Policy Name/Title: Clinical Criteria-Application	**P&P Number:** UM 70-19-17	**Effective** 08/01/2019	**Rev. No.:** 7

Policy & Procedures (P&P) – Name/Title: Clinical Criteria-Application		P & P Number:	**UM 70-19-17**
		P&P Effective Date:	08/01/2019
P&P Committee Approval Date:	08/01/2019; 12/29/2020; 04/27/2021; 05/21/2021; 09/23/2021; 08/4/2022; 03/14/2023; 08/3/2023;	P&P Revision Number:	7
Scope of Coverage:	Medicare/Medi-Cal	P&P Revision Date:	12/18/2020; 4/16/2021, 05/12/2021; 8/23/2021; 06/8/2022; 03/14/2023, 07/7/2023

Purpose:

1. To provide a standardized written process for applying clinical criteria that is objective and based on a member's individual needs and assessment of the local delivery system when determining the medical appropriateness of health care services.

Policy:

1. Actively practicing practitioners and Utilization Management staff are involved in the development, implementation, analysis, and corrective action, if necessary, of standardized clinical criteria. The Clinical Criteria used to make Utilization decisions and the procedure for appropriately applying these criteria are reviewed annually and updated or revised when appropriate.
2. At least annually, consistency in criteria application shall be evaluated. This evaluation is performed to ensure consistency for application of physician and non-physician reviewers. The Interrater Reliability Survey shall be performed at least annually and acts on opportunities to improve consistency, if applicable.
3. The organization reviews its UM criteria and procedures against current clinical and medical evidence and updates them, when appropriate. If new scientific evidence is not available, a designated group may determine if further review of a criterion is necessary.

Definitions:

1. Clinical Criteria are systematically developed and evidence-based clinical practice guidelines that assist practitioner and patient decisions about appropriate health care for specific circumstances.

Procedures:

1. Utilization Management staff conducts pre-certification, admission, and concurrent review using

the following utilization criteria hierarchy:

1.1. CMS National Coverage Determinations (NCD)
1.2. Local Coverage Determinations (LCD)
1.3. Local Coverage Articles (LCA) (Active/Retired)
1.4. Medicare Claims Processing Manual
1.5. Medicare Benefit Policy Manual
1.6. Medicare Managed Care Manual
1.7. Medicare Program Integrity Manual
1.8. In the absence of Medicare guidelines:
  1.8.1. Health Plan Medical Policy Website (i.e., SCAN Medical Policy Website)
  1.8.2. Nationally recognized evidence-based guidelines (i.e., Apollo Managed Care Guidelines, Milliman Care Guidelines)
  1.8.3. CMS Drug Compendia
1.9. For Alignment Health Plan utilization criteria hierarchy:
  1.9.1. Member's Evidence of Coverage (EOC)
  1.9.2. Medicare Coverage Database for NCD and/or LCD
  1.9.3. (Alignment) health plan medical coverage guidelines (if available)
  1.9.4. Other evidence-based guidelines such as Milliman

2. The application of the clinical criteria involves appropriate actively practicing practitioners in developing, adopting, and reviewing criteria. These guidelines are utilized in conjunction with a review of the member’s medical status, laboratory values, and diagnostic tests to evaluate medical services, needs, and level of care.

3. When applying the criteria, consider, at a minimum, the following individual characteristics:
   3.1. Age
   3.2. Comorbidities
   3.3. Complications
   3.4. Progress of treatment
   3.5. Psychosocial situation
   3.6. Home environment, when applicable

4. When UM Criteria are applied, an assessment of the local delivery system is required, and the following should be considered:
   4.1 Care is available within the service area
   4.2 Benefit coverage
   4.3 Coverage of benefits for Skilled Nursing Facilities (SNF), sub-acute care facilities, or home care where needed
   4.4 Availability and coverage of benefits for Skilled Nursing Facilities, sub-acute care facilities, or home care to support the member after discharge from the hospital
   4.5 Local hospital's ability to provide all recommended services within the estimated length of stay
   4.6 Other factors that may impact implementation of an individual member's care plan.
   4.7 Availability of inpatient outpatient and transitional facilities

4.8 Availability of outpatient services in lieu of inpatient services such as surgicenters vs. inpatient surgery
4.9 Availability of highly specialized services, such as transplant facilities or cancer centers

5. Identify the currently approved Clinical Criteria in use, Optimal Recovery Guideline (ORG) reference number, diagnosis, and/or reason(s) for admission.
   5.1. Apply the four (4) basic efficiency principles:
      5.1.1. Care provided with the necessary expertise
      5.1.2. Care in the least intensive setting
      5.1.3. No delays in treatment
      5.1.4. No unnecessary services

6. If the member meets criteria for admission, document the:
   6.1. Goal length of stay on initial review
   6.2. If criteria for continued inpatient stay changes during the member's hospitalization, document the new reference ORG number, criterion/criteria met
   6.3. Specific reason(s)
      6.3.1. Age
      6.3.2. Clinical status
      6.3.3. Comorbidities
      6.3.4. Complications
      6.3.5. Delay in transfer to lower level of care
      6.3.6. Delay in treatment
      6.3.7. Home environment
      6.3.8. Progress of treatment
      6.3.9. Psychosocial situation

7. The following procedures must be performed at Medicare-certified facilities (https://www.cms.gov/medicare/medicare-general-information/medicareapprovedfacilitie):
   7.1. Carotid artery stenting
   7.2. Certain oncologic PET scans in Medicare-specific studies
   7.3. Lung-volume reduction surgery
   7.4. Ventricular assist device (VAD) destination therapy

8. If the member does not meet criteria for admission, identify alternatives to admission and document:
   8.1. Referral to the Senior Medical Director or designee
   8.2. Reason(s) for not meeting criteria
   8.3. Clinical Criteria reference (ORG number not met) that identifies why criteria not met
   8.4. Available alternatives to admission per the Regional Medical Director or designee
   8.5. Notation that alternatives to admission discussed with provider(s), name of contact, date and time of call

9. When requests for coverage are received for Behavioral Health/Substance Abuse the member's clinical status and baseline mental health status assessment data should include the following:
   9.1. Clinical presentation, including medical and mental health status, past clinical history, medications and treatments, (both medical and psychiatric) and family history
   9.2. Voluntary or involuntary admission
   9.3. Diagnostic and Statistical Manual of Mental Disorders (DSM) Axis codes
   9.4. Document the clinical information and sub-dimensions
      9.4.1. Homicidal intent
      9.4.2. Irritability/aggression
      9.4.3. Potential for self-injury
      9.4.4. Suicidal ideation/intent
   9.5. Functional Impairment and sub-dimensions
      9.5.1. Nutritional impairment
      9.5.2. School or work impairment
      9.5.3. Sleep disturbance
      9.5.4. Social isolation
   9.6. Mental Status Examination and sub-dimensions
      9.6.1. Affect
      9.6.2. Appearance
      9.6.3. Behavioral condition or neurovegetative status
      9.6.4. Delusions
      9.6.5. Hallucinations
      9.6.6. Orientation
      9.6.7. Speech
      9.6.8. Thought content
   9.7. Substance Use/Abuse/Dependence
      9.7.1. Patterns of use/abuse
      9.7.2. Scope of use/abuse
      9.7.3. Withdrawal potential
   9.8. Mental Illness
   9.9. Environmental stress/type
      9.9.1. Family stress
      9.9.2. Housing
      9.9.3. Stress with school
      9.9.4. Stress with job
      9.9.5. Other stressors
      9.9.6. Support system

10. Level of care for substance abuse
   10.1. Alcohol Intoxication and/or Withdrawal Potential
   10.2. Biomedical Conditions and Complications
   10.3. Emotional/Behavioral Conditions and Complications
   10.4. Recovery Environment
   10.5. Relapse/Continued Use Potential

10.6. Treatment Resistance/Acceptance

11. Availability of Criteria - The Clinical review criteria shall be made available to the Practitioner, Member, and to the Public upon request.
    11.1. The disclosure of the clinical criteria will be accompanied by the following disclaimer statement: "*The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.*"
    11.2. The criteria shall be provided in writing to the Practitioner/Member upon request.
        11.2.1. A copy of the actual printed document shall be faxed/mailed to the Practitioner/Member as requested with the required disclaimer statement.
        11.2.2. The criteria shall be provided to the Public upon request as stated/referenced through the Innovative Management Systems ("IMS") Website.
            11.2.2.1. Upon notification IMS shall provide a copy of the specific criteria with the required disclaimer statement.

12. U.S. Preventive Services Task Force ("USPSTF")
    12.1. The latest edition of the Guide to Clinical Preventive Services will be used to determine the provision of clinical preventive services to asymptomatic, health adult members. The USPSTF guidelines are made available to practitioners on our website.
    12.2. Sensitive and preventive services are exempt from prior authorization.

List of Criteria Sets Include:

1. CMS National Coverage Determination (NCD)
2. Local Coverage Determination (LCD)
3. Local Coverage Articles (LCA) (Active and Retired)
4. Medicare Claims Processing Manual
5. Medicare Benefit Policy Manual
6. Medicare Managed Care Manual
7. In the absence of Medicare guidelines:
    1. Health Plan Medicare Policy Website (i.e., SCAN Medical Policy Website)
    2. Nationally recognized evidence-based guidelines (i.e., Apollo Managed Care Guidelines, Milliman Care Guidelines)
    3. CMS Drug Compendia

Authority/References:

1. California Health and Safety Code (CA HSC) 1363.5 – Clinical Criteria, Disclosure, Disclaimer
2. National Committee for Quality Assurance (NCQA) Standards and Guidelines – Clinical Criteria for UM Decision
3. UM-Inter-Rater-Reliability Policy and Procedure
4. CMS Manuel System Pub 100-08 Medicare Program Integrity Transmittal 512.
5. 42 CFR 422.204(b)(1) and (3)

6. Medicare Managed Care Manual, Chapter 6, 60.2
7. http://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilitie/

Revision History

Revision Date	Revision Made	Approved By
12/18/2020	Addition of Apollo as criteria	P&P Committee
4/16/2021	Addition of language re. procedures in Medicare-certified facilities	P&P Committee
05/12/2021	Addition of Availability of inpatient outpatient and transitional facilities; Availability of outpatient services in lieu of inpatient services such as surgicenters vs. inpatient surgery; Availability of highly specialized services, such as transplant facilities or cancer centers	P&P Committee
8/23/2021	Update to utilization criteria; added USPSTF	P&P Committee
6/8/2022	Update to utilization criteria	P&P Committee
3/14/2023	Update to utilization criteria	P&P Committee
7/7/2023	Update to utilization criteria for health plan specific hierarchy	P&P Committee