BCBSA)
3. Well-designed controlled clinical studies that have appeared in peer review journals
4. Prior decisions by the Independent Review Entity (IRE) contracted by CMS.

Commercial Hierarchy:

- EOC or Evidence of Coverage (Used for Benefit Determinations)
- Health Plan Policy (If Applicable)
- Nationally Recognized Clinical Criteria (MCG, Interqual)
- Provider Organization Internally Developed Criteria
- Other criteria (e.g. NCCN for Oncology, ASAM and DSM V for BH, etc)

Commercial Hierarchy for Blue Shield:

- BSC Medical Policy
- Evolent Specialty Services, Inc. (Evolent), Recognized evidenced based criteria, Professional Guidelines (including non-profit professional associations)
- MCG Guidelines,
- PMG/IPA Policy (HMO LOB only)

Medi-Cal Hierarchy:

- EOC or Evidence of Coverage (Used for Benefit Determinations)
- Medi-Cal Criteria (DHCS Guidelines, CA Health and Safety Code, Knox Keene Act, Medi-Cal Provider Manual, Medi-Cal Policies, All Plan Letter)
- Health Plan Policy (If Applicable)
- Nationally Recognized Clinical Criteria (MCG, Interqual)

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- Provider Organization Internally Developed Criteria
- Other criteria (e.g. NCCN for Oncology, ASAM and DSM V for BH, etc)

Medi-Cal Inpatient Hierarchy for Blue Shield:

- 2024 Blue Shield of California (BSC) Promise Health Plan (PHP) Evidence of Coverage (EOC)
- Medi-Cal guidelines (DHCS)
 - a. Medi-Cal Provider Manual
 - b. APLs
- MCG guidelines
- Professional guidelines (including non-profit professional associations/evidence-based reviews/peer-reviewed articles) including but not limited to:
 - a. NCCN
 - b. AAFP
 - c. ACP
 - d. AAP
 - e. ACOG
- Blue Shield Promise medical policy, as applicable

Medi-Cal Outpatient Hierarchy for Blue Shield:

- 2024 Blue Shield of California (BSC) Promise Health Plan (PHP) Evidence of Coverage (EOC)
- Medi-Cal guidelines (DHCS)
 - a. Medi-Cal Provider Manual
 - b. All Plan Letters (APLs)
- MCG Guidelines
- Blue Shield Promise medical policy, as applicable

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- Professional guidelines (including non-profit professional associations/evidence-based reviews/peer-reviewed articles) including but not limited to:
 - a. National Comprehensive Cancer Care Network (NCCN)
 - b. American Academy of Family Physicians (AAFP)
 - c. American College of Physicians (ACP)
 - d. American Academy of Pediatrics (AAP)
 - e. The American College of Obstetricians and Gynecologists (ACOG)
 - f. World Professional Association for Transgender Health (WPATH)
- Contracted external medical review agency

Dual Eligible Plans or Special Needs Plan: Used the Medicare Hierarchy First, if Medicare does not have benefits/ non-covered, Use the Medi-Cal Criteria Hierarchy.

For Humana HealthCare Members:

For Humana authorizations, in order to ensure consistent clinical decision making, which includes the use and application of appropriate criteria, Humana requires documentation in our organization’s clinical system of the criteria used to make all utilization management decisions (e.g., approvals, denials, and partial approvals/modifications).

Please ensure that the Guideline Name and Criteria is notated in the MDREVIEW as well as ALL Approvals.

You will also need to notate that the CMS – NCD/LCD Guidelines cannot be found if you will be using the MCG or any other guidelines.

Here is an example of an approval in which CMS criteria is not available:

Request is for Consult with an Orthopedist for a member with Knee Pain. Since there are no CMS criteria for consults, the MCG Guideline would be used.

APPROVED note header:

- PLP LVN (Initials & Credentials)

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- No NCD/LCD criteria available (Indicate that CMS criteria cannot be found)
- MCG (Must include where Criteria was found)
- Knee Pain - Referral Management (Criteria Name)
- RMG: R-0055 (AC) (Criteria reference number)

For United Healthcare Members:

The delegate uses the following hierarchy when applying UM criteria:

Commercial Hierarchy: (UHC West Hierarchy)

- a. Eligibility
- b. EOC/Schedule of Benefit (SOB)
- c. Benefit Interpretation Policy (BIP)
- d. Medical Management Guidelines (MMG)
- e. Medical/Drug Policy (when not addressed in MMG)
- f. MCG Care Guidelines
- g. Hayes

UM delegates may access UHC’s medical policies and coverage determinations at E&I Commercial benefit interpretation policies are listed in the resources.

UHC Medicare Hierarchy:

Criteria are used in the order specified in the hierarchy. Use the first level of criteria that applies:

- a. Plan Eligibility and Coverage (benefit plan package or EOC)
- b. CMS Criteria
 - (i) National Coverage Determination (NCD)
 - (ii) Local Coverage Determination (LCD) used only for the area specified in the LCD
 - (iii) Local Coverage Medical Policy Article (LCA)

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(iv) Medicare Benefit Policy Manual (MBPM)

- c. If no CMS coverage criteria, then UHC Medical Policy, Coverage Determination Guideline, Medical Benefit Drug Policies may be used. May use Medicare Advantage Coverage Summaries as index to find applicable review criteria and guidance. Coverage Summaries are not a citable source.
- d. Evidence based criteria such as MCG or InterQual after MAP-TAC approval
- e. Other evidence-based resources such as Hayes, NCCN (National Comprehensive Cancer Network), AHRQ (Agency for HealthCare Research and Quality evidence reports, or high-quality evidence-based literature.

For Blue Shield Commercial Members:

IPA/Medical Group Will apply Hierarchy of Criteria as follow:

- Federal and State Law Mandates (i.e., Code of Federal Regulations, Department of Managed HealthCare);
- Health Plan Medical Policy and/or Clinical Guidelines;
- National Evidence Based Guidelines (e.g., Milliman, Up-To-Date, US Preventative Services Task Force, National Comprehensive Cancer Network, etc.);
- Society Guidelines (e.g., American Medical Association, American Congress of Obstetricians and Gynecologists, National Guidelines Clearinghouse, etc.);
- Diagnostic and Statistical Manual of Mental Disorders (DSM), current edition.

For SCAN members:

In order to apply for the above criteria, the IPA/Medical Group must also use Program Integrity Manual as criteria used for clinical review and UM decision-making.

Appropriate actively practicing health care practitioners must be involved in development and/or adoption, review, and application of standardized criteria. Appropriate actively practicing behavioral health care practitioners must be involved in the development and/or adoption, review, and application of behavioral health care for Medical

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Groups/IPAs with Medicare contracts only.

The Medical Group/IPA annually reviews the UM criteria and the procedures for applying them and updates the criteria when appropriate.

Staff must document the UM Criteria being utilized in both the system and on the member and provider written notification.

- The organization uses should state Medicare coverage guidelines and written coverage decisions of Local Medicare Contractors (LCD).
- There is evidence the organization complies with medical review hierarchy used for decisions in Utilization Management that the organization complies with National Coverage Decisions (NCD), general.

Evidence-based:

Member’s care shall not be discontinued until the member’s treating provider has been notified and agrees with the care plan. Clinical review criteria shall be evaluated and updated as necessary to comply with regulatory and health plan requirements. All criteria are based on written medical evidence to support necessity of the request.

Applying Criteria:

Clinical criteria application should be based on individual needs and treating providers care plan. The description should not be burdensome for the member, the practitioner, or the health delivery organization’s staff, and should only require the presence of diagnosis / criteria that are the basis for the coverage determination and to assure the services are clinically appropriate.

The following factors should considered when applying criteria:

- a. Age
- b. Comorbidities
- c. Complications
- d. Progress of treatment
- e. Psychosocial situations

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- f. Home environment
- g. Characteristics of the local delivery system that are available for the patient. Such as:
 - (i) Availability of SNFs (Skilled Nursing Facilities)
 - (ii) Home care after discharge
 - (iii) Subacute facilities
 - (iv) Medi-Cal standards for LTSS
 - (v) Medicare standards for acute services

The UM staff shall base referral determinations on the individual needs and requirements of the individual patient requirements. When utilizing clinical review criteria in making a referral determination, the UM staff shall include the above factors as stated above as a part of the review criteria. These factors must be included in the decision-making process. When the above factors indicate that UM guidelines are not appropriate, staff shall consult with the UM physicians regarding alternative criteria and care. The IPA/Medical Group’s decision to deny or authorize an amount, duration, or scope that is less than requested shall be made by a qualified health care professional with appropriate clinical expertise in treating the condition or disease. The Contractor’s decisions regarding UM, Member education, coverage of services, and other areas included in the practice guidelines must be consistent with the clinical practice guidelines. For Medicare reviews, the physician reviewer should have knowledge of Medicare Coverage Criteria. For Dually Eligible members (Medicare and Medi-Cal), the reviewing physician should have knowledge of both Medicare and Medi-Cal. To allow for appropriate expertise, if multiple items are requested, the authorization may need to be reviewed by a physician with the appropriate expertise. The provider should have a current / unrestricted license to practice in the US for Medicare, and the State of CA for Medi-Cal.

To decrease unnecessary disruptions in care, Medicare authorizations should be approved for as long as medically necessary, taking into account the length of the course of treatment, the provider’s recommendations, the applicable coverage criteria, and the member’s clinical history.

Assessment of Local Delivery System: The following will also be taken into consideration when reviewing a request. The UM Nurse should take into consideration the local delivery system and its availability to comply with access standards set forth by the Federal (Medicare - CMS) and State (Medi-

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Cal – DHCS and Commercial – DMHC) regulatory agencies. If the local delivery cannot meet access standard requirements, the group may allow Tertiary or Out of Network providers to facilitate the care for the member. See below considerations:

- Availability of inpatient outpatient and transitional facilities.
- Availability of outpatient services in lieu of inpatient services such as urgicenters vs. inpatient surgery.
- Availability of highly specialized services, such as transplant facilities or cancer centers.
- Availability of skilled nursing facilities, subacute care facilities or home care in the organization’s service area to support the patient after hospital discharge.
- Local hospitals’ ability to provide all recommended services within the estimated length of stay.

Responses Regarding Denial Notification:

The utilization management staff shall generate the member referral notification that is consistent with regulatory and Health Plan requirements. Please note that all MD Reviews of must be in writing and are in adherence with written notification standards no more if the authorization is approved or denied.

Services may not be denied if they were previously approved through Prior Authorization determination. Cases may not be reopened once determined unless for good cause / fraud / etc.

Request for UM Criteria:

The Utilization Management department will disclose upon request the Utilization Management policies, procedures, and criteria used to authorize, modify, or deny healthcare services to contracted healthcare practitioners, providers, members, potential members, and the public. Any such requests will be logged.

The Member Rights and Responsibilities Notice posted in each physician’s office states that any person may request the utilization review criteria, policies and procedures used by the IPA/Group. The notice states that any person may request this information by sending a letter to the address/P.O. box listed on the notice.

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Any denial letters sent to members and practitioners also advise how to request this information.

The criteria is made available to practitioners, providers, members and the public upon request.

Notification of how to obtain a copy of the UM criteria used to make referral determinations as well as how to contact the physician reviewer is posted on the website at www.capcms.com.

Practitioners can obtain a copy of the decision-making criteria upon request by calling the Customer Service Department at (888) 445-0062. Criteria and policies are distributed by mail, fax, e-mail, provider manual, provider intranet site or on its website, if it informs practitioners that the information is available online. The organization mails the criteria to practitioners who do not have fax, email or internet access.

Disclosure Notice sent with criteria or guidelines requested by members and the public includes the following disclosure notice: “The materials provided to you are guidelines used by this IPA/Group to authorize, modify or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefit covered under your contract”.

References

Clinical Criteria for UM Decisions (UTM.03.04)

CA Commercial Mental Health Substance Use Disorder SB: 855: List of criteria which list is not exclusive- the law allows for the use of guidelines not on the list that otherwise meet the criteria. Use DMHC LINK for list reference: CA Commercial DMHC 1/5/21: APL 21-002-SB855, MH SUDCoverage; APL 21-002Attachment A Criteria, West

<https://www.uhcprovider.com/en/policies-protocols/commercial-policies.html>