



**Gold Coast
Health PlanSM**
A Public Entity

**2019
UTILIZATION
MANAGEMENT
Program Description**

Gold Coast Health Plan
Utilization Management Program Description

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I. Mission and Values

The Utilization Management (UM) Program is designed to support Gold Coast Health Plan's Mission to improve the health of our members through the provision of high quality care and service. It is also designed to support the values, which are as follows:

- Integrity: Achieving the highest quality standards of professional and ethical behavior, with transparency in all business and community interactions.
- Accountability: Taking responsibility for our actions and being good stewards of our resources.
- Collaboration: Working together to empower our GCHP community to achieve shared goals.
- Trust: Building relationships through honest communication and by following through on our commitments.
- Respect: Embracing diversity and treating people with compassion and dignity.

II. Purpose and Scope of the Utilization Management Program

The UM Program is designed to ensure that medically appropriate services are provided to all members of the Plan through a comprehensive framework that assures the provision of high quality, cost effective, medically appropriate healthcare services in compliance with the patient benefit coverage and in accordance with regulatory and accreditation requirements. The utilization management structures and processes are clearly defined and responsibility is assigned to appropriately trained individuals. The program description includes the scope of the program and the processes and resources used in making determinations based on plan benefits and medical appropriateness.

The UM Program of the Plan is charged to ensure that:

1. GCHP staff utilize, as applicable, established current criteria for approving, modifying, deferring, or denying requested services. In addition, the individual needs of the member are considered whenever a UM decision is made and the manner in which providers are involved in the development and adoption of specific criteria used to establish medical necessity is clearly documented.
2. Clinical Guidelines, standards, and criteria set by regulatory and any accrediting agencies are adhered to as appropriate for the Plan. Decisions are based upon evidence-based criteria and consistent with professionally recognized standards of care.
3. All medical services are delivered at appropriate levels of care and are appropriate for the needs of the individual member, i.e. not over-utilized or under-utilized.
4. There is separation of medical decisions from fiscal and administrative management to assure that medical decisions will not be unduly influenced by fiscal and administrative management.
5. Authorized care matches the benefits defined in the member's Evidence of Coverage ("EOC").
6. Services are provided by GCHP contracted providers, (e.g., network physicians and hospitals), unless otherwise authorized by the Plan. For the purposes of this document, "provider" refers to individuals and organizations that provide care to Plan members.
7. All contracted health care practitioners are aware of procedures and services which require prior authorization and are aware of the timeframe necessary to obtain prior authorization for these services.
8. Establishment of a specialty referral system to track and monitor referrals requiring prior authorization to include authorized, denied, deferred, or modified referrals, and the timeliness of referrals. Providers are informed of the prior authorization and referral process.

9. The utilization management team of physicians, licensed staff, and unlicensed staff are trained and qualified to assess the clinical information which is used to make utilization management decisions and provide the service within their respective scope of practice. Appropriately licensed health professionals supervise all review decisions.
10. Provides procedures for continuously reviewing the performance of health care personnel, the utilization of services and facilities, and cost.
11. Written UM Program, UM protocols and program evaluation are approved annually by GCHP UM Committee and reported to the GCHP Quality Improvement Committee ("QIC").
12. The UM Program is integrated with the Quality Improvement (QI) Program to ensure continuous quality improvement.
13. An annual evaluation of the UM Program is prepared and includes a description of the accomplishments of the Plan, work plan, program evaluations, policies and procedures. It shall also include reporting on the Plan's operation using statistical data and other information regarding the care delivered to members and any suggested revisions.

III. Goals of the Utilization Management Program

The UM Program goals are to:

1. Provide access to the most appropriate and cost effective healthcare services
2. Ensure that authorized services are covered under the member's health plan benefits
3. Develop protocols to determine services which are consistent with professionally recognized standards of care, as determined by physicians and other providers in the medical community, and in areas served by the Plan
4. Initiate necessary procedural revisions to prevent the recurrence of problematic utilization issues
5. Facilitate communication and develop positive relationships between members and providers, as well as among the Primary Care Physicians (PCPs), specialists and the Plan
6. Monitor and evaluate healthcare services provided through GCHP's network by tracking and trending data
7. Monitor, evaluate and improve continuity and coordination of care
8. Identify specific services that are over-utilized or under-utilized, and develop appropriate responses to these findings
9. Continuously improve the UM Program
10. Ensure cohesive interdepartmental and UM processes
11. Identify potential quality of care/quality of service issues which may require further review by the Quality Improvement Program of the Plan

IV. Utilization Management Protocols

1. In making determinations of benefit coverage and/or medical necessity, the Plan uses written utilization review criteria, developed in consideration of Plan-specific provider and member demographics. This criteria include:
 - a. **MCG**— includes medical literature, textbooks and nationally recognized evidence- based clinical guidelines published in all fields of medicine, practice observations and database analyses, and reviewed by expert consultants. The Care Guidelines support quality care

through the incorporation of measures for four nationally recognized quality programs, including HEDIS®. MCG guidelines address the unique issues confronted by those managing the care of Medi-Cal members.

- b. Gold Coast Health Plan Medical Policies- Developed by Gold Coast Health Plan's Chief Medical Officer (CMO) and Medical Director. Guidelines are developed utilizing national professional organization literature, State and Federal guidelines as well as other relevant clinical research material. The new guideline is presented for review to the Gold Coast Medical Advisory Committee. The Committee members have the opportunity to present supporting arguments of documentation that may lead to changes in the policy.
 - c. Other-Nationally Recognized Criteria - From time to time a service is requested that does not have clear medical necessity criteria in any of the sources mentioned above. In these cases, UM staff will refer to guidelines from national professional organizations.
 - d. Other-Evaluation of new technology, experimental and investigative - The Physician Medical Reviewers utilize UpToDate®. UpToDate is an evidence-based, physician-authored clinical decision support resource which clinicians trust to make the right point-of-care decisions. UpToDate uses more than 5,100 world-renowned physician authors, editors and peer reviewers with a rigorous editorial process to synthesize the most recent medical information into trusted, evidence-based recommendations that are proven to improve patient care and quality.
2. The criteria are evaluated, updated as appropriate and approved annually by the UM Committee. Documentation of approval by the UM Committee can be found in the minutes of the UM Committee. UM Committee minutes and activities are presented to the Plan's QIC for oversight.
 3. All criteria, policies and procedures of the Plan are made available, upon request, to all participating providers and members.
 4. At least annually, personnel involved with UM decision-making are evaluated for consistency and accuracy of the application of criteria. This is the responsibility of the Executive Director of Health Services.
 5. All needed emergency services are arranged for or facilitated, including appropriate coverage of costs.
 6. Initial emergency services, defined as those which are necessary to screen and stabilize the patient, do not require prior authorization, and are paid in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. Emergency services are also covered if an authorized representative, acting for the Plan, authorized the provision of these services.
 7. Documentation for case review and authorization, modification or denial of services demonstrates efforts made to obtain all pertinent clinical information to support the UM decision-making process at all levels. Plan actions taken on requested services may include approvals, modifications and denials. Written notifications of Plan actions are sent to members and providers within a timeframe that is consistent with the type of requests and regulatory and any accreditation requirements. Denial letters will include the reason for the denial and the specific UM criteria or benefits interpretation used in making the determination. Appeal information is included in all denial notifications. (See Appendix A "Communication Services/Timeliness of UM Decisions")
 8. GCHP has policies and procedures for the referral/authorization process and associated time frames (See Appendix "A").

9. Appropriately licensed health care professionals supervise all UM review decisions. A licensed physician reviews any denial that is based on medical necessity. Board-certified physician consultants from appropriate specialty areas assist in making medically appropriate determinations when necessary.
10. Monitoring of UM data is performed to detect potential under- and over-utilization. Data are monitored across practices and provider sites of PCPs and specialists. Appropriate interventions are implemented whenever under- or over-utilization is identified. Interventions are measured to determine their effectiveness, and further strategies may be implemented to achieve appropriate utilization.
11. Determinations for care or service are made according to GCHP approved timeframes.
 - a. Determinations are monitored to ensure compliance with approved timeliness standards.
 - b. If the standards are not met, GCHP will take action to improve performance based on the recommendations from the UM and/or QA Committees.
12. There are mechanisms to evaluate the effects of the UM program and process using member and provider satisfaction data, staff interviews and/or other appropriate methods.
13. Utilization tracking and trending data are submitted on a regular basis to the UM Committee. The data are analyzed by the UM Committee to determine opportunities for improvement. The UM Committee makes recommendations for necessary interventions based on the findings. After intervention strategies have been implemented, re-evaluation is done with the results reviewed by the UM Committee.
14. The UM Program includes continuous quality improvement processes which are coordinated with Quality Improvement Program activities as appropriate. The UM and QI Committees work together to resolve any cross-related issues or problems.
15. The Utilization Management Program includes the effective processing of prospective (pre-service), concurrent and retrospective review determinations by qualified medical professionals.

The areas of review will include:

- a. Inpatient hospitalizations
- b. Outpatient surgeries and selected services
- c. Rehabilitative services
- d. Selected ancillary services
- e. Home health services & Durable Medical Equipment (DME)
- f. Selected pharmaceutical services
- g. Selected physician office services
- h. Out-of-network services
- i. Selected Behavioral Health Therapy services (currently delegated)

Prior authorization requirements shall NOT apply to:

- a. Emergency services
- b. Family planning services
- c. Preventive services
- d. Basic prenatal care
- e. Sexually transmitted disease services
- f. HIV testing
- g. Abortion
- h. Non-medical Transportation (NMT)

Additional services do not require prior authorization. GCHP's prior authorization list will contain a complete list of services that require prior authorization.

16. When indicated, the UM team may refer members to case management. The case management program provides for the clinical and administrative identification, coordination, and evaluation of the services delivered to a member who requires close management of his/her care. The case management program ensures continuity and coordination of care to improve the health status of members who are at risk for additional health care problems and complications. Appropriate health education programs may be offered to members.
17. The Utilization Management Program Description, Work Plan (which may be incorporated into the QI Work Plan), policies and procedures, goals for the coming year, and program evaluation are reviewed, approved and updated as necessary, at least annually, by the UM Committee, and by the QIC.
18. The following Affirmative Statement is posted in the UM department and includes the following associates: medical and clinical directors, physicians, UM directors and managers, licensed UM staff including management personnel who supervise clinical staff and any associate in any working capacity that may come in contact with members during their care continuum:
 - UM decision making is based only on appropriateness of care and service and existence of coverage.
 - The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care.
 - Financial incentives for UM decision makers do not encourage decisions that may result in underutilization.
 - GCHP does not use incentives to encourage barriers to care and service.
 - GCHP does not make hiring, promotion or termination decisions based upon the likelihood or perceived likelihood that an individual will support or tend to support the denial of benefits.

The Affirmative Statement is emailed to all staff members and physicians. It is widely distributed via a newsletter mailed to all members, via the Physician's operation manual sent to all practitioners and via a letter mailed to all facilities/providers. It is also available on the Plan website.

V. Organizational Structure and Responsibility

Structure: GCHP's organizational chart reflects the utilization management personnel and committee reporting structures. Staff positions and committee descriptions explain associated responsibilities, duties and reporting relationships. The staff ratios are consistent with the organization's needs and are accommodated by the departmental budget. (See Appendix B "Health Services Organization Chart").

Medical Director

The Utilization Management Program functions ultimately under direction of the Medical Director or his/her designee, who is fully involved in the UM program implementation. Licensed and non-licensed healthcare professionals, including administrative support associates, nurses, physicians and other clinically educated professionals have authority to function within the UM Program based upon their job descriptions. The Medical Director or designee must meet job description requirements that include education, training or professional experience in medical or clinical practice, and must have a current

license to practice without restrictions in the State of California. Responsibilities of the Medical Director include:

1. Development and implementation of the Utilization Management Program
2. Provides the direction, guidance and control for the medical components of GCHP's services
3. Develops and interprets medical policies
4. Oversees the outpatient and inpatient referrals, ensuring consistent medical necessity decision making and timely reviews of grievances and appeals
5. Provides clinical supervision and consultation to utilization management nurses and staff
6. Makes utilization review/coverage determinations including denials, modifications, closed treatment requests and appeals
7. Represents the Plan in a liaison role with other agencies, practitioners, and facilities
8. Consults with Plan Providers when requested or when contacted by the provider
9. Safeguards Protected Health Information
10. References and follows the utilization guidelines and policies adopted by the Health Plan
11. Consults with specialist providers when necessary and appropriate to make a decision on a requested treatment or medical service
12. Participates in inter-rater review audits
13. Assists in the formulation of new policies and guidelines when necessary

Reviewing Physicians

Responsibilities:

1. Provides clinical supervision and consultation to utilization management nurses and staff
2. Makes utilization review/coverage determinations including denials, modifications, closed treatment requests and appeals
3. Consults with Plan Providers when requested or when contacted by the provider
4. Safeguards Protected Health Information
5. References and follows the utilization guidelines and policies adopted by the Health Plan
6. Consults with specialist providers when necessary and appropriate to make a decision on a requested treatment or medical service
7. Participates in inter-rater review audits

Executive Director, Health Services

Qualifications include a Doctorate degree in nursing, business, public health or health administration or a closely related field, and must possess and maintain a valid California Nursing License. Responsibilities include the oversight, operational execution, supervision and evaluation of the Utilization Management Program under the direction of the CMO and in coordination with the Medical Director. Identification of trends through the analysis of UM data and coordination with the Quality Improvement Program is a focus to continuously improve the care and services provided to the membership of GCHP.. The Executive Director, Health Services is responsible for managing the UM Staff which may include the following positions:

1. Utilization Review (UM) Managers
2. Care Management (CM) Managers
3. Health Services Trainer/auditor
4. Registered nurses

5. Social workers
6. Unlicensed support staff
7. Analysts
8. Clerical Staff
9. Health Education Staff
10. Quality Improvement Staff

VI. Utilization Management Committee

The Utilization Management (UM) Committee is established as a standing sub-committee of the QI Committee of GCHP. The Committee structures and processes are clearly defined in the Quality Improvement Description.

The Utilization Management Committee oversees the implementation of the Program and promotes the optimum utilization of health care services, while protecting and acknowledging member rights and responsibilities, including their right to appeal denials of service. The UM Committee is multi-disciplinary and monitors continuity and coordination of care as well as under- and over- utilization of services. Any perceived or actual utilization management problems are reviewed by the UM Committee. The committee meets quarterly. The Quality Improvement and Utilization Management Committees work together on overlapping issues.

VII. Structure and Membership of the Utilization Management Committee

Physician members of the UM Committee are appointed by the Medical Director. The Medical Director has substantial involvement in the implementation of the UM Program. The UM Committee physician membership includes the Chief Medical Officer (CMO), the UM Committee Chairman (which is the Medical Director), and Reviewing Physicians.

Non-physician UM Committee members are appointed by the Medical Director. These members include Executive Director, Health Services, Director of Quality Improvement, Director of Pharmacy, Managers of both UM and CM, Compliance designee, and clerical support staff. Representatives from the Claims/Operations, Network Operations, and Contracting Departments may be asked to attend the meetings.

A quorum of at least 3 physicians must be present at each meeting. The UM Committee meets on a regular basis, at least quarterly. Only clinical Staff have voting privileges on the UM Committee. Additional UM Committee meetings or subcommittee meetings are scheduled at the discretion of the UM Committee Chairman. During the period of time between UM Committee meetings, the Medical Director or physician designee may function as an interim decision-maker to resolve any UM issues as may need expediting. Minutes of committee actions are maintained.

VIII. Functions of the UM Committee

The UM Committee ("UMC") oversees the timely development and implementation of an effective utilization management program, which includes the following:

1. Continuous monitoring and improvement of the UM program.
2. Determination and description of care and services to be provided to members of the Plan.
Such determinations are based on relevant clinical information and physician consultation, which reflect current descriptions of "best practice", and which also describe proper and effective utilization practices.

3. Implementation of UM decision-making criteria based on reasonable medical evidence and professionally recognized standards, with the input of board-certified physicians from various specialties.
4. Oversight of Utilization of services through review of reports regarding major aspects of the Utilization Management Program of the Plan.
5. Evaluation of measurement tools to ensure the consistent and accurate application of UM criteria.
6. Monitoring and reviewing UM decisions to ensure that qualified health professionals properly assess the clinical information used to support UM decisions. A licensed physician reviews all denials based on medical appropriateness and a psychiatrist reviews all behavioral health denials based on medical necessity ensuring that such denial decisions are based on and meet professionally recognized standards.
7. Supervision of the identification, analysis and resolution of utilization management problems especially as this function relates to the review of provider practice patterns. In particular, the under- and over-utilization of services, the proper use of network resources, issues of access to care and clinical performance by the provider, are all topics which may be addressed. Findings may require referral of potential quality problems to the Quality Improvement Committee for further review and intervention.
8. Evaluation of retrospective review based on clinical information received.
9. Assist in the interpretation of medical benefits associated with medically necessary care and services.
10. Ensuring that approved updated criteria and guidelines are communicated to contracted providers and are available upon request.
11. Overseeing establishment of task forces which may assist the UM Committee. The function and goals of such task force may be among the following:
 - a. Obtaining member and provider feedback about utilization management issues
 - b. Monitoring and evaluating referrals to non-contracted providers and facilities
 - c. Recommending new specialists for inclusion on the Plan's Provider Panel
 - d. Developing criteria for focus studies
 - e. Researching UM criteria to determine medical necessity
12. The UM Committee reviews delegated utilization management activities.
13. The Disease Management and Complex Case Management Programs are reviewed and any recommended updates or changes are presented to the UM Committee.

IX. Delegated Utilization Management

When Utilization Management is delegated to another entity, the Utilization Management operations and activities are conducted by qualified UM staff who must meet job description requirements that include education, training, or professional experience in medical or clinical practice and must have a current California license to practice without restrictions. Pre-contractual audits occur to assess whether key components are in place to ensure that the entity will adhere to Gold Coast Health Plan requirements. Each delegated organization must have a Utilization Management Program that is approved annually by Gold Coast Health Plan's Utilization Management Committee, as well as a signed Delegation Agreement in place.

Each delegation agreement details the key components, processes and reporting requirements of the delegate.

X. Behavioral Health Services for Medi-Cal Members

Behavioral Health conditions are an important factor in addressing medical issues. For Medi-Cal members, behavioral health has been delegated by DHCS to both Ventura County Mental Health Department and to Gold Coast Health Plan. The County provides specialty mental health care and substance use disorder treatment as described by the SMHS Program Waiver under Section 1915(b) of the Social Security Act. The Managed Medi-Cal Health plans provide all other services related to behavioral health and categorized by mild to moderate dysfunction. GCHP has contracted with a Managed Behavioral Health Organization (MBHO) to identify and treat mild to moderate mental health conditions.

Beacon Health Strategies and College Health IPA (CHIPA) (the GCHP MBHO) manages a network of providers and administers outpatient mental health benefits for Medi-Cal beneficiaries with mild to moderate conditions. These benefits include:

- Individual and group mental health treatment (psychotherapy);
- Psychological testing to evaluate a mental health condition;
- Outpatient services to monitor drug therapy; and
- Psychiatric consultation
- Autism treatment services
- Behavioral Health Treatment for members under 21 years old

Members who are diagnosed with a severe mental health condition are referred to the County Mental Health Department for treatment.

To ensure continuity of care, a memorandum of understanding has been developed with the County to provide for open dialog when members cross over from one level of care to the other. Both GCHP and Beacon Health will develop processes for referral to the County and in some instances back to the member's PCP for treatment and follow up.

XI. Carved-out and Linked Services for Medi-Cal Members

Some services for Medi-Cal members are carved out as described in Evidence of Coverage (EOC). Members may be linked to services such as Child Health and Disability Prevention Program, waiver programs and Regional Centers. Gold Coast Health Plan UM/CM staff will assist providers in making referrals to and in locating necessary linked and carved-out services.

XII. Denials, Appeals and Grievances

Denials are based on benefit coverage, medical necessity and are often due to the lack of sufficient clinical information being provided by the physician, practitioner, or facility. Only Gold Coast Health Plan physicians can issue a denial decision. Attempts to reach the treating physician are often made prior to issuing denials and Gold Coast Health Plan physicians are always available to discuss the denial with the practitioner. Denial decisions are communicated verbally and in writing as required by contract.

A qualified physician reviews and performs all service denials. All Gold Coast Health Plan physicians who review and perform denials demonstrate education, training or professional experience in medical or clinical practice prior to employment by Gold Coast Health Plan. When one of Gold Coast Health Plan's

qualified physicians does not have applicable expertise to assess the medical necessity of a requested service, the Chief Medical Officer, Medical Director or Physician Reviewer directs review to an appropriately licensed professional. A qualified physician reviews all denials of requests for prior authorization.

Denial notifications include:

- A clear, concise and specific explanation of the reasons for the plan's decision;
- A reference to the criteria or guidelines used as a basis for the plan's decision, and notice that upon request the member and/or provider can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion upon which the denial decision was based;
- Other clinical reasons used as a basis for a decision regarding medical necessity that are easily understood and do not contain abbreviations;
- The name and direct telephone number and extension of the physician or pharmacist responsible for the decision (for written or electronic communications to providers only); and
- Information on how the member and/or provider may file an appeal with the plan, and when applicable, request an administrative hearing.

Appeals

Gold Coast Health Plan's Health Services Department participates in the thorough, appropriate and timely resolution of clinical appeals.

Gold Coast Health Plan has procedures in place for timely response to pre-service, post-service, and expedited appeals. These procedures are detailed in Gold Coast Health Plan Policies and Procedures, Member Appeal Process (GA-002).

Gold Coast Health Plan will appoint a physician not involved in the prior adverse decision to review the appeal. The appointed person must be neither the individual who made the adverse determination that is the subject of the appeal nor a subordinate of (i.e., directly supervised by) such individual.

XIII. Confidentiality

Individuals engaged in the UM Program activities shall maintain confidentiality of all member information and any other information developed or presented as part of the Program. Gold Coast Health Plan protects the confidentiality of member information in such a manner that is consistent with divulging or collecting only enough information from the member, subscriber or appropriate healthcare provider, that is necessary to conduct business activities. Activities and documents that are part of the UM Program are considered confidential and are maintained in compliance with legal requirements.

XIV. ACKNOWLEDGMENT AND APPROVAL

Approvals:

Print Name: **Nancy Wharfield, M.D.**
Chief Medical Officer

Signature: Nancy Wharfield

Date: 1/25/19

Print Name: **Kathy Neal, RN, DNP**
Executive Director, Health Services

Signature: Kathy Neal

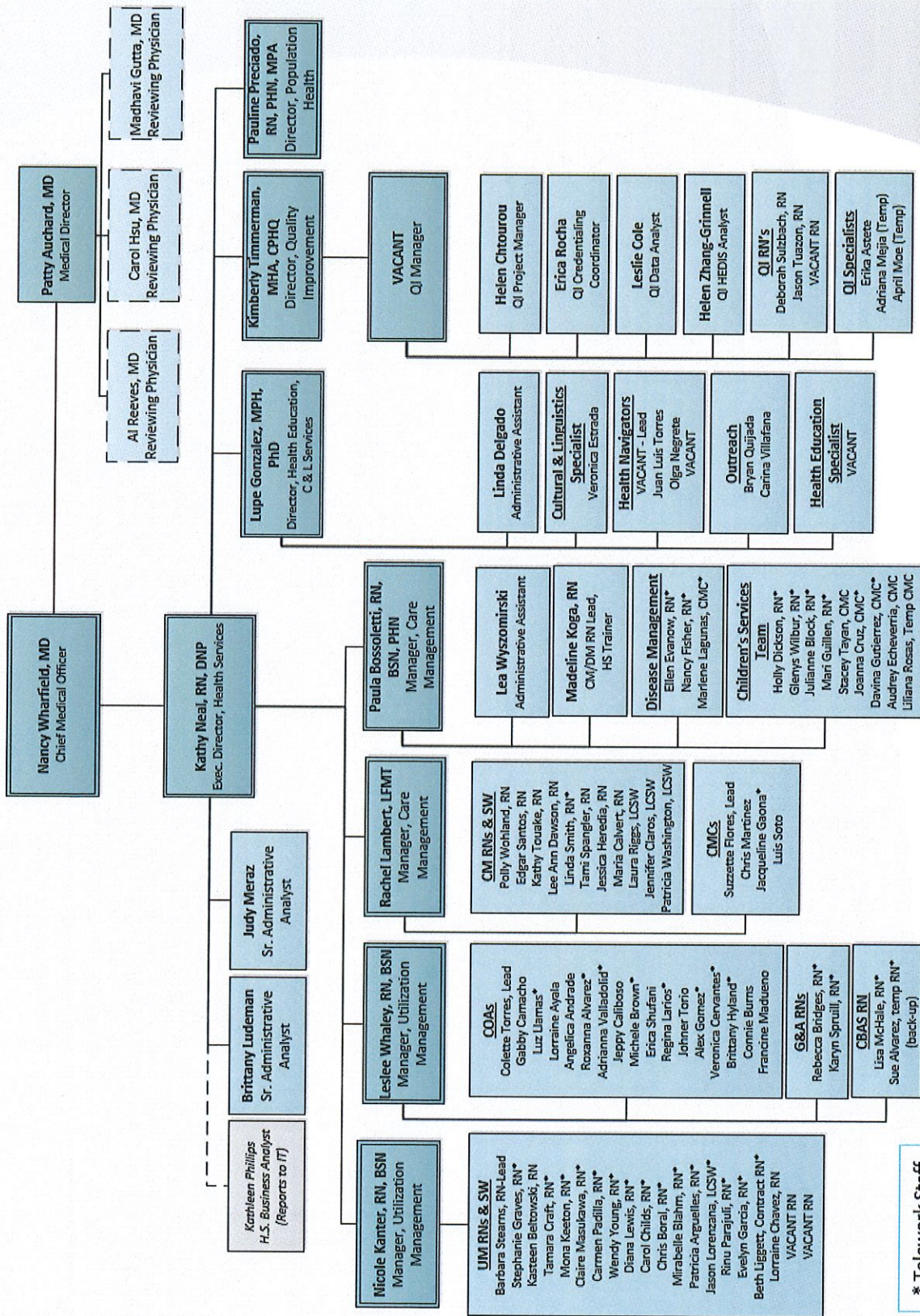
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Appendix A: Communication Services/Timeliness of UM Decisions

Decision Timeframe	Medi-Cal Contract
<u>Emergency Care</u>	No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.
<u>Post-stabilization</u>	<p>Upon receipt of an authorization request from an emergency services provider, UM shall render a decision within 30 minutes or the request is deemed approved, pursuant to Title 28 CCR Section 1300.71.4.</p> <p>Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.</p>
<u>Concurrent Review of authorization for treatment regimen already in place</u>	<p>Within 24 hours of the receipt of the request, consistent with urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01 (h)(3). An additional 48 hours is allowed if clinical information has been requested but not received. (Health and Safety Code Section 1367.01(h) (2).</p>
<u>Retrospective Review</u>	Within 30 calendar days in accordance with Health and Safety Code Section 1367.01(h)(1).
<u>Pharmaceuticals</u>	Twenty-four (24) hours or one (1) business day on all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1).
<u>Routine Authorizations</u>	Five (5) working days from receipt of the information reasonably necessary to render a decision (these are requests for specialty service, cost control purposes, out-of-network not otherwise exempt from prior authorization) in accordance with Health and Safety Code Section 1367.01(h)(1), or any future amendments thereto, but, no longer than 14 calendar days from the receipt of the request. The decision may be deferred and the time limit extended an additional 14 calendar days only where the Member or the Member's provider requests an extension, or Gold Coast Health Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.
<u>Expedited Authorizations</u>	For requests in which a provider indicates, or UM determines that, following the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, UM must make an expedited authorization decision and provide notice as expeditiously as the Member's health condition requires and no later than 72 hours after receipt of the request for services. UM may extend the 72 hour time period by up to 14 calendar days if the Member requests an extension, or if Gold Coast Health Plan justifies, to the DHCS upon request, a need for additional information and how the extension is in the Member's interest. Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such.



Health Services Department



Updated: 1/14/2019

* Telework Staff