Gold Coast Health Plan℠
A Public Entity

POLICY AND PROCEDURE	
TITLE: Decision and Notification Timeframes Medical Authorization	
DEPARTMENT: Health Services	**POLICY #:** HS-005
EFFECTIVE DATE: 01/26/2011	**REVIEW/REVISION DATE:** 09/22/2025
COMMITTEE APPROVAL DATE: Not Set	**RETIRE DATE:** Not Set
PRODUCT TYPE: Medi-Cal	**REPLACES:** v.3 Decision and Notification Timeframes Medical Authorization

I. Purpose

A. The purpose of this policy is to define the timeframes for the decision and notification of pre-service, concurrent and post-service review of the requests for authorization of services.

II. Policy

A. Gold Coast Health Plan (GCHP) ensures compliance with local and state regulatory requirements and accreditation standards when making Utilization Management (UM) decisions and notifications. Only a California licensed Physician who is competent to evaluate the specific clinical or behavioral health issues involved in the health care services by the requested provider may deny or modify requests for authorization related to medical necessity.

III. Definitions

A. **Concurrent Review:** Concurrent review is a review that is performed while the patient is receiving care during a hospital stay. It includes the review of requests for extended stays or additional services and evaluates the level and setting of care.

B. **Expedited 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.

C. **Medically Necessary or Medical Necessity:** Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or

alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I section 14059.5(a) and 22 CCR section 51303(a). For Members less than 21 years of age, a service is Medically Necessary if it meets the EPSDT standard of Medical Necessity set forth in 42 USC section 1396d(r)(5), as required by W&I sections 14059.5(b) and 14132(v).

D. **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.

E. **Post-service Review:** Any request received for review of care or services that have already been delivered, including a request for coverage of an acute inpatient stay after the member's discharge.

F. **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.

G. **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.

IV. Procedure

A. Pre-Service Review for Authorization of Services
   i. Non-urgent care decisions are made within five (5) business days from the receipt of the information reasonably necessary to make the determination in accordance with Health and Safety Code (HSC) Section 1367.01, or any future amendments thereto, but no longer than fourteen (14) calendar days from the receipt of the request.
      1. Verbal notification of deferrals, denials, modifications, reductions, suspensions, or terminations of covered services are made to the requesting provider within twenty-four (24) hours of making the decision.

2. Written or electronic confirmations of deferrals, denials, modifications, reductions, suspensions, or terminations of covered services are sent to the provider and member within two (2) business days of the decision.
3. Written or electronic confirmations of approvals are made to the requesting provider within two (2) business days of the decision.

ii. Expedited authorization decisions are made within seventy-two (72) hours after the receipt of all clinical information reasonably necessary to make a determination. The provider is initially notified within twenty-four (24) hours of making the decision and in writing within two (2) working days of making the decision.

iii. Concurrent Review of authorization for treatment regimen already in place shall be completed in a timely fashion appropriate for the nature of the member's condition, not to exceed five (5) working days from the date of receipt, in accordance with HSC Section 1367.01 (h) (1).

iv. 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 Department of Health Care Services ("DHCS") Policy Letter 14-003, Welfare and Institutions Code Section 14103.6 and HSC Section 1367.01.

v. Hospice Services: Members may access hospice services within twenty-four (24) hours of request. Routine hospice care does not require authorization in accordance with DHCS All Plan Letter (APL) 13-014.

vi. Physician Administered Drugs (PADs) must follow the applicable timeliness requirements as required by federal and state regulations:
    1. Requests for authorization of physician administered drugs billed on a medical or institutional claim must be responded to within 24 hours or one business day of receipt of the request, in accordance with 42 USC section 1396r-8, 42 CFR sections 438.210 and 438.3, and Welfare and Institutions (W&I) Code section 14185.
    2. If the physician administered drug is a "covered outpatient drug," as defined in 42 USC section 1396r-8(k)(2) and (k)(3), an extension of time to respond is not permitted. However, if the drug is not considered a "covered outpatient drug," an extension of time to respond may be obtained, as allowed under 42 CFR section 438.210.

3. For reference, 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:
    a. Inpatient services
    b. Hospice services
    c. Dental services
    d. Physician services
    e. Outpatient hospital services
    f. Nursing facility services and services provided by an intermediate care facility for individuals with intellectual disabilities
    g. Other laboratory and x-ray services
    h. Renal dialysis

B. Hospital Care
    i. Emergency Care: No prior authorization required, following the reasonable person standard to determine that the presenting complaint might be an emergency.
    ii. Post-stabilization: Upon receipt of an authorization request from an emergency services provider, GCHP shall respond to request within thirty (30) minutes or the service is deemed approved in accordance with Title 22 CCR Section 53855 (a), or any future amendments thereto.
    iii. Non-urgent care following an exam in the emergency room: GCHP shall respond to request within thirty (30) minutes or the service shall be deemed approved.
    iv. The decision to approve, modify, or deny requested concurrent inpatient services is made within twenty-four (24) hours of notification and the receipt of the information reasonably necessary to make a determination. The provider is notified verbally or in writing within twenty-four (24) hours of the receipt of the request. The provider and member are notified on how to initiate an expedited appeal at the time of notification for denied or modified services.
        1. For cases where the clinical information provided to GCHP is not sufficient to determine medical necessity, the requesting provider is contacted with a request for additional clinical information reasonably necessary to make a decision based on the member's medical condition. The decision to approve, modify or deny requested concurrent inpatient services is then made within seventy-two (72) hours of the receipt of the request. The provider and member are notified verbally or in writing within twenty-four (24) hours of the decision.

2. Facility care for inpatient services should not be discontinued until the enrollee's treating provider has been notified of the plan's decision and a plan of care has been agreed upon by the treating provider that is appropriate for the medical needs of the patient.

C. Post-service Review for Authorization of Services
   i. The decision and notification to approve, deny or modify post-service requests is made within thirty (30) calendar days of receipt of information reasonably necessary and requested by the plan to make a determination. If the decision is a denial or modification, the provider is also notified electronically or in writing within thirty (30) calendar days of the receipt of the request.

D. Communications
   i. Written communications regarding decisions will identify the specific health care service denied or modified, and include the following:
      1. The action taken by the plan.
      2. A clear, concise explanation of reasons for the plan's decision.
      3. A description of the criteria or guidelines used.
      4. The clinical reasons for the decisions regarding medical necessity
      5. A citation of the specific regulations or plan authorization procedures supporting the action.
      6. Criteria or guidelines availability upon request.
      7. The name of the health care professional responsible for the decision.
      8. The direct UM phone number to contact for questions regarding the denial or to request to speak with the physician reviewer
      9. Appeal instructions.
      10. The member's right to request a State Fair Hearing.
      11. An explanation on how to request a State Fair Hearing.
          a. The member's right to represent himself/herself, or to be represented by legal counsel, friend or other spokesperson at the fair hearing.
          b. GCHP's address and the State toll-free telephone number for information on legal representation.
          c. The time limit for requesting a State Fair Hearing.
   ii. Instructions explaining how the member may request an administrative hearing and aid paid pending.
   iii. Written translation of member information will be provided in the threshold language using a qualified translator.

iv. A copy of the member NOA will be provided in alternate formats and/or ancillary aides for members who selected this service in accordance with APL 22-002 and GCHP policy and procedure (P&P) HECL-010.

V. Attachments

A. N/A

VI. References

A. 22 CCR § 51014.1 and 53855
B. APL 13-014 Hospice Services and Medi-Cal Managed Care (or its successor)
C. APL 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services
D. APL 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (or its successor)
E. APL 22-002 Alternate Format Selection for Members with Visual Impairments
F. APL 22-006 Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services (or its successor)
G. DHCS Contract 23-30242, Exhibit A, Attachment III
H. DHCS Contract 23-30242, Exhibit A, Attachment III, Subsection 2.3.2, Timelines for Medical Authorization
I. GCHP P&P HECL-010 Alternative Format Selection
J. HSC § 1367.01
K. Policy Letter (PL) 14-003 Enteral Nutrition Products

VII. Revision History

STATUS	DATE REVISED	REVIEW DATE	REVISION AUTHOR/APPROVER	REVISION SUMMARY
Created		01/26/2011	MD.	
Approved		01/26/2011	CEO	
Revised	03/02/2014		CEO	
Approved		03/07/2016	CEO	
Revised	01/14/2019		Utilization Management Manager	
Approved		01/25/2019	Utilization Management Committee	
Revised	04/15/2019		Utilization Management Manager	
Approved		09/06/2019	DHCS	

STATUS	DATE REVISED	REVIEW DATE	REVISION AUTHOR/APPROVER	REVISION SUMMARY
Revised	06/10/2020		Utilization Management Manager	
Approved		08/07/2020	Utilization Management Committee	
Approved		08/11/2020	Interim Compliance Officer	
Revised	6/8/2021		Utilization Management Manager	Revised to include standards of determining threshold languages per APL 21-004
Approved		07/29/2021	Utilization Management Committee	
Approved		09/14/2021	Policy Review Committee	
Approved		12/01/2021	CEO	
Revised	6/9/2022		Utilization Management Director	Revised to include AFS selection for member NOA's per APL 22-002
Approved		06/10/2022	Policy Review Committee	
Approved		07/01/2022	DHCS	
Approved		07/19/2022	CEO	
Revised	8/31/2022		Utilization Management Director	Revised in accordance with Operational Readiness Deliverable R.0070
Revised	9/8/2023		Utilization Management Manager	Annual Review, added under Communications, edited references
Approved		9/20/2023	Policy Review Committee	
Approved		10/26/2023	Utilization Management Committee	
Approved		11/18/2023	CEO	
Reviewed		08/27/2024	Utilization Management Manager	Annual Review, no changes noted
Revised	9/10/2024		Utilization Management Director	Revised to include definitions and

STATUS	DATE REVISED	REVIEW DATE	REVISION AUTHOR/APPROVER	REVISION SUMMARY
				timeframes for physician administered drugs.
Revised	09/23/2024		Senior Policy Analyst	Updated reference to DHCS Contract in “VI. References” section.
Revised	08/07/2025		Sr. Administrative Analyst	Updated Procedure and references to align with DHCS Contract amendment “timeliness for medical authorization”