

# **TECHNICAL ASSISTANCE GUIDE FOR MEDICAL AUDITS**

**CATEGORY 1: UTILIZATION MANAGEMENT PROGRAM**

**June 2026**

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# INTRODUCTION

In accordance with California Welfare and Institutions Code Section 14456, the Department of Health Care Services (DHCS) conducts medical audits of Medi-Cal Managed Care Plans (MCPs) on an annual basis. Medical audits evaluate MCPs' compliance with the DHCS contractual requirements and applicable laws and regulations. The Contract and Enrollment Review Division (CERD) of DHCS' Audits and Investigations (A&I) is responsible for performing the mandated audits. The audit scope encompasses the following six categories of review:

- » Category 1 – Utilization Management
- » Category 2 – Population Health Management and Coordination of Care
- » Category 3 – Network and Access to Care
- » Category 4 – Grievances, Appeals, and Member's Rights
- » Category 5 – Quality Improvement and Health Equity Transformation Program
- » Category 6 – Plan Organization and Administration

## USING THE TECHNICAL ASSISTANCE GUIDE (TAG)

The TAGs are designed to identify key elements commonly evaluated by A&I's audit process to promote transparency. The TAG is grouped by subcategories and includes the following components, as applicable:

**Requirement:** This column identifies "key" statutory, regulatory, and contractual requirements related to core managed care organization systems and processes that may be included in scope and additional areas identified based on risk. While this narrows the audit scope, the audit team may investigate the MCP's compliance with other requirements.

- » MCPs are ultimately responsible for ensuring compliance with all provisions of the DHCS contract as well as any applicable All Plan Letters (APLs), Plan Letters (PLs) and Dual Policy Letters.
- » The contract requirements can be supplemented with applicable laws, regulations, APLs, etc.
- » This TAG cites language from the DHCS Boilerplate Contract and related Federal and State laws and regulations.
- » "Contractor" means "MCP" or "Plan" in this document.

**Documentation Reviewed:** The items in this column reflect a hierarchy of documents.

- » Initially listed items (√) indicated will most likely confirm contractual compliance or not.
- » Lower listed alternate/optional documents (Δ) may contain information that will help determine the status of the MCP's compliance with a particular requirement.
- » Documents are not only reviewed for individual compliance, but as reference in the review of all other evidence and interviews to determine actual implementation in practice, effectiveness and MCP actions taken.
  - The Documents include, but are not limited to:
    - Policies and Procedures
    - Organizational Charts
    - Committee Meeting Minutes
    - Monitoring Reports
    - Data Logs
- » Verification Studies (▲) are listed in this section where applicable.

**Examples of Best Practices:** This column details strategies implemented by some MCPs to either demonstrate compliance with a contract requirement or correct an identified deficiency. MCPs and individual audits can present distinct characteristics, and best practices may not transfer seamlessly. The audit team does not audit to best practices but may use them to evaluate compliance. It remains the responsibility of the MCP to demonstrate that it is meeting its contractual obligations.

# CATEGORY 1: UTILIZATION MANAGEMENT PROGRAM OVERVIEW

## Introduction/Overview

Utilization Management is a Managed Care Plan's (MCP) approach to controlling the cost of healthcare benefits by assessing medical necessity (using evidenced-base clinical criteria) for each service requested. The purpose is to ensure patients receive the right care at the right time while controlling costs and preventing inappropriate use of specialty services. An effective utilization management program also helps prevents inappropriate denials of coverage, unnecessary expenses, and regulatory non-compliance.

The Category 1 Audit Program includes the following subcategories:

- » 1.1: Utilization Management Program
- » 1.2: Prior Authorization Reviews and Review Procedures
- » 1.3: Timeframes for Medical Authorization
- » 1.4 Review of Utilization Data
- » 1.5: Delegating Utilization Management Activities
- » 1.6: Post-Stabilization Authorization (Contract Sections 2.3.2; 3.2.6; 3.3.16; 5.1.3; 5.2.6)

# CATEGORY 1.1: UTILIZATION MANAGEMENT PROGRAM

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3</u></b></p> <p><b><u>Utilization Management (UM) Program</u></b></p> <p>Contractor must develop, implement, and update as needed (but at least annually), and improve its Utilization Management (UM) program to ensure appropriate processes are used to review and approve the provision of Medically Necessary Covered Services for its Members.</p> <p><b><u>Contract Exhibit A, Attachment I, Section 1.0 Definitions</u></b></p> <p>For Adults: Medically Necessary or Medical Necessity means 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&amp;I section 14059.5(a) and 22 CCR section 51303(a). Medically Necessary services must include services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity.</p> <p>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&amp;I sections 14059.5(b) and 14132(v). Without limitation, Medically Necessary services for Members less than 21 years of age include all services necessary to achieve or maintain age-appropriate growth and development, attain, regain or</p>	<ul style="list-style-type: none"> <li>✓ UM Program Description</li> <li>✓ Policies &amp; Procedures</li> <li>✓ UM Work Plan</li> <li>✓ UM Program Evaluation</li> <li>△ UM Committee (UMC) Meeting Minutes</li> <li>△ Quality Management Committee (QIC) Meeting Minutes</li> </ul>	<p>The Plan has a written UM program description that the UMC, QIC, and Board review, renew, and approve annually, which includes incorporation of evidence-based guidelines such as MCG, InterQual or NCCN.</p> <p>The Plan also implements Continuous Quality Improvement (CQI) measures.</p> <p>The Plan’s written UM program description includes the role and responsibilities of the UM Committee.</p>

<b>Requirement</b>	<b>Documentation to Review</b>	<b>Examples of Best Practices</b>
<p>maintain functional capacity, or improve, support, or maintain the Member's current health condition. Contractor must determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the Child.</p>		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3</u></b></p> <p><b><u>Medical Director</u></b></p> <p>Contractor must ensure that its UM program:</p> <p>A. Includes a designated medical director or clinical director responsible for the UM process in accordance with Health and Safety Code (H&amp;S) section 1367.01, and qualified staff responsible for the UM program.</p> <p>B. Prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities must not be structured to provide incentives to deny, limit, or discontinue Medically Necessary Covered Services.</p> <p><i>Note: The Contract outlines additional requirements for Medical Director in Section 1.1.6. These are covered under Audit Category 6: Plan Administration and Organization</i></p>	<ul style="list-style-type: none"> <li>✓ UM P&amp;Ps</li> <li>✓ UM Organizational Chart, including key individuals and qualifications</li> <li>✓ CMO, Medical Director, UM Director, Pharmacy Director, BH UM Director licenses and resumes</li> <li>△ UM Program Description</li> <li>✓ △ Quality Management Committee (QIC) Meeting Minutes</li> </ul>	<p>The Plan produces organizational charts that are current, updated, and include appropriately qualified clinical staff responsible for the UM program.</p> <p>The Plan's P&amp;Ps demonstrate that medical decisions are not influenced by fiscal and administrative management.</p> <p>Medical Director responsibilities include ensuring medical decisions are rendered by qualified medical personnel and not influenced by fiscal or administrative management considerations, ensuring all health care provided meets acceptable standards of care, developing and implementing medical policy consistent with applicable standards of care, resolving grievances related to Quality of Care, and participating in the implementation of Quality Improvement and Health Equity activities.</p> <p>The Plan has process in place to report any changes in the status of the Chief Medical Director to their DHCS Contract Manager within ten calendar days.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3</u></b></p> <p><b><u>Second Opinion</u></b></p> <p>Contractor must ensure that its UM program:</p> <p>C. Allows for a second opinion from a qualified health professional within the Network, if available. If a qualified health professional within the Network is not available, Contractor must authorize an out-of-network provider to provide the second opinion at no cost to the Member, in accordance with 42 CFR section 438.206.</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ UM Program Description</li> <li>✓ Member Handbook/EOC</li> </ul>	<p>The Plan's policies, procedures, and Member Handbook/EOC clearly indicate that a second opinion from a qualified health professional is available at no cost to the member.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3</u></b></p> <p><b><u>Availability of P&amp;Ps for Providers and Members</u></b></p> <p>Contractor must ensure that its UM program:</p> <ul style="list-style-type: none"> <li>D. Makes available to Network Providers all relevant UM policies and procedures upon request.</li> <li>E. Makes available to Members all relevant UM policies and procedures upon request. Makes available to Members clinical criteria used by Contractor, Subcontractors, and Downstream Subcontractors, as applicable for assessing Medical Necessity for Covered Services.</li> </ul> <p><i>Note: See "Availability of P&amp;Ps and Criteria on Plan's Website" on Page 12 of this Audit Program.</i></p>	<p>✓ Refer to Page 12</p>	<p>Refer to Page 12</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3</u></b>  <b><u>Prior Authorization Training for Network Providers</u></b></p> <p>Contractor must ensure that its UM program:</p> <p>F. Provides training to Network Providers on the procedures and services that require Prior Authorization for Medically Necessary Covered Services, and ensures that all Network Providers are aware of the procedures and timeframes necessary to obtain Prior Authorization for Medically Necessary Covered Services, within 30 calendar days of executing this Contract and within 30 calendar days of contracting with a Network Provider.</p> <p><b><i>For Reference:</i></b>  <i>CFR requirement for decision timeframes included on next page regarding new guidelines effective January 1, 2026</i></p>	<ul style="list-style-type: none"> <li>✓ Provider Manual</li> <li>✓ Provider Trainings</li> <li>△ Provider Newsletters</li> <li>△ Plan Website</li> </ul>	<p>The Plan produces documentation to support that providers are educated on an ongoing basis regarding Prior Auth and timeframes (e.g., Provider Manual, provider newsletters, fax blasts, documented outreach by Provider Services, documented trainings, etc.). The Plan has UM procedures on Plan website.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>CFR Title 22 Section 438.210</u></b></p> <p><b><u>Coverage and Authorization of Services: Timeframe for Decisions</u></b></p> <p>Standard Authorization Decisions:</p> <p>For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and:</p> <p>(A) For rating periods that start before January 1, 2026, within state established time frames that may not exceed 14 calendar days after receiving the request for service.</p> <p>(B) For rating periods that start on or after January 1, 2026, within state established time frames that may not exceed 7 calendar days after receiving the request for service.</p> <p>(ii) Standard authorization decisions may have an extension to the timeframes in paragraph (d)(1)(i) of this section up to 14 additional calendar days if—</p> <p>(A) The enrollee or the provider requests the extension; or</p> <p>(B) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.</p> <p><i>Note: See Section 1.3 of this Audit Program for further information on authorization timeline requirements.</i></p>	<p>See Above</p>	<p>In addition to above:</p> <p>For D-SNPs: The Plan must consider both Medicare and Medi-Cal coverage criteria when making an Integrated Organization Determination (IOD).</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3</u></b></p> <p><b><u>Standing Referral Process</u></b></p> <p>Contractor must ensure that its UM program:</p> <p>G. Has a Standing Referral process providing a determination within three Working Days from the date the request is made by the Member or the Member's Primary Care Providers (PCP) and all appropriate Medical Records and other items of information necessary to make the determination are provided. Once a determination is made, the referral must be made within four Working Days of the date that the proposed treatment plan, if any, is submitted to Contractor's medical director or the medical director's designee, in accordance with H&amp;S section 1374.16.</p> <p>H. Has a specialty referral system to track and monitor referrals requiring Prior Authorization by Contractor. When Prior Authorization is delegated to Subcontractors and Downstream Subcontractors, Contractor must ensure that Subcontractors and Downstream Subcontractors have systems in place to track and monitor referrals requiring Prior Authorization and must furnish documentation of Subcontractor's and Downstream Subcontractor's referrals to DHCS upon request. Contractor's specialty referral systems must include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. Contractor's specialty referral systems must include information on requested out-of-Network services. Contractor must ensure that all</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures describing standing referral, referral tracking, and/or UM processes and reports</li> <li>✓ Referral Tracking Reports</li> <li>✓ UM Committee Meeting Minutes</li> <li>△ Provider Manual</li> <li>△ Provider Newsletters</li> <li>△ UM Program Description</li> </ul>	<p>The Plan has a process to ensure that standing referral requests are adjudicated within 3 working days and a referral is made within 4 working days.</p> <p>The Plan has policies and procedures for closed loop referrals.</p> <p>The Plan generates reports that measure the numbers, types, and timeliness of authorized, denied, deferred, and modified Prior Authorizations (PA) at a set frequency (e.g., monthly, quarterly, etc.).</p> <p>The Plan is able to demonstrate how providers are made aware of their referral tracking processes.</p> <p>The Plan uses procedures for ensuring data accuracy and reliability and assists with scheduling appointments, understanding treatment options, and accessing resources to ensure patients receive timely and coordinated care.</p>

<b>Requirement</b>	<b>Documentation to Review</b>	<b>Examples of Best Practices</b>
Network Providers are aware of the specialty referral processes and tracking procedures.		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3</u></b></p> <p><b><u>Integration of UM Activities in the QIS</u></b></p> <p>Contractor must ensure that its UM program:</p> <ol style="list-style-type: none"> <li>I. Integrates UM activities into the Quality Improvement System (QIS) specified in Exhibit A, Attachment III, Section 2.2 (Quality Improvement and Health Equity Transformation Program (QIHETP)), including a process to integrate reports on the number and types of service requests, denials, deferrals, modifications, Appeals, and Grievances to the medical director or their designee.</li> </ol>	<ul style="list-style-type: none"> <li>✓ UM Program Description</li> <li>✓ QM Program Description</li> <li>✓ UM and QI Committee Meeting Minutes</li> </ul>	<p>The Plan's QI or UM Program Description and/or committee meeting minutes show review of UM reports by medical director or designee as part of quality improvement efforts.</p> <p>The Plan has a log of the types of service requests that tracks denials, modifications, appeals and grievances.</p> <p>The Plans' UM program has processes to identify actual and/or potential quality issues during utilization review activities and refer them to the Chief Medical Officer as appropriate, or their designee.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3</u></b></p> <p><b><u>Timelines and Parity with Mental Health/SUD Services</u></b></p> <p>Contractor must ensure that its UM program:</p> <p>J. Has timelines and processes that do not impose Quantitative Treatment Limitations (QTL) or Non-Quantitative Treatment Limitations (NQTL) more stringently on covered mental health and Substance Use Disorder (SUD) services than are imposed on medical/surgical services, in accordance with the parity in mental health and SUD requirements in 42 CFR section 438.900, et seq.</p>	<ul style="list-style-type: none"> <li>✓ UM P&amp;Ps</li> <li>✓ UM Program Description</li> <li>✓ QM Program Description</li> <li>✓ UM and QI Committee Meeting Minutes</li> </ul>	<p>The Plan's P&amp;Ps and program descriptions outline criteria to ensure that service limitations are not more strict than those for medical and surgical services.</p> <p>The Plan has P&amp;Ps to ensure if there is an overlap between Medicare, Medicaid and EPSDT benefits (e.g., medical services and durable medical equipment services), the Plan will apply the definition of medical necessity that is the more generous of the applicable Medicare and California Medi-Cal standards.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3</u></b>  <b><u>Availability of P&amp;Ps and Criteria on Plan’s Website</u></b>  Contractor must ensure that its UM program:</p> <p>K. Makes Contractor’s UM policies and procedures available to Members and Providers on Contractor’s website and upon request. These policies and procedures must set out how Contractor authorizes, modifies, delays, or denies health care services via Prior Authorization, concurrent authorization, or Retrospective Review, under the services provided by Contractor in accordance with 42 CFR section 438.915.</p> <p>a. Contractor must ensure that policies and procedures for authorization decisions are based on the Medical Necessity of a requested Covered Service and are consistent with criteria or guidelines supported by sound clinical principles and evidence-based practice.</p> <p>b. Contractor must ensure that policies, processes, strategies, evidentiary standards, and other factors used for UM are consistently applied to medical/surgical, mental health, and SUD services and benefits.</p> <p>c. Contractor must notify Network Providers, as well as Members and Potential Members upon request, of all services that require Prior Authorization, concurrent authorization, or Retrospective Review, and ensure that all Network Providers are aware of</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Provider Manual</li> <li>✓ Provider Trainings</li> <li>✓ UM Program Description</li> <li>✓ UM Criteria</li> <li>✓ UM and QI Committee Meeting Minutes</li> <li>△ Provider Newsletters</li> <li>△ Plan Website</li> </ul>	<p>The Plan produces documentation to support provider involvement in the development and/or adoption of medical criteria/guidelines for UM decision-making that are based on evidence-based practice and sound clinical principles (e.g., UMC meeting minutes show review/approval of criteria/guidelines).</p> <p>The Plan produces documentation to support that providers are educated on an ongoing basis for PA procedures and timeframes (Provider Manual, Provider newsletters, fax blasts, documented outreach by Provider Services, documented trainings).</p> <p>The Plan has UM procedures and criteria on its website and has processes in place to ensure they are available to providers and members upon request.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p>the procedures and timeframes necessary to obtain authorization for these services.</p> <p><i>Note: See APL 22-006: Medi-Cal Managed Care Health Plan Responsibilities for Non-Specialty Mental Health Services for details on non-specialty mental health coverage.</i></p>		

## CATEGORY 1.2: PRIOR AUTHORIZATIONS AND REVIEW PROCEDURES

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b>  <b><u>Consultation with Providers for Determining Medical Necessity</u></b></p> <p>Contractor must ensure that its Prior Authorization, concurrent review, and Retrospective Review authorization procedures meet the following minimum requirements, in accordance with H&amp;S section 1367.01:</p> <p>A. Contractor must consult with Providers as needed for Prior Authorization requests for the purposes of determining Medical Necessity for Covered Services unless doing so would lead to undue delay in care;</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures related to PA of medical services</li> <li>✓ UM Meeting Minutes</li> <li>✓ Medical Necessity Criteria</li> </ul>	<p>Verification Studies show that appropriate communication occurs between the Plan and Providers as needed to ensure a seamless process for members to receive needed services.</p> <p>Policies and Procedures identify the services excluded from prior authorization when provided by a qualified licensed healthcare provider. Examples of services that do not require prior auth: emergency and urgent care; crisis stabilization; family planning; preventive services (includes dental); basic prenatal care; communicable disease and testing,, and out of area renal dialysis.</p>
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b>  <b><u>Decisions by Qualified Health Care Professional</u></b></p> <p>Contractor must ensure that is Prior Authorization, concurrent review, and retrospective review authorization procedures meet the following minimum requirements, in accordance with H&amp;S section 1367.01:</p> <p>B. Decisions to deny or to authorize an amount, duration, or scope that is less than requested must be</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures related to PA of medical and pharmacy services</li> <li>✓ UM Reports and UM / QI Committee Meeting Minutes</li> </ul>	<p>The Plan's UM Program Description and/or Policies and Procedures indicate that a qualified health care professional with appropriate clinical expertise in treating the condition and disease makes UM decisions.</p> <p>The Plan ensures qualified health care professionals have the appropriate</p>

Requirement	Documentation to Review	Examples of Best Practices
<p>made by a qualified health care professional with appropriate clinical expertise in treating the medical or Behavioral Health condition and disease or Long-Term Services and Supports (LTSS) needs. Appropriate clinical expertise may be demonstrated by relevant specialty training, experience, or certification. Qualified health care professionals do not have to be an expert in all conditions and may use other resources to make appropriate decisions.</p>	<ul style="list-style-type: none"> <li>✓ Professional Credentials (licenses, CVs, etc.)</li> <li>△ UM Program Description</li> </ul>	<p>credentials for adjudicating prior authorizations.</p>
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b>  <b><u>Supervision by Qualified Health Care Professionals and Pharmacy Services</u></b></p> <p>Qualified health care professionals must supervise the review of medical decisions, including service reductions, and must review all denials that are made, in whole or in part, based on Medical Necessity.</p> <p>Contractor is not responsible for the review of Prior Authorizations for physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient Prescription Drugs provided by an outpatient pharmacy. Contractor must review Prior Authorizations for physician administered drugs which include Prescription Drugs administered by a health care professional in a clinic, physician’s office, or outpatient setting; medical supplies; and enteral nutritional products. These Prescription Drugs and supplies are</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures for PA</li> <li>✓ Verification Study ▲ Review Medical PAs (especially denials and modifications) to confirm that a physician denies or modifies the service</li> </ul> <p>Note: Verification Study should not include pharmacy benefit items since they are adjudicated by Magellan /Medi-Cal RX</p> <ul style="list-style-type: none"> <li>△ UM Program Description</li> </ul>	<p>The Plan’s Policies and Procedures state that qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole, or in part, on the basis of medical necessity.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p>covered under the medical benefit and would be included in the medical claim or encounter.</p> <p><i>Note: Effective January 1, 2022, DHCS transitioned all outpatient Medi-Cal pharmacy benefit services from Managed Care to fee-for-service through the Medi-Cal Rx program.</i></p>		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b>  <b><u>Supervision by Qualified Health Care Professionals and Pharmacy Services</u></b></p> <p>C. Qualified health care professionals must supervise the review of medical decisions, including service reductions, and must review all denials that are made, in whole or in part, based on Medical Necessity.</p> <p>Contractor is not responsible for the review of Prior Authorizations for physician administered drugs, medical supplies, enteral nutritional products, and covered outpatient Prescription Drugs provided by an outpatient pharmacy. Contractor must review Prior Authorizations for physician administered drugs which include Prescription Drugs administered by a health care professional in a clinic, physician’s office, or outpatient setting; medical supplies; and enteral nutritional products. These Prescription Drugs and supplies are covered under the medical benefit and would be included in the medical claim or encounter.</p> <p><i>Note: Effective January 1, 2022, DHCS transitioned all outpatient Medi-Cal pharmacy benefit services from Managed Care to fee-for-service through the Medi-Cal Rx program.</i></p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures for PA</li> <li>✓ Verification Study ▲ Review Medical PAs (especially denials and modifications) to confirm that a physician denies or modifies the service</li> </ul> <p>Note: Verification Study should not include pharmacy benefit items since they are adjudicated by Magellan /Medi-Cal RX</p> <p>△ UM Program Description</p>	<p>The Plan’s Policies and Procedures state that qualified health care professionals supervise review decisions, including service reductions, and a qualified physician will review all denials that are made, whole, or in part, on the basis of medical necessity.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b></p> <p><b><u>Written Criteria: Provider Input</u></b></p> <p>D. Contractor must establish written criteria or guidelines for UM that are developed with practicing health care Providers. The written criteria or guidelines must be based on sound clinical practices and processes which are evaluated and updated when necessary, and at least annually, in accordance with H&amp;S section 1363.5.</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ UM Program Description</li> <li>✓ UM Criteria</li> <li>✓ UM and QI Committee Meeting Minutes</li> <li>✓ Written Criteria or Guidelines for utilization review are evaluated at least annually</li> <li>✓ Verification Study ▲ Review Medical PAs (especially denials and modifications) to confirm current evidence-based criteria, correct criteria for the case, case decisions consistent with criteria and application of criteria among reviewers</li> </ul>	<p>The Plan produces documentation to support provider involvement in the development and/or adoption of medical criteria/guidelines for UM decision-making that are based on evidence-based practice and sound clinical principles (e.g., UMC meeting minutes showing review and approval of criteria/guidelines).</p> <p>The Plan annually evaluates and updates written criteria / guidelines based on sound clinical practices.</p> <p>Verification Studies show appropriate criteria selection and case adjudication.</p> <p>The Plan conducts inter-rater reliability (IRR) testing at a set frequency to ensure that decision makers consistently apply criteria/guidelines. The Plan provides evidence of IRR testing at least annually.</p> <p>When audit results demonstrate inconsistent application, the Plan provides documentation showing follow-up action.</p> <p>The Plan conducts regular surveys to gather provider input on the effectiveness and clarity of written</p>

Requirement	Documentation to Review	Examples of Best Practices
	<ul style="list-style-type: none"> <li>✓ IRR Test ▲ (or comparable procedure) of all UM decision-makers</li> </ul>	<p>criteria and maintains logs of all reviews and approvals of written criteria, including the names of providers involved and the dates of review.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b></p> <p><b><u>Provider and Member Notification Requirements: Clear and Concise Responses and Direct Contact Information</u></b></p> <p><b>E.</b> Contractor must provide a clear and concise written explanation of the reasons for denying, deferring, or modifying a service; a description of the criteria or guidelines used; and the clinical reasons for the decision based on Medical Necessity. Any written communication to a Provider of a denial, delay, or modification of a request must include the name and telephone number of Contractor’s health care professional responsible for the denial, delay, or modification.</p> <p><b>HSC Section 1367.01</b></p> <p>Any written communication to a provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider to contact the professional responsible for the denial, delay, or modification easily.</p> <p><b>(h)</b> Responses regarding decisions to deny, delay, or modify health care services shall include a clear and concise explanation of the reasons for the Plan’s decision, a description of the criteria or guidelines used,</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Verification Study</li> <li>✓ NOA Templates</li> <li>✓ Verification Study ▲ NOAs clearly outline reasons for decisions</li> <li>△ Staff Training</li> <li>△ Meeting Minutes</li> </ul>	<p>Plan has a process to ensure all required elements of NOA letter content and “Your Rights” Attachment information are included with every adverse benefit determination.</p> <p>Plan conducts ongoing monitoring (e.g., audits, quality checks, etc.) that includes tracking and trending analysis at a set frequency to specifically measure clearly documented decisions in PA files and NOAs.</p> <p>When monitoring demonstrates non-compliance, Plan takes follow-up action and substantiates it through documentation (e.g., re-training, increased staffing, discussion in UM Committee meeting minutes).</p> <p>The Plan’s process ensures that the decision-maker’s phone number is given to providers for adverse benefit determinations based on medical necessity. Or the Plan monitors the effectiveness of an alternative process.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p>and the clinical reasons for the decisions regarding medical necessity. Responses shall also include information as to how the enrollee may file a grievance with the Plan</p> <p><b><u>APL 21-011</u></b></p> <p><b><u>Grievance and Appeal Requirements, Notice and "Your Rights" Templates</u></b></p> <p><b>II. C. 1.</b> If the MCP can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision-maker through means other than a direct phone number (e.g. number to the specific unit of UM department), a direct phone number or extension is not required. The MCP must conduct ongoing oversight to monitor the effectiveness of this process.</p>		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b></p> <p><b><u>Provider and Member Notification: NOA</u></b></p> <p><b>F.</b> Contractor must notify Members regarding denied, deferred or modified referrals as specified in Exhibit A, Attachment III, Subsection 5.1.5, (Notices of Action for Denial, Deferral, or Modification of Prior Authorization Requests). Contractor must publish on its website an Appeals procedure for both Providers and Members.</p> <p><b><u>APL 21-011</u></b></p> <p><b><u>Grievance and Appeal Requirements, Notice and “Your Rights” Templates</u></b></p> <p><b>II.B.</b> MCPs must provide members with written notice of adverse benefit determination using the appropriate DHCS-developed, standardized NOA template and NOA “Your Rights” template. MCPs are not permitted to make any changes to the templates without prior review and approval from DHCS, except to insert information specific to the member.</p> <p><b>II. C 1.</b> For decisions based in whole or in part on medical necessity, the written NOA must contain all of the following:</p> <p><b>a.</b> A statement of the action the MCP intends to take.</p> <p><b>b.</b> A clear and concise explanation of the reasons for the decision.</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Verification Study</li> <li>✓ NOA Templates</li> <li>✓ Verification Study ▲ NOAs clearly outline reasons for decisions</li> </ul>	<p>Plan has a process to ensure all required elements of NOA letter content and “Your Rights” Attachment information are included with every adverse benefit determination.</p> <p>Plan conducts ongoing monitoring (e.g., audits, quality checks, etc.) at a set frequency to specifically measure clearly documented decisions in PA files and NOAs.</p> <p>When monitoring demonstrates non-compliance, Plan takes follow-up action and substantiates it through documentation (e.g., re-training, increased staffing, discussion in UM Committee meeting minutes, etc.).</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b>c.</b> A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline.</p> <p><b>d.</b> The clinical reasons for the decision. The MCP must explicitly state how the member’s condition does not meet the criteria or guidelines.</p> <p><b>e.</b> For written notification to the provider, the name and direct telephone number or extension of the decision maker.</p> <p>The above requirements only pertain to decisions based in whole or in part on medical necessity. For all other Adverse Benefit Determinations that are not based on medical necessity (e.g., denials based on a lack of information, or benefit denials, etc.), MCPs must still ensure that the NOA provides a clear and concise explanation of the reasons for the decision.</p> <p><b>II. C 2.</b> MCPs must use the NOA “Your Rights” templates attached to this APL and must include all of the following required elements:</p> <p><b>a.</b> The member’s or provider’s right to request an internal Appeal with the MCP within 60 calendar days from the date on the NOA.</p> <p><b>b.</b> The member’s right to request a State Hearing after filing an internal Appeal with the MCP and receiving</p>		

Requirement	Documentation to Review	Examples of Best Practices
<p>notice that the Adverse Benefit Determination has been upheld.</p> <p><b>c.</b> The member’s right to request a State Hearing without having to exhaust the MCP’s internal appeal process, in instances of deemed exhaustion.</p> <p><b>d.</b> Procedures for exercising the member’s rights to request an Appeal.</p> <p><b>e.</b> Circumstances under which an expedited review is available and how to request one.</p> <p><b>f.</b> Circumstances under which an expedited review is available and how to request one.</p> <p>The member’s right to Aid Paid Pending and instructions on how to timely file for an appeal (i.e., within 10 days of the NOA or before the effective date of the intended action) of a decision to terminate, suspend, or reduce services. MCPs must provide Aid Paid Pending regardless of whether the member makes a separate request to the MCP when the member timely files an appeal of a decision to terminate, suspend, or reduce services.</p>		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b></p> <p><b><u>Timely Manner for Decisions and Appeals</u></b></p> <p><b>G.</b> Decisions and Appeals must be made in a timely manner and not be unduly delayed when Member’s medical condition requires time sensitive services.</p> <p><i>Note: “Timeframes for Medical Authorization” are covered in Section 1.3 of this Audit Program</i></p>	<p>Refer to Pages 35-38</p>	<p>Refer to Pages 35-38</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b></p> <p><b><u>Services Excluded from Prior Authorization Requirements</u></b></p> <p><b>H.</b> Prior Authorization requirements must not be applied to Emergency Services, family planning services, preventive services, basic prenatal care, sexually transmitted disease services, Human Immunodeficiency Virus (HIV) testing, or initial mental health and SUD assessments.</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Verification Study ▲</li> </ul>	<p>P&amp;Ps show the Plan clearly lists PA exclusions.</p> <p>Verification Study confirms Plan does not require PA for these services.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b></p> <p><b><u>Record Retention Requirements</u></b></p> <p>I. Records relating to Prior Authorization requests, including any Notices of Action (NOA), must meet the retention requirements described in Exhibit E, Section 1.22 (Inspection and Audit of Records and Facilities).</p> <p><b><u>Additional Reference:</u></b></p> <p>42 CFR Sections 438.3(h) and (u)</p> <p>42 CFR Section 438.230(c)</p>	<p>Policies &amp; Procedures</p>	<p>The Plan has P&amp;Ps that ensure prior auth records are retained for a minimum of ten years from the final date of the Contract Phaseout Period or from the date of completion of any audit, whichever is later. The Plan ensures regular training and education for maintaining records for external review.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.1</u></b>  <b><u>Provider and Member Notification Requirements</u></b></p> <p><b>J.</b> Contractor must notify the requesting provider of any decision to deny, approve, modify, or delay a service authorization request, a request by a Member, or a Member’s provider for the provision of a covered service, or when authorizing a service in an amount, duration, or scope that is less than requested. The notice to the Provider may be oral or in writing.</p> <p><b><u>Contract Exhibit A, Attachment III, Section 4.6.4</u></b>  <b><u>Notice of Action</u></b></p> <p><b>2)</b> For standard authorization requests, Contractor must notify the requesting provider of its authorization decision within 24 hours of the decision and send the written NOA to the member within two working days in accordance with H&amp;S Code section 1367.01 (h)(1) and (3).</p> <p><b><u>APL 21-011</u></b>  <b><u>Grievance and Appeal Requirements, Notice and “Your Rights” Templates</u></b></p> <p><b>II A. For standard authorization requests:</b> Decisions to approve, modify, or deny requests must be communicated by the MCP to the provider within 24 hours of the decision and to the member within two business days using the appropriate NOA template.</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Verification Study ▲</li> </ul>	<p>Verification Study shows providers and members receive written notification of any decision to deny, approve, modify, or delay a service authorization request, as contractually specified.</p> <p>Study shows the Plan initially calls/faxes providers within 24 hours of decision.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b>II C. For adverse benefit determinations:</b> Decisions must be communicated to the member in writing. In addition, with the exception of decisions rendered retrospectively, decisions must be communicated to the provider initially by telephone or facsimile and also in writing.</p>		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 5.3.1</u></b></p> <p><b><u>Covered Services and FFS Parity</u></b></p> <p><b>A.</b> Contractor must ensure that Covered Services and other services required in this Contract are provided to a Member in an amount no less than what is offered to Med-Cal beneficiaries in Medi-Cal Fee-For-Service (FFS), as defined in the most current Medi-Cal Provider Manual and consistent with current, evidence-based medical standards.</p> <p><b>B.</b> Contractor must ensure that services provided are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the Covered Services are furnished. Contractor must not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of the diagnosis, type of illness, or condition. Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity or utilization control for services that are not medical services (such as Community Support services), provided the services furnished are reasonably expected to achieve their purpose and are provided in a manner that reflects the Member’s ongoing needs, including but not limited to services for chronic conditions.</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures UM Criteria</li> <li>✓ Verification Study of Medical PAs ▲</li> </ul>	<p>The Plan provides Medi-Cal covered benefits and offers these benefits to members in an amount no less than what is described in the Medi-Cal Provider Manual.</p> <p>The Plan’s UM criteria are not more restrictive than Medi-Cal Provider Manual or current evidence-based standards.</p> <p>The Plan has processes in place to monitor for under/over utilization and compares results to nationally recognized thresholds. For results outside of thresholds, the Plan conducts a qualitative analysis. The UM Program description, and P&amp;Ps are reviewed by the Plan and revised as necessary annually.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 5.2.10</u></b></p> <p><b><u>Access Rights and Language Assistance</u></b></p> <p><b>3. b.</b> The Plan must provide full and immediate translation of written materials ...for LEP Members and potential members who speak threshold or concentration standard languages, fully translated member information including member rights information, form letters and individual notices, and NOA letters</p> <p><b><u>Contract Exhibit A, Attachment III, Section 4.6.4</u></b></p> <p><b><u>Notice of Action</u></b></p> <p>b. Contractor must ensure all NOAs informing a Member of an ABD are in writing in a format and language that, at a minimum, meets the standards set forth 42 CFR sections 438.10, 438.404, and 438.408; W&amp;I section 14029.91; 22 CCR section 53876; and Exhibit A, Attachment III, Subsection 5.1.3 (Member Information), and APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services.</p> <p><b><u>APL 21-011</u></b></p> <p><b><u>Grievance and Appeal Requirements, Notice and “Your Rights” Templates</u></b></p> <p><b>V.</b> Specifically, MCPs must fully translate NOAs/NARs, including the clinical rationale for the MCP’s decision that</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Staff Training</li> <li>✓ Tracking System</li> <li>✓ Verification Study ▲</li> </ul>	<p>Verification Study demonstrates the Plan lists the member’s primary language and for threshold languages, the Plan sends members NOAs (including clinical rationale) written in members’ languages. Plan sends NDN and LAT with all NOAs.</p> <p>The Plan has a tracking system to monitor the use and effectiveness of the language assistance service.</p> <p>The Plan retains professional interpreters who are trained in medical terminology and confidentiality requirements.</p>

<b>Requirement</b>	<b>Documentation to Review</b>	<b>Examples of Best Practices</b>
<p>must be included in the NOA/NAR. DHCS has made it clear that immediate translation of the entire NOA/NAR is required by federal and state law.</p> <p><i>Note: Language assistance, translation services, and noticing requirements are covered more extensively in the Category 4 Audit Program: Grievances, Appeals, and Member's Rights.</i></p>		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>APL 21-015</u></b></p> <p><b><u>Benefit Standardization and Mandatory Managed Care Enrollment Provisions of CalAIM Initiatives</u></b></p> <p><b><u>Attachment 2: Major Organ Transplant Requirements</u></b></p> <p>MCPs must directly refer adult members or authorize referrals to a transplant program that meets DHCS criteria for evaluation within 72 hours of a member’s PCP or specialist identifying the member as a potential candidate for the MOT and receiving all the necessary information to make a referral or authorization.</p> <p>MCPs can then authorize the request for the MOT after the transplant program confirms the MOT candidacy of the member. MCPs can apply appropriate UM protocols that do not establish unreasonable or arbitrary barriers for accessing coverage. However, if an authorization request for MOT is denied, the MCP’s Chief Medical Officer must review the request and determine the appropriateness of the denial.</p> <p>Expedited authorizations are required if the organ that the member will receive is at risk of being unusable due to any delay in obtaining prior authorization or if the transplant program has the ability to provide immediate transplant services that would benefit the member’s condition. The expedited authorization are required to be completed in no later than 72 hours following receipt of appropriate medical necessity documentation.</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Referral Tracking Reports (timeliness)</li> <li>✓ UM Committee Meeting Minutes for above report review</li> <li>✓ Verification Study of Medical PAs ▲</li> </ul>	<p>Verification Study and policies/procedures confirm compliance, and the Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement for expedited request decision timeframes, extensions.</p> <p>MOT referrals to COE, expedited MOT requests, and expedited transitions (SNF and subacute care).</p> <p>The Plan has an authorization log for cadavers and living donors regardless of a living donor’s Medi-Cal eligibility.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>APL 23-004</u></b></p> <p><b><u>Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care Requirements</u></b></p> <p>Effective January 1, 2023, MCPs in all counties must authorize and cover medically necessary skilled nursing facility (SNF) services (provided in both freestanding and hospital-based facilities). Effective January 1, 2023, for all MCPs in all counties, prior authorization requests for members who are transitioning from an acute care hospital are to be considered expedited, requiring a response time of no greater than 72 hours, including weekends.</p> <p><i>Note: SNFs are also discussed in Contract Sections 2.2.11 (for QAPI related requirements) and 5.3.7 (for scope of services).</i></p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Referral Tracking Reports (timeliness)</li> <li>✓ UM Committee Meeting Minutes for above report review</li> <li>✓ Verification Study of Medical PAs ▲</li> </ul>	<p>Verification Study and policies/procedures confirm compliance, and the Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement for expedited request decision timeframes, extensions.</p> <p>MOT referrals to COE, expedited MOT requests, and expedited transitions (SNF and subacute care).</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>APL 23 - 027</u></b></p> <p><b><u>Subacute Care Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care Requirements:</u></b></p> <p>Effective January 1, 2024, MCPs in all counties must authorize and cover medically necessary adult and pediatric subacute care services (provided in both freestanding and hospital-based facilities). Effective January 1, 2024, all MCPs in all counties must expedite prior authorization requests for members who are transitioning from an acute care hospital to a subacute care facility. MCPs must make all authorization decisions in a timeframe appropriate for the nature of the member’s condition, and all authorization decisions must be made within 72 hours after the MCP receives relevant information needed to make an authorization decision.</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Referral Tracking Reports (timeliness)</li> <li>✓ UM Committee Meeting Minutes for above report review</li> <li>✓ Verification Study of Medical PAs ▲</li> </ul>	<p>Verification Study and policies/procedures confirm compliance, and the Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement for expedited request decision timeframes, extensions.</p> <p>MOT referrals to COE, expedited MOT requests, and expedited transitions (SNF and subacute care).</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>APL 23-028: Dental Services</u></b></p> <p><b><u>Intravenous Moderate Sedation and Deep Sedation/General Anesthesia Coverage Requirements</u></b></p> <p>If the provider provides clear medical record documentation of both number 1 and number 2 below, then the MCP Member must be considered for IV moderate sedation or deep sedation/general anesthetic.</p> <p>1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the MCP Member.</p> <p>2. Use of minimal sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the MCP Member.</p> <p>If the provider documents any one of numbers 3 through 6 below, then the MCP Member must be considered for IV moderate sedation or deep sedation/general anesthetic.</p> <p>3. Use of effective communicative techniques and the inability for immobilization (MCP Member may be dangerous to self or staff) failed or was not feasible based on the medical needs of the MCP Member.</p> <p>4. MCP Member requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or minimal sedation.</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ UM Criteria</li> <li>✓ UM Committee Minutes</li> <li>✓ Verification Study of dental general anesthesia / deep sedation samples, especially for children ▲</li> </ul>	<p>Policies and Verification study confirm MCPs use APL 23-28 criteria for determinations. MCPs do not require all provider records for the prior authorization process as long as submitted information substantiates that member met DHCS criteria.</p>

<b>Requirement</b>	<b>Documentation to Review</b>	<b>Examples of Best Practices</b>
<p>5. MCP Member has acute situational anxiety due to immature cognitive functioning.</p> <p>6. MCP Member is uncooperative due to certain physical or mental compromising conditions.</p> <p>Additionally, and not as a prerequisite to authorization, the provider must meet the requirements for chart documentation which, in addition to above, includes diagnosis, treatment plan, and documentation of perioperative care (preoperative, intraoperative and postoperative care) for the dental procedure pertinent to the request.</p>		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>APL 23-005</u></b></p> <p><b><u>Requirements for EPSDT Services</u></b></p> <p>For Members under the age of 21, MCPs are required to provide and cover all Medically Necessary EPSDT services, defined as any service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of the MCP Contract, regardless of whether such services are covered under California’s Medicaid State Plan for adults, when the services are determined to be Medically Necessary to correct or ameliorate defects and physical and mental illnesses or conditions.</p> <p>A service does not need to cure a condition in order to be covered under EPSDT. Services that maintain or improve the child’s current health condition, or those that can prevent adverse health outcomes, are also covered under EPSDT because they “ameliorate” a condition. Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems. Services are covered when they prevent a condition from worsening or prevent development of additional health problems. The common definition of “ameliorate” is to “make more tolerable or to make better.” Additional services must be provided if determined to be Medically Necessary for an individual child.<sup>9</sup> Medical Necessity decisions are individualized. Flat or hard limits based on a monetary</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ UM Criteria</li> <li>✓ Member Appeals</li> <li>✓ Committee Meeting Minutes (UM and G&amp;A)</li> <li>✓ Verification Study of EPSDT Services ▲</li> </ul>	<p>Policies and Verification Study confirm MCPs use appropriate definition of medical necessity for EPSDT, review on case-by-case basis, and allow coverage of maintenance services if medically necessary to ameliorate condition.</p>

<b>Requirement</b>	<b>Documentation to Review</b>	<b>Examples of Best Practices</b>
<p>cap or budgetary constraints are not consistent with EPSDT requirements and, thus, are not permitted.</p> <p>MCPs must provide all age-specific assessments and services required by the MCP Contract and the AAP/Bright Futures periodicity schedule.</p> <p>MCPs are also responsible for ensuring Members under the age of 21 have timely access to all Medically Necessary services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.</p> <p>See APL 23-005 for details for list of EPSDT services according to SSA Section 1905(r) and Title 42 of the USC Section 1396d(r) as well as requirements for carved out services.</p>		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>APL 20-018</u></b></p> <p><b><u>Ensuring Access to Transgender Services</u></b></p> <p>MCPs must analyze transgender service requests under both the applicable medical necessity standard for services to treat gender dysphoria and under the statutory criteria for reconstructive surgery. A finding of either “medically necessary to treat gender dysphoria” or “meets the statutory criteria of reconstructive surgery” serves as a separate basis for approving the request.</p> <p>If the MCP determines that the service is medically necessary to treat the member’s gender dysphoria, the MCP must approve the requested service. If the MCP determines the service is not medically necessary to treat gender dysphoria (or if there is insufficient information to establish medical necessity), the MCP must still consider whether the requested service meets the criteria for reconstructive surgery, taking into consideration the gender with which the member identifies.</p> <p>When analyzing transgender service requests, MCPs must consider the knowledge and expertise of providers qualified to treat gender dysphoria (including the member’s providers) and must use nationally recognized medical/clinical guidelines. One source of clinical guidance for the treatment of gender dysphoria is found in the most current “Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ UM Criteria</li> <li>✓ Member Appeals</li> <li>✓ UM Committee Minutes</li> </ul>	<p>Policies and Verification Study confirm MCPs determine if services are medically necessary for gender dysphoria OR meets statutory criteria for reconstructive surgery. MCPs review on case-by-case basis using nationally recognized guidelines.</p> <p>The Plan ensures that health care providers have specialized training in transgender health and are knowledgeable about gender-affirming treatments.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p>People,” published by the World Professional Association for Transgender Health.</p> <p>MCPs may apply non-discriminatory limitations and exclusions, conduct medical necessity and reconstructive surgery determinations, and/or apply appropriate utilization management criteria that are non-discriminatory. MCPs may not categorically exclude health care services related to gender transition on the basis that it excludes these services for all members. MCPs must not categorically limit a service or the frequency of services available to a transgender member. For example, classifying certain services, such as facial feminization surgery, as always “cosmetic” or “not medically necessary for any Medi-Cal member” is an impermissible “categorical exclusion” of the service. MCPs must consider each requested service on a case-by-case basis and determine whether the requested service is either “medically necessary to treat the member’s gender dysphoria” or meets the statutory definition of “reconstructive surgery.”</p>		

## CATEGORY 1.3: TIMEFRAMES FOR MEDICAL AUTHORIZATION

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.2</u></b></p> <p><b><u>Timeframes for Medical Authorization</u></b></p> <p>A. Emergency Services: Contractor must not require Prior Authorization for Emergency Services for complaints or conditions that a prudent layperson would determine could seriously jeopardize their physical or mental health.</p> <p>B. Post-stabilization: Contractor must respond to a Network Provider’s or out-of-Network Provider’s request for authorization for Post-Stabilization care services within 30 minutes or the service is deemed approved, in accordance with APL 23-009.</p> <p><i>Note: Post-Stabilization Authorizations are discussed in more detail in Section 1.6 of this Audit Program.</i></p> <p>C. Non-Urgent Care Following an Exam in the Emergency Room:</p> <p>Contractor must respond to a Provider’s request for post stabilization care services within 30 minutes or the services is deemed approved.</p> <p>D. Retrospective review for treatment received: Contractor must accept requests for Retrospective review within a reasonably established time limit, not to exceed 365 calendar days from the date of service. Contractor must communicate decisions to the Provider and to the member or authorized representative within 30 calendar</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ UM Committee Minutes</li> <li>✓ Verification Study of post-stabilization and retrospective requests ▲</li> </ul>	<p>The Plan’s Policies and Procedures and Verification Studies comply with post-stabilization and retrospective review request decision timeframes and documentation requirements.</p>

<b>Requirement</b>	<b>Documentation to Review</b>	<b>Examples of Best Practices</b>
days of the receipt of information reasonably necessary to make the determination, in accordance with 42 CFR section 438.404 (a) and Health and Safety Code Section 1367.01(h)(1).		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.2</u></b></p> <p><b><u>Timeframes for Medical Authorization</u></b></p> <p>E. <b>Routine and concurrent authorizations:</b> Contractor must respond to routine requests and concurrent requests as expeditiously as the Member’s condition requires, but no longer than five (5) working days from receipt of the information reasonably necessary and requested by Contractor to render a decision, and no longer than 14 calendar days from Contractor’s receipt of the request, in accordance with 42 CFR section 438.210 and H&amp;S section 1367.01.</p> <p><b><u>APL 21-011</u></b></p> <p><b><u>Grievance and Appeal Requirements, Notice and “Your Rights” Templates”</u></b></p> <p>II. A. 1. For Standard requests (prior auth and concurrent), federal law permits and extension of the initial 14 calendar day authorization timeframe by up to 14 days if the member or the provider requests an extension, or if the MCP can justify its need for additional information and demonstrate how the extension is in the member’s interest.</p> <p><i>Note: Per <b>CMS-0057-F</b> (Section 4 – Requirements To Send Prior Authorization Decisions Within Certain Timeframes): Beginning January 1, 2026, Medicaid Managed Care Plans are required to send prior authorization decisions within 7 calendar days for standard requests.</i></p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Referral Tracking Reports (timeliness)</li> <li>✓ UM Committee Meeting Minutes for above report review</li> <li>✓ Verification Study of Medical PAs (concurrent and standard prior authorizations) ▲</li> </ul>	<p>Verification Study and P&amp;Ps confirm compliance, and the Plan conducts ongoing monitoring, tracking and trending (e.g., audits, quality checks) at a set frequency to ensure compliance with the contractual requirement for routine prior auth and concurrent review decision timeframes and extensions.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.2</u></b></p> <p><b><u>Timeframes for Medical Authorization</u></b></p> <p>F. Expedited Authorizations: Contractor must make expedited authorization decisions for service requests where a member’s Provider indicates, or a Contractor, subcontractor, downstream subcontractor, or Network Provider determines that, following the standard timeframe for Prior Authorizations and concurrent requests could seriously jeopardize the Member’s life, health or ability to attain, maintain, or regain maximum function, in accordance with 42 CFR section 438.210 and H&amp;S section 1367.01. Contractor must provide its authorization decision as expeditiously as the Member’s health condition requires, but no longer than 72 hours after Contractor’s receipt of the request for services. Contractor must also expedite Prior Authorization requests for Members who are transitioning from an acute care hospital to all settings, including Contractor’s chosen Community Supports, and make an authorization decision in a timeframe that is appropriate to the nature of the Member’s condition but is no longer than 72 hours after Contractor’s receipt of all information needed to make an authorization decision.</p> <p><b><u>APL 21-011</u></b></p> <p><b><u>Grievance and Appeal Requirements, Notice and “Your Rights” Templates”</u></b></p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Referral Tracking Reports (timeliness)</li> <li>✓ UM Committee Meeting Minutes for above report review</li> <li>✓ Verification Study of Medical PAs ▲</li> </ul>	<p>Verification Study and P&amp;Ps confirm compliance, and the Plan conducts ongoing monitoring, tracking and trending (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement for expedited request decision timeframes, extensions.</p>

<b>Requirement</b>	<b>Documentation to Review</b>	<b>Examples of Best Practices</b>
<p><b>II. A. 2.</b> Federal law permits an extension of the initial 72-hour authorization timeframe by up to 14 calendar days if the member requests the extension, or if the MCP can justify its need for additional information and demonstrates how the extension is in the member's interest.</p>		

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.2</u></b></p> <p><b><u>Timeframes for Medical Authorization</u></b></p> <p>G. Hospice Services: Contractor may only require Prior Authorization for inpatient hospice care. Contractor must respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and APLs.</p> <p>H. Therapeutic Enteral Formula: Contractor must comply with all timeframes for medical authorization of Medically Necessary therapeutic enteral formula billed on a medical or institutional claim and the equipment and supplies necessary for delivery of enteral formula billed on a medical or institutional claim, as set forth in all applicable DHCS APLs, Welfare and Institutions Code (W&amp;I) section 14103.6, and H&amp;S section 1367.01.</p> <p>I. Physician Administered Drugs: For medical authorization of Medically Necessary physician administered drugs billed on a medical or institutional claim, Contractor must comply with the same timeframes as other medical services, as set out in this subsection.</p>	<ul style="list-style-type: none"> <li>✓ Policies &amp; Procedures</li> <li>✓ Referral Tracking Reports (timeliness)</li> <li>✓ UM Committee Meeting Minutes for above report review</li> <li>✓ Verification Study of Medical PAs ▲</li> </ul>	<p>Verification Study and policies/procedures confirm compliance, and the Plan conducts ongoing monitoring (e.g., audits, etc.) at a set frequency to ensure compliance with the contractual requirement for expedited request decision timeframes, extensions.</p>

## CATEGORY 1.4: REVIEW OF UTILIZATION DATA

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract, Exhibit A, Attachment III, Section 2.3.3</u></b></p> <p><b><u>Review of Utilization Data</u></b></p> <p>A. Contractor must include within the UM Program mechanisms to detect both under- and over- utilization of health care services, including Behavioral Health services. The Contractor’s internal reporting mechanisms to detect Member utilization and Provider prescribing patterns must be reported to DHCS no later than 30 calendar days after the beginning of each calendar year and upon request.</p> <p>B. Contractor must monitor utilization data to appropriately identify Members eligible for Enhanced Care Management (ECM) and applicable Community Supports as specified in Exhibit A, Attachment III, Subsection 4.4.6 and 4.5.6.</p> <p>C. Contractor must monitor and track Non-Specialty Mental Health (NSMH) utilization data for Members. Upon request, Contractor must submit data to DHCS.</p>	<ul style="list-style-type: none"> <li>✓ UM Program Description</li> <li>✓ UM Work Plan</li> <li>✓ Policies &amp; Procedures</li> <li>✓ UM and QI Committee Meeting Minutes</li> <li>✓ List of UM and Under / Over Utilization Reports Produced and the Frequency and Distribution List of Each Report</li> </ul>	<p>The Plan provides documentation showing it reviews under and overutilization reports for member utilization of Behavioral Health services, and NSMH services as well as provider prescribing patterns. The Plan monitors utilization data to identify members who qualify for ECM.</p>

## CATEGORY 1.5: DELEGATING UTILIZATION MANAGEMENT ACTIVITIES

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.4</u></b></p> <p><b><u>Delegating UM Activities</u></b></p> <p>Contractor may delegate UM activities. If Contractor delegates any UM activities, Contractor must comply with Exhibit A, Attachment III, Subsection 2.2.5 (<i>Subcontractor and Downstream Subcontractor Quality Improvement Activities</i>).</p> <p><i>Note: Delegation is covered extensively in the Category 5 Audit Program: Quality Improvement and Health Equity Transformation Program</i></p>	<ul style="list-style-type: none"> <li>✓ Delegation Agreements, including sections describing specific delegated duties</li> <li>✓ Policies &amp; Procedures related to UM delegation</li> <li>✓ Plan UM Delegation Grid</li> </ul>	<p>The Plan's delegation agreements clearly specify all delegated UM functions and the responsibilities of both the Plan and the delegated entity.</p> <p>The Plan's delegation agreements clearly states how it will inform and disseminate information to the delegated entity of any changes to the UM program.</p> <p>If the organization delegates UM activities, the Delegation Agreement must include the evaluation and oversight process.</p>

## CATEGORY 1.6: POST-STABILIZATION AUTHORIZATION

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 2.3.2</u></b></p> <p><b><u>Timeframes for Medical Authorization</u></b></p> <p>B. Post-stabilization: Contractor must respond to a Network Provider’s or out-of-Network Provider’s request for authorization for Post-Stabilization care within 30 minutes or the service is deemed approved, in accordance with APL 23-009.</p> <p>C. Non-Urgent Care Following an Exam in the Emergency Room: Contractor must respond to a Provider’s request for post-stabilization care services within 30 minutes or the services is deemed approved.</p> <p>D. Retrospective review for treatment received: Contractor must accept requests for Retrospective review within a reasonably established time limit, not to exceed 365 calendar days from the date of service. Contractor must communicate decisions to the Provider and to the member or authorized representative within 30 calendar days of the receipt of information reasonably necessary to make the determination, in accordance with 42 CFR section 438.404 (a) and Health and Safety Code Section 1367.01(h)(1).</p> <p><b><u>42 CFR 438.404</u></b></p> <p><b><u>Timely and adequate notice of adverse benefit determination</u></b></p>	<ul style="list-style-type: none"> <li>✓ Policies and Procedures</li> <li>✓ UM Committee meeting minutes</li> <li>✓ Verification Study of post-stabilization and retrospective requests ▲</li> </ul>	<p>The Plan’s Policies and Procedures and Verification Studies comply with post-stabilization and retrospective review request decision timeframes and documentation requirements.</p>

Requirement	Documentation to Review	Examples of Best Practices
<p>(a) Notice. The MCO, PIHP, or PAHP must give enrollees timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in §438.10.</p>		
<p><b><u>Contract Exhibit A, Attachment III, Section 3.2.6</u></b></p> <p><b><u>Emergency Department Protocols</u></b></p> <p>Contractor must develop and maintain protocols for communicating and interacting with emergency departments in and out of its Service Area. Contractor's protocols must be distributed to all emergency departments in the Service Area and must include, at a minimum, the following:</p> <ul style="list-style-type: none"> <li>A. All information on telephone or other secure methods of communicating with Contractor's triage and advice systems;</li> <li>B. Contact information for Contractor's designated contact person responsible for coordinating Emergency Services who is available 24 hours a day for the coordination of Emergency Services and Post-Stabilization Care Services;</li> </ul>	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
<p>D. Procedures for emergency departments to report Contractor’s system and/or protocol failures and Contractor’s processes for correcting deficiencies when failures occur;</p> <p>E. Procedures for the authorization and payment of Medically Necessary Post-Stabilization Care Services consistent with 42 CFR section 438.114, APL 19-008, and APL 23-009.</p>		
<p><b><u>Contract Exhibit A, Attachment III, Section 3.3.16</u></b></p> <p><b><u>Emergency Services and Post-Stabilization Care Services</u></b></p> <p><b><u>B. Post-Stabilization Care Services</u></b></p> <p>2) In accordance with 28 CCR section 1300.71.4, Contractor must approve or disapprove a request for Post-Stabilization Care Services made by a Provider on behalf of a Member within 30 minutes of the request. If Contractor fails to approve or disapprove authorization within the required timeframe, the authorization is deemed approved.</p> <p>3) Contractor is also financially responsible for Post-Stabilization Care Services obtained within or outside Contractor’s Network that are not authorized by Contractor, Subcontractor, or Downstream Subcontractor, but administered to maintain, improve, or</p>	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
<p>resolve the Member’s stabilized condition if Contractor, Subcontractor, or Downstream Subcontractor does not respond to a request for authorization within 30 minutes; Contractor, Subcontractor, or Downstream Subcontractor cannot be contacted; or Contractor, Subcontractor, or Downstream Subcontractor and the treating Provider cannot reach an agreement concerning the Member’s care. In this situation, the treating Provider may continue with care of the Member until Contractor, Subcontractor, or Downstream Subcontractor is reached and assumes responsibility for the Member’s care or one of the criteria of 42 CFR section 422.113(c)(3) is satisfied.</p>		
<p><b><u>CCR Tit. 28 § 1300.71.4</u></b></p> <p><b><u>Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services</u></b></p> <p>The following rules set forth emergency medical condition and post-stabilization responsibilities for medically necessary health care services after stabilization of an emergency medical condition and until an enrollee can be discharged or transferred. These rules do not apply to a specialized health care service plan contract that does not provide for medically necessary health care services following stabilization of an emergency condition.</p> <p>(a) Prior to stabilization of an enrollee's emergency medical condition, or during periods of destabilization (after stabilization of an enrollee's emergency medical condition)</p>	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
<p>when an enrollee requires immediate medically necessary health care services, a health care service plan shall pay for all medically necessary health care services rendered to an enrollee.</p> <p>(b) In the case when an enrollee is stabilized but the health care provider believes that the enrollee requires additional medically necessary health care services and may not be discharged safely, the following applies:</p> <p>(1) A health care service plan shall approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half hour of the request.</p> <p>(2) If a health care service plan fails to approve or disapprove a health care provider's request for authorization to provide necessary post-stabilization medical care within one half-hour of the request, the necessary post-stabilization medical care shall be deemed authorized. Notwithstanding the foregoing sentence, the health care service plan shall have the authority to disapprove payment for (A) the delivery of such necessary post-stabilization medical care or (B) the continuation of the delivery of such care; provided, that the health care service plan notifies the provider prior to the commencement of the delivery of such care or during the continuation of the delivery of such care (in which case, the plan shall not be obligated to pay for the continuation of such care from and after the time it provides such notice to the provider, subject to the remaining provisions of this paragraph) and in both cases the disruption of such care</p>		

Requirement	Documentation to Review	Examples of Best Practices
<p>(taking into account the time necessary to effect the enrollee's transfer or discharge) does not have an adverse impact upon the efficacy of such care or the enrollee's medical condition.</p> <p>(3) Notwithstanding the provisions of subsection (b) of this rule, a health care service plan shall pay for all medically necessary health care services provided to an enrollee which are necessary to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer or the enrollee is discharged.</p> <p>(c) In the case where a plan denies the request for authorization of post-stabilization medical care and elects to transfer an enrollee to another health care provider, the following applies:</p> <p>(1) When a health care service plan responds to a health care provider's request for post-stabilization medical care authorization by informing the provider of the plan's decision to transfer the enrollee to another health care provider, the plan shall effectuate the transfer of the enrollee as soon as possible,</p> <p>(2) A health care service plan shall pay for all medically necessary health care services provided to an enrollee to maintain the enrollee's stabilized condition up to the time that the health care service plan effectuates the enrollee's transfer.</p> <p>(d) All requests for authorizations, and all responses to such requests for authorizations, of post-stabilization medically</p>		

Requirement	Documentation to Review	Examples of Best Practices
<p>necessary health care services shall be fully documented. All provision of medically necessary health care services shall be fully documented. Documentation shall include, but not be limited to, the date and time of the request, the name of the health care provider making the request, and the name of the plan representative responding to the request.</p>		
<p><b><u>Contract Exhibit A, Attachment III, Section 5.1.3</u></b></p> <p><b><u>Member Information</u></b></p> <p><b><u>I. Member Handbook</u></b></p> <p>4) Although Contractor is required to use the DHCS Member Handbook template, Contractor remains solely responsible for ensuring that Members receive the following information through the Member Handbook:</p> <p>h) Definition of what constitutes an Emergency Medical Condition, Emergency Services, and post-stabilization services. The Member Handbook must expressly state that Prior Authorization is not required to receive Emergency Services and include the use of 9-1-1 for obtaining Emergency Services.</p>	See Above	See Above

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment III, Section 5.2.6</u></b></p> <p><b><u>Access to Emergency Service Providers and Emergency Services</u></b></p> <p>D. Contractor must have a medical director or licensed physician acting on behalf of Contractor’s medical director, who is available 24 hours a day, seven days a week to authorize Medically Necessary Post-Stabilization Care Services, to respond to hospital inquiries within 30 minutes, and to coordinate the transfer of a Member whose Emergency Medical Condition is stabilized.</p> <p>G. If Contractor delegates its Emergency Services and Post-Stabilization Care Services oversight obligations to Network Providers, Subcontractors, or Downstream Subcontractors, it must ensure a licensed physician is available seven days a week, 24 hours a day, to authorize Medically Necessary Post-Stabilization Care Services and coordinate the transfer of stabilized Members in an emergency department to an appropriate Network Provider, if necessary, as required under Health &amp; Safety Code (H&amp;S) section 1371.4.</p>	<p>See Above</p>	<p>See Above</p>

Requirement	Documentation to Review	Examples of Best Practices
<p><b><u>Contract Exhibit A, Attachment I, Section 1.0</u></b></p> <p><b><u>Definitions</u></b></p> <p>Post-Stabilization Care Services means Covered Services related to an Emergency Medical Condition that are provided after a Member’s condition is stabilized, in accordance with 42 CFR section 438.114 and 28 CCR section 1300.71.4, to improve or resolve the Member’s condition.</p> <p><b><u>42 CFR § 438.114</u></b></p> <p><b><u>Emergency and Poststabilization Services</u></b></p> <p>(a) Definitions. As used in this section—</p> <p><i>Poststabilization care services</i> means covered services, related to an emergency medical condition that are provided after an enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in paragraph (e) of this section, to improve or resolve the enrollee's condition.</p> <p>(d) Additional rules for emergency services.</p> <p>(3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment.</p>	<p>See Above</p>	<p>See Above</p>