



<b>Policy and Procedure No: UM 35.5</b>		<b>Revision No:5</b>
<b>Division: Care Management</b>		
<b>Department: Utilization Management</b>		
<b>Title: PHC-CA Clinical Criteria and Guidelines</b>		
<b>Effective Date: 12/31/2017</b>		
<b>Supersedes Policy No: UM 35.0, UM 35.1, UM 35.,2, UM 35.3, UM 35.5</b>		
<b>Reviewed/Revised by: Tiffany Jarrett</b>		<b>Review/Revision Date: 9/5/2025</b>
<b>Approving Committee: Utilization Management Committee</b>		<b>Date: 12/15/2025</b>
<b>Executive Oversight Committee Date: 12/16/2025</b>		

**Purpose:**

To define how PHC California (The Health Plan) establishes Clinical Review criteria and guidelines for decision making processes ensuring that authorization determinations are consistent with its Utilization and Care/Case Management Program.

**Policy:**

1. The Health Plan ensures that decisions related to Utilization Management (UM) and coverage or denial of requested Covered Services, and/or supplies, are consistent with the criteria and guidelines described within this policy.
2. On an annual basis, the Health Plan administers Inter-Rater Reliability testing to all personnel who perform authorization determinations and issue individual Corrective Action Plans (CAPs) to staff who score below the acceptable threshold. Please reference the Health Plan’s IRR Policy, which is listed in supporting documents.
3. The Health Plan does not engage in practices that specifically reward Practitioners, or other individuals, for denying, limiting, or discontinuing coverage or care. This does not, however, omit the ability of the Health Plan to engage in performance incentives to staff for appropriate utilization of services, both over and under, as part of the Triple AIM to improve Member Access, Experience and Quality of Care through improved efficiency of utilization of care.
4. The Health Plan ensures that UM activities and decisions are appropriate and promote quality care by utilizing clinical criteria and practice guidelines that:
  - a. Are based on reasonable local and national medical evidence, or a consensus of health care professionals in the field;
  - b. Consider the needs of the enrolled population that may be specific to the geographical region, cultural make up or availability of network services. The Health Plan should consider at minimum the following in its decision-making processes:
    - i. Age
    - ii. Comorbidity
    - iii. Complications/Complexity of this SNP membership
    - iv. Psychosocial factors

- v. Home environment
  - vi. Social Determinates of Health
  - vii. Availability of services being provided (skilled, home health, inpatient, etc.)
  - viii. Benefit coverage
  - ix. Compliance concerns (treatment plan and medication adherence)
- c. Are developed in consultation with contracted Community facing Providers; and
  - d. Are reviewed and updated annually or as appropriate, by submitting the recommended criteria and guidelines to the Utilization Management Committee (UMC) voting physician members for review and approval.
5. The Health Plan conducts the Utilization Review using criteria and guidelines that are approved and adopted in Utilization and Care/Case Management (UMCM) Program. Such criteria and guidelines may include, but are not limited to:
- a. Medi-Cal Provider Manual
  - b. Nationally recognized Evidence Based criteria such as InterQual or Milliman Care Guidelines (MCG);
  - c. National Comprehensive Cancer Network (NCCN) Guidelines;
  - d. Specialty society guidelines, such as American Academy of Pediatrics (AAP);
  - e. Centers of Excellence Guidelines;
  - f. Preventive health guidelines (i.e., U.S. Preventive Services Task Force, American College of Obstetrics and Gynecology (ACO Guidelines);
  - g. Behavioral health Clinical Practice Guidelines from the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP)
  - h. SAMSHA.Gov
  - i. Benefit Structure and Guidelines
  - j. National Institute of Health (NIH) Guidelines
  - k. Center for Disease Control (CDC) Guidelines
  - l. Articles in Peer-Reviewed Literature
6. The Health Plan evaluates technological advancements in medical procedures, behavioral health procedures, and medical devices for inclusion in the benefits package.
7. In accordance with the Health Plan's Delegation Oversight Policy and its UM Delegation



Agreement, the Delegate submits its Utilization Review criteria and guidelines to the Health Plan for approval annually.

8. Upon member or treating physician request, the Health Plan and its UM Delegates provides orally or in writing, all criteria used in making UM decisions including, but not limited to, discharge and continued stay criteria, and clinical practice guidelines.
9. The Health Plan and its delegates ensures its UM policies processes, strategies, evidenced based standards, and other factors used for UM or utilization review are consistently applied to medical/surgical, behavioral health, and substance use disorder services and benefits.

**Procedure:**

1. The Health Plan documents Utilization Review criteria and guidelines for all prior authorization determinations that cite criteria in the authorization case notes.
2. The Health Plan evaluates technological advancements in medical procedures (i.e. HIV-specific interventions (e.g. ART-related surgeries) and medical devices (i.e. smart pill bottles and remote monitoring), and related criteria and guidelines. New technology is reviewed for safety, efficacy, and alignment with CDC/DHHS guidelines and DHCS covered benefits in consideration of updating the benefits package.
  - a. The Health Plan actively engages healthcare professionals with relevant clinical expertise to provide input on the evaluation and implementation of healthcare technologies, as deemed appropriate.
3. On an annual basis, the Health Plan’s Director of Care Coordination or Designee submits criteria and guidelines to the Utilization Management Committee (UMC) and Quality Improvement and Health Equity Committee (QIHEC) for review and approval
4. Upon approval by the UMC and QIHEC, the UM team adopts and implement the approved criteria, including those related to technological advancements, into the UM Program.
5. Utilization Management Leadership:
  - a. Distributes the criteria and guidelines to the Plan and its delegates professional reviewers;
  - b. Activates the criteria and guidelines in the UM systems; and
  - c. Makes the criteria and guidelines available to Members and Providers, upon request.
6. Delegated entities, pursuant to the Health’s Delegation Agreement, adopts and implements Evidence-Based criteria and guidelines related to utilization authorization determinations.

**Definitions:**

N/A



**Monitoring:**

1. The Director of Care Coordination or designee monitors and ensures all UM delegates review and approve this requirement annually by the Delegate’s Utilization Management Committee.
2. On an annual basis, the Health Plan’s Director of Care Coordination or Designee conducts Inter-Rater Reliability assessments on all professional reviewers and shares results and any CAPs implemented to the UMC Review and input.
3. The Director of Care Coordination or Designee submits a request to the QIHEC to implement any updates to the criteria when generated as an action item from the UMC.
4. The Health Plan reviews and approves annual Delegate’s UM activities including its utilization criteria and guidelines in accordance with its Delegation Agreement and Oversight Policies.
5. This policy is updated as often as necessary and reviewed and approved annually by the Utilization Management Committee.

**Reference(s):**

1. California Health and Safety Code § 1300.71.4. Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services.
2. 28 CCR § 1300.71.4, 28 CA ADC § 1300.71.4
3. <https://www.acog.org/About-ACOG/ACOG-Departments/Deliveries-Before-39-Weeks/ACOG-Clinical-Guidelines>
4. <https://www.uspreventiveservicestaskforce.org/>

**Regulatory Approval(s):**

Date	Version	Agency	Purpose	Response
8/29/2023	35.3	DHCS	2024 Operational Readiness R.0131	Approved
7/19/2024		DHCS	Regulatory Audit	File and Use
TBD	35.5	DHCS	MCOD Portal Item D.0330.31	Pending

