SAN FRANCISCO HEALTH PLAN

CO-57 UM Clinical Criteria

APPROVAL/REVIEW/REVISION HISTORY			
Signature	**Title**	**Date**	**Action**
DocuSigned by: Nina Maruyama 9D4617B1400D431...	CCO	4/22/2025	Policy Update
Signed by: Steve O'Brien 60DFB20814944C4...	CMO	4/22/2025	

SFHP POLICY AND PROCEDURE

Utilization Management Clinical Criteria

Policy and Procedure Number:	CO-57
Department:	Clinical Operations
Accountable Lead:	Clinical Operations Analyst
Lines of Business and Coverage Programs Affected:	☒Medi-Cal ☐Medicare Advantage D-SNP ☒Healthy Workers HMO ☐Healthy SF ☐City Option ☐All lines of business and coverage programs as listed above

POLICY STATEMENT

San Francisco Health Plan (SFHP) conducts utilization management (UM) to manage covered benefits through the consistent application of medical necessity criteria used in a systematic hierarchy. For services subject to Clinical Operations' medical benefit, UM review is performed through the evaluation of a member's relevant clinical information against established clinical criteria that meet professional standards of care.

SFHP uses external criteria State/Federal (Medi-Cal/CMS), Milliman Care Guidelines (MCG), and when available and, in limited circumstances, internally developed and approved criteria.

SFHP internally reviews and recommends changes to its clinical and level of care criteria through the UM Committee (UMC) to ensure they continue meeting professional standards of care. Annually, the UMC approves each set of clinical criteria with an annual review and discussion from the Quality Improvement and Health Equity Committee (QIHEC).

Physician Administered Drugs (PADs) are a medical benefit and are subject to the criteria application procedures outlined in section 1. Criteria Hierarchy.

Prescription drugs dispensed at a walk-in pharmacy are not a medical benefit and not within the scope of this policy.

PROCEDURE

I. Criteria Hierarchy

Resources are used to assist the Clinical Operations Nurse and Medical Director staff (hereafter referred to as UM staff) in determining the medical necessity of requested services. The following criteria hierarchy is used to guide clinically sound medical necessity decisions:

1. State/Federal (Medi-Cal/CMS) criteria
    a) Code of Federal Regulations (CFR)
    b) California Code of Regulations (CCR) Titles 22 & 28
    c) California Welfare and Institution Code (CA W&I)
    d) California Health and Safety Code (CA HSC)
    e) Department of Health Care Services (DHCS) Medi-Cal Provider Manuals and All Plan Letters
    f) Department of Managed Health Care (DMHC) All-Plan Letters
2. Evidenced Based Guidelines
    a) MCG Health Care Guidelines
    b) World Professional Association for Transgender Health (WPATH)
    c) Medical / Professional Associations, i.e. American Society of Addiction Medicine
3. SFHP internally developed and approved criteria:
    a) EPSDT Private Duty Nursing
4. Specialty Practice Criteria

SFHP utilizes an Independent Review Organization when there are no available external or internally developed and approved criteria. The specialty physician consulting services of Medical Review Institute of America (MRIoA) provides expertise for medical necessity determinations outside the expertise of SFHP's internal medical directors. MRIoA utilizes a nationwide network of board-certified physician specialists and professionals in over 133 specialties and sub-specialties of medicine.

Chief Medical Officer (CMO) or physician designee (MD) reviews the evidence in consultation with relevant external, independent specialty expertise obtained from SFHP's Independent Review Organization when there are no available external or internally developed and approved criteria.

II. Application of Criteria

A. SFHP and its Delegated Medical Group (DMG) UM staff, including Carelon for non-specialty mental health services, must use professionally accepted evidence-based criteria.
B. Clinical information evaluated with reference to these criteria may include, but are not limited to:
    i. Office and hospital records
    ii. History of the presenting problem

iii. Physical examination results
iv. Diagnostic testing results
v. Treatment plans and progress notes
vi. Information on consultations with the treating practitioner
vii. Evaluations from any other health care practitioners and providers
viii. Any operative and pathological reports
ix. Rehabilitation evaluations
x. Patient characteristics and information
xi. Treating physician statements of medical necessity

C. Criteria must be applied in conjunction with consideration of the individual member needs and characteristics such as age, cultural and linguistic needs, comorbidities, complications, progress of treatment, psychosocial needs, and the home and/or work environment. In addition, characteristics of the local delivery system available to the individual, including aspects such as the availability of alternative levels of care, timely accessibility of covered services, cultural preferences for treatment modalities, availability of specialty providers, access to community resources, familial influences and supports, benefit coverage for the available alternatives, and ability of local providers to provide all recommended services within the required access standards must also be considered.

D. Requests that do not meet medical necessity criteria are referred to a SFHP MD for further evaluation. The SFHP MD may request additional clinical documentation, request external independent review if the scope of the requested service is outside their field of experience/expertise, approve based on clinical judgement and supplemental considerations (e.g., EPSDT benefit protocols, advanced evidence-based information) or deny based on lack of medical necessity. Denials for reasons of medical necessity are only made by a SFHP MD.

III. Review and Approval of Criteria

A. The UMC reviews clinical criteria as needed, but at least annually to ensure that they are current. Information sources to gather data on potential changes to clinical criteria include, but are not limited to:

1. Evaluation of member complaints, grievances, and appeals.
2. Frequent and consistent overturns of SFHP denials through Independent Medical Review (IMR).
3. New and/or revised statutory or regulatory requirements, including DHCS directives and All Plan Letters or Policy Letters.
4. Changes to guidelines or practice protocols.
5. Increased volume or rate of denied authorization requests.
6. Availability of new technologies and/or treatments.
7. Addition of new benefits or services.
8. Concerns raised through the Member Advisory Committee (MAC), Pharmacy and Therapeutics Committee (P&T), or QIHEC.
9. Provider or member input/feedback.

B. In considering the development of and/or changes to clinical criteria, the UMC considers the following:
   1. New technologies (See CO-54 Evaluation of New Technology).
   2. Other health plans' criteria – reflecting community standards of care.
   3. Evidence-based clinical practice guidelines produced by specialist associations, U.S. government agencies, and health care organizations.
   4. Medicare and Medicaid (Medi-Cal) guidelines.
   5. Benefit changes.
   6. Statutory and regulatory changes.

C. Annually, the UMC and the QIHEC review and approve the criteria hierarchy; review and approve the adopted SFHP-developed criteria; and review and approve the vendor purchased criteria. The intent of the annual reviews is to assess SFHP's UM criteria and procedures against current clinical and medical evidence, and when appropriate, update the criteria. The annual QIHEC review ensures:
   1. The UM criteria is distributed, reviewed, and approved by applicable network practitioners.
   2. Network practitioners with clinical expertise in the area being reviewed have the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria.
   3. Non-staff network practitioners are involved in developing, adopting, and reviewing criteria, because they are subject to application of the criteria.

IV. Communication of UM Criteria

The public, including providers and members, may obtain the relevant UM criteria for specific medical procedures or conditions on request at no cost. Providers may contact SFHP Clinical Operations and members may contact SFHP Customer Service to request the materials. When disclosed to the public, the notice that accompanies the criteria states, "The materials provided to you are criteria 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." Providers and members are informed, at least annually, how they may obtain copies of UM criteria utilized for decision-making and are provided upon request. SFHP also communicates prior authorization procedures and timeframes with providers and members through the Provider Manual, Member Handbook/EOC, and SFHP website.

MONITORING

1. SFHP's Clinical Operations Department performs inter-rater reliability (IRR) audits at least annually for both physicians and nurse reviewers to evaluate the consistency and accuracy with which its reviewers apply UM criteria.
   a. For Gender Affirmation services, Custodial Care, and EPSDT Private Duty Nursing, SFHP utilizes an internally developed IRR assessment tool, developed by SFHP's UM Managers, using hypothetical case scenarios to

assess the accurate and consistent application of patient clinical presentations against SFHP's Gender Affirming Services, Custodial Care and ESPDT Private Duty Nursing medical necessity criteria. Reviewers are allowed two opportunities to reach the passing threshold of 90 percent.

b. For all other inpatient and outpatient services, the assessment is a standard IRR tool created by MCG using hypothetical case scenarios and multiple-choice answers to assess the accurate and consistent application of patient clinical presentations against medical necessity criteria. Reviewers are allowed two opportunities to reach the passing threshold of 90 percent.
c. For new staff, IRR testing will be completed before the new hire conducts unsupervised utilization reviews. The passing threshold for new staff is 90 percent.

Reviewers who are unable to reach the IRR percent threshold are immediately placed on an educational corrective action, which may include but is not limited to attendance of an internal training session, more frequent case review, supervisor feedback, and IRR reassessment.

SFHP's Clinical Operations Department also conducts quarterly internal audits of randomly selected authorizations utilizing a proprietary audit tool, which includes NCQA, DHCS, and DMHC requirements. These include administrative requirements (turnaround time, Notice of Action readability, inclusion of appropriate appeal and grievance rights language) and clinical requirements (accurate criteria selection, accurate application of clinical information).

Results of the IRR assessment and the internal audits are presented to the UMC and discussed for potential improvements. Final versions are submitted to QIHEC for review and comment.

2. SFHP's Clinical Operations Department reviews this policy and procedure to evaluate the utilization management guidelines at least annually and more frequently if necessary. Any changes to the guidelines are reviewed by SFHP's Utilization Management Committee (UMC) for consistency with sound clinical principles. UMC approves each set of clinical criteria with an annual review and discussion from the Quality Improvement and Health Equity Committee (QIHEC).

3. SFHP employs the following monitoring mechanisms to reevaluate an existing or identify the need to develop new UM criteria:
    a) Medical record audits by SFHP's Clinical Operations Department.
    b) Reports of cases sent for external medical review due to no criteria available
    c) Review of Clinical Operations utilization reports by SFHP's UMC
    d) Review of member and provider satisfaction surveys, complaints, grievances, and member appeals by SFHP's Health Service Programs Department. All member appeals, including those of delegated groups not authorized to conduct appeals oversight, are reviewed against SFHP's criteria hierarchy.

e) Overturns of medical necessity denials, especially overturns in which additional clinical information was not needed to reach the alternative determination by SFHP.

4. The UMC reviews Appeals, IMRs, and State Fair Hearings resulting in authorization decisions made by SFHP or one of its delegated medical groups. The UMC recommends corrective action and/or identifies where the Clinical Operations Department can revise the authorization process, if necessary, to improve the member experience, to address any barriers, and ensure the utilization management criteria are consistent with current industry and evidence-based practices. The Quality Improvement Committee reviews an Appeals Report (overturned and upheld appeals) every quarter regarding the activity of medical authorizations.

5. When SFHP delegates UM to a contracted medical group, SFHP is accountable for assuring that the delegated medical group conducts UM according to SFHP's standards, which incorporate applicable DMHC, DHCS, and NCQA requirements. For each delegated medical group, SFHP's Clinical Operations and Compliance and Regulatory Affairs:
    a) Review the UM program to identify if the medical group is following the standards of application, approval, and evaluation of medical necessity criteria.
    b) Review a sample of UM files to evaluate compliance with the use of relevant criteria and clinical information, as well as the availability of criteria to practitioners.

DEFINITIONS

Medical Necessity: The Medi-Cal definition of Medical Necessity is reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. For members who are eligible for EPSDT services, services are determined to be medically necessary when needed to correct or ameliorate defects and physical and mental illnesses or conditions.

AFFECTED DEPARTMENTS/PARTIES

Compliance and Regulatory Affairs
Health Services – Health Services Programs
Medical Directors
Quality Improvement and Health Equity Committee (QIHEC)
Utilization Management Committee (UMC)

RELATED POLICIES & PROCEDURES, DESKTOP PROCESS & PROCESS MAPS

1. CO-22: Authorization Requests
2. CO-33: EPSDT and EPSDT Supplemental Services
3. CO-54: Evaluation of New Technology
4. CO-61: Gender Affirmation Services
5. DO-02: Oversight of Delegated Functions
6. Pharm-08: Annual Review of Formulary, Prior Authorization Criteria, and Policies
7. UM Criteria for EPSDT Private Duty Nursing

REVISION HISTORY

Original Date of Issue:	August 20, 2015
Revision Date(s):	February 17, 2017; April 20, 2017; September 21, 2017; April 19, 2018; November 21, 2019; December 12, 2019; May 21, 2020, November 19, 2020; April 19, 2020; October 21, 2021; November 18, 2021; September 22, 2022; March 20, 2023; May 18, 2023; March 30, 2024; August 22, 2024; October 17, 2024; April 17, 2025

REGULATORY SUBMISSION HISTORY (to be completed by CRA only)

DHCS Approval Date(s): April 13, 2021
DMHC Approval Date(s): n/a

REFERENCES

1. DHCS/SFHP Contract Exhibit A, Attachment III, Section 2.3 Utilization Management Program
2. H&S Code §§1363.3, 1367.01,1363.5(a); 1363.5(b)(4), (5); 1363.5(c), and 1374.551
3. W&I Code §14059.5
4. DMHC APL 21-002 – Implementation of Senate Bill 855, Mental Health and Substance Use Disorder Coverage
5. The World Professional Association for Transgender Health (WPATH) Standards of Care, 8th Version (SOC 8).
6. NCQA UM 2; Element B: Availability of Criteria
7. NCQA UM 11 Procedures for Pharmaceutical Management
8. DMHC Technical Assistance Guide

SAN FRANCISCO HEALTH PLAN
Here for you

P.O. Box 194247
San Francisco, CA 94119
1(415) 547-7800
1(415) 547-7821 FAX
sfhp.org

Date

FirstName LastName

1234 Address Street
San Francisco, CA 94110

RE: Request for Criteria

Dear [member or provider],

This letter is in response to your request for the criteria used to make our authorization decision for [requested procedure or service.]

The materials provided to you are criteria 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 for [Medi-Cal HMO or Healthy Workers HMO].

If you have any questions, please contact xxx at (415) xxxx

Sincerely,

San Francisco Health Plan

Clinical Operations