POLICY AND PROCEDURE	
TITLE: Prior-Authorization Requests	
DEPARTMENT: Health Services	**POLICY #:** HS-001
EFFECTIVE DATE: 04/08/2011	**REVIEW/REVISION DATE:** 09/22/2025
COMMITTEE APPROVAL DATE: Not Set	**RETIRE DATE:** Not Set
PRODUCT TYPE: Medi-Cal	**REPLACES:** v.3 Prior-Authorization Requests

I. Purpose

A. The purpose of this policy is to define the process by which Gold Coast Health Plan ("GCHP") performs pre-authorization activities in accordance with contractual, regulatory, and licensing requirements.
B. To outline Utilization Management ("UM") determination and notification time frame requirements for conducting pre-service reviews.

II. Policy

A. Gold Coast Health Plan's utilization management staff and delegated entities, comprised of qualified and licensed clinical professionals, will use evidence-based guidelines ("EBG") to evaluate medical necessity for pre-service requests in accordance with CA Health and Safety Code ("HSC") Section 1367.01 and 42 Code of Federal Regulations ("CFR") 438.910(d) regarding mental health parity.

III. Definitions

Evidence Based Guidelines (EBG): Clinical guidelines based on the summary of relevant medical literature that enhances the clinical decision-making process in which theory-derived, research-based knowledge informs the provision of care. Sources of EBG may include, but are not limited to, clinical practice guidelines from MCG, government agencies including Medicare and Medi-Cal, and other nationally recognized professional medical societies.

Pre-Service: Utilization Management review that is performed for medical necessity determination prior to a non-emergency/elective admission or other course of treatment that requires authorization for payment. Failure to obtain authorization will mean that Gold Coast Health Plan may not pay for the service. Services requiring authorization are in the Provider Manual, Member Handbook, and posted to Gold Coast Health Plan's website for providers and members.

Medically Necessary or Medical Necessity: Those services that are covered benefits and are reasonable and necessary services to protect life, to prevent

significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

Physician-Administered Drugs (PADs): An outpatient drug provided or administered to a recipient and billed by a Provider and not self-administered by a patient or caregiver. Such providers include, but are not limited to, physician offices, clinics and hospitals. Physician-administered drugs include both injectable and non-injectable drugs.

Utilization Management (UM): The process of evaluating and determining coverage for and appropriateness of medical care services, as well as providing any needed assistance to clinician or patient, in cooperation with other parties, to ensure appropriate use of resources.

Urgent Authorizations: An expedited request for review when it has been determined that the standard timeframes for review will seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

IV. Procedure

A. Gold Coast Health Plan ensures that its pre-authorization review procedures meet the following minimum requirements:
   1. The list of services requiring prior authorization is reviewed on an as-needed bases and no less than once annually.
   2. Qualified health care professionals supervise review decisions, including service reductions, and a qualified Physician reviews all denials that are made, in whole or in part, on the basis of medical necessity. For purposes of this provision, the review of the denial of a pharmacy prior authorization may be by a qualified Physician or Pharmacist.
   3. Gold Coast Health Plan UM program does not impose Quantitative Treatment Limitations (“QTL”), or Non-Quantitative Treatment Limitations (“NQTL”) more stringently on covered mental health and substance use disorder services than are imposed on medical/surgical services in accordance with the parity in mental health and substance use disorder requirements in 42 CFR 438.900 et seq.
   4. Gold Coast Health Plan utilizes EBG such as MCG Care Guidelines which are a set of written criteria or guidelines for Utilization Review that are based on sound medical and behavioral health evidence, are consistently applied, regularly reviewed, and updated.

5. Gold Coast Health Plan EBG and utilization review policies and procedures are available to Members and Providers upon request.
6. Reasons for decisions are clearly documented.
7. Notification to Members regarding denied, deferred, or modified referrals is made as specified contractually. There are well-publicized appeal procedures for both providers and Members.
8. Decisions are made in a timely manner.
9. Prior Authorization requirements are not applied to Emergency Services, Minor Consent Services, family planning services, preventive services, primary care services, basic prenatal care, mild to moderate mental health assessments and/or treatments, sexually transmitted disease services, HIV testing and other sensitive services.
10. Prior Authorization is required for all genetic testing except for cancer biomarking testing in members with advanced or metastatic stage 3 or 4 cancer, or cancer progression or recurrence in the member with advanced or metastatic stage 3 or 4 cancer.
11. Services with out-of-network providers may be authorized when a provider type or service is unavailable within the network.
    a. Members are provided with education on the following through member informing materials, including but not limited to the member handbook:
        1. How to obtain out-of-network care.
        2. Their right to access emergency services at an out-of-network provider.
        3. Their right to seek out-of-network family planning services.
12. Records, including any Notice of Action, shall meet the retention requirements described contractually.
13. Gold Coast Health Plan notifies the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice to the provider may be oral or in writing.
14. If Gold Coast Health Plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified 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 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.

B. Timeframes for Medical Authorization
    1. Emergency and Urgent Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.
    2. Post-stabilization: Upon receipt of an authorization request from an emergency services provider, contractor shall respond to request within 30 minutes or the service is deemed approved in accordance with Title 22 CCR Section 53855 (a), or any future amendments thereto.
    3. Non-urgent care following an exam in the emergency room: Response to request within 30 minutes or deemed approved.
    4. Concurrent Review of authorization for treatment regimen already in place: within 5 working days or less consistent with urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01 (h) (1).
    5. Retrospective review: Within 30 calendar days in accordance with Health and Safety Code Section 1367.01 (h) (1).
    6. Pharmaceuticals (Covered Outpatient Drugs as defined by SSA 1927(k)(2)): Within 24 hours or one business day on all drugs that require prior authorization.
        a. A covered outpatient drug does not include any drug, biological product, or insulin provided as part of or incident to and in the same setting as any of the following services:
            1. Inpatient Services
            2. Hospice Services
            3. Dental Services
            4. Physician Services
            5. Outpatient hospital services

6. Nursing facility and services provided by an intermediate care facility for individuals with intellectual disabilities.
7. Other laboratory and x-ray services; or
8. Renal dialysis

b. Physician administered drugs (PAD's) excluded from the definition of Covered Outpatient Drugs requiring prior authorization will be processed per the applicable expedited, routine, or retrospective authorization timeframes per DHCS and NCQA.

7. Therapeutic Enteral Formula for Medical Conditions in Infants and Children: Decisions will be made in a timely manner based on the sensitivity of the medical condition. Timeframes for Medical Authorization of medically necessary therapeutic enteral formulas for infants and children and the equipment/supplies necessary for delivery of these special foods are set forth in MMCDPL 14-003, Welfare and Institutions Code Section 14103.6 and Health and Safety Code Section 1367.01.
8. Routine authorizations: Five (5) business days from the 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.
9. Expedited authorizations: For requests in which a provider indicates, or Gold Coast Health Plan determines that, following the standard timeframe for authorizations could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, Gold Coast Health Plan makes an expedited authorization decision and provides notice as expeditiously as the Member's health condition requires no later than 72 hours after the receipt of all clinical information needed to approve the request for services. Gold Coast Health Plan 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 can justify, 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 is immediately processed as such.

a. Expedited authorizations that do not meet the definition of "urgent" may be reclassified and handled with in the timeframe of the appropriate request type (i.e., preservice or post service).

C. Denial, Deferral, or Modification of Prior Authorization Requests

1. Gold Coast Health Plan notifies Members of a decision to deny, defer, or modify requests for Prior Authorization by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification is provided as specified in Title 22 CCR Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.
2. Gold Coast Health Plan provides for a written notification to the Member and the Member's authorized representative on a form approved by DHCS, informing the Member of all the following:
   a. A statement of the action Gold Coast Health Plan intends to take
   b. A clear and concise explanation of the reasons for the decision
   c. A description of the criteria or guidelines used
   d. The medical reason(s) in layman's terms that the service was denied and access to the clinical criteria used if they desire.
   e. The Member's right to, method of obtaining, and time limit for requesting a fair hearing to contest the denial, deferral, or modification action and the decision the Contractor has made, the reason(s) for the action and the specific regulation(s) or plan authorization procedures supporting the action.
   f. The Member's right to represent themselves at the fair hearing or to be represented by legal counsel, friend or other spokesperson.
   g. The name and address of Gold Coast Health Plan and the Department of Social Services (DSS) toll-free telephone number for obtaining information on legal service organizations for representation.

h. The member's right to file an appeal with Gold Coast Health Plan and time limit for requesting an appeal. The address and/ or phone number to contact for assistance in filing an appeal.

3. Gold Coast Health Plan provides notification to beneficiaries and their authorized representatives within 2 business days not to exceed 14 calendar days from the receipt of the request in accordance with the time frames set forth in Title 22 CCR Sections 51014.1 and 53894. Such notice is deposited with the United States Postal Service in time for pick-up no later than the third business day after the decision is made.
4. Plan notifies the Member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request Gold Coast Health Plan provides written notification of the decision to Members no later than 28 calendar days from the receipt of the original request.

D. Member Denial Wording
1. In order to ensure that every member denial letter clearly explains the clinical reasons for the decision regarding medical necessity, the following process is followed at Gold Coast Health Plan.
   a. The UM Nurse is responsible for alerting the physician reviewer (in print or electronically) that a Member letter is needed for the case.
   b. The physician reviewer is responsible for documenting the denial reasons in a clear and simple manner that can be understood by a Member.
   c. The UM nurse or non-clinical operational assistant creates the letter with the physician reviewer's exact wording. Nurse sign off may be required.
   d. Written translation of member information will be provided in the threshold language using a qualified translator.

V. Attachments

A. Prior Authorization Request

VI. References

A. 22 CCR Section 51340, 51340.1, 51014.1, 51014.2, 51003, 53894
B. 22 CCR Section 53855 (a)
C. 28 CCR 1300.71.4, 1300.67.8
D. 42 CFR Section 447.502
E. APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
F. APL 21-011 Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments
G. APL 22-010 Cancer Biomarker Testing
H. APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services
I. DHCS MMCDPL 14-003 Enteral Nutrition Products
J. Health and Safety Code, Section 1367.01, 1367.0 l (h)(3). 1367.01 (h)(I)
K. Welfare and Institutions Code, Section l 4185(a)(I),14103.6

VII. Revision History

STATUS	REVIEW DATE	DATE REVISED	REVISION AUTHOR/APPROVER	REVISION SUMMARY
Created		04/08/11	CEO	
Revised		10/18/13	CEO	
Reviewed	09/17/13		UM Director	
Revised		12/19/17	Sr. Director of Health Services	
Reviewed	12/19/17		CMO	
Approved	12/21/17		DHCS	
Approved	04/12/18		CEO	
Revised		12/14/18	Utilization Management Manager	
Approved	01/28/19		UM Committee	
Approved	05/06/19		DHCS	
Approved	05/08/19		CEO	
Reviewed	10/07/19		Utilization Management Managers	
Revised		09/24/20	Utilization Management Manager	
Approved	10/29/20		Utilization Management Committee	
Approved	11/30/20		Interim CEO	
Revised		08/11/21	Utilization Management Manager	Added APL 21-004

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STATUS	REVIEW DATE	DATE REVISED	REVISION AUTHOR/APPROVER	REVISION SUMMARY
Revised		09/14/21	DEI	Reviewed for gender neutral pronouns
Approved	9/14/21		Policy Review Committee	
Approved	10/28/21		Utilization Management Committee	
Approved	12/14/21		DHCS	
Approved	12/15/21		CEO	
Revised		8/26/2022	Utilization Management Manager	Revised for cancer biomarker testing.
Approved	9/14/2022		Policy Review Committee	
Approved	9/27/2022		DHCS	
Approved	10/27/2022		Utilization Management Committee	
Revised		12/16/2022	Utilization Management Director & Care Management Director	Revised in accordance with Operational Readiness deliverable R.0131
Approved	1/12/2023		CEO	
Reviewed	1/6/2023		Utilization Management Director	Reviewed in accordance with Operational Readiness deliverables R.0067 & R.0069
Revised		11/14/2023	Utilization Management Manager	removed reference to PBM in A.1, no other changes
Approved	01/23/2024		Policy Review Committee	
Approved	01/24/2024		Utilization Management Committee	
Approved	02/20/2024		CEO	
Revised		10/7/2024	Utilization Management Manager	Revised definitions and procedures to align with NCQA
Reviewed	10/28/2024		Utilization Management Manager	Reviewed, no changes.