HealthSmart Management Services Organization, Inc

Policy Statement:

Criteria and guidelines used in making utilization review decisions shall be:

- Developed with involvement from actively practicing health care providers.
- Applied in consideration of the local delivery system.
- Consistent with accepted standards of practice.
- Objective and based on medical evidence.
- Available to all providers, staff, and members upon written request.

Utilization Management Clinical Criteria Hierarchy

Federal or State Guidelines, where applicable, the following hierarchy will be followed:

The Utilization Management Committee will use the following hierarchy of criteria resources:

1. Member eligibility and benefits will be verified prior to applying criteria.

2. Federal or State Guidelines, where applicable, the following hierarchy will be followed:

- For Medicare/Medicare Advantage:
  CMS is Primary Source with hierarchy:
  - National Coverage Determinations [NCD]
  - Local Coverage Determinations [LCD],
  - Local Coverage Articles [LCA],
  - Medicare Manuals [Medicare Managed Care, Medicare Benefit Policy, Medicare Program Integrity, Medicare Claims Processing]

    - For Part B Drug and Biologicals Only: Use Medicare Approved Drug Compendia and/or relevant guidance from the FDA according to the rules in the Medicare Benefit Policy Manual Chapter 15, Section 50.4, and sub-chapters, paying special attention to the distinctions for anti-cancer chemotherapy regimen drugs (50.4.5) and immunosuppressive drugs (50.5.1)

- For Medi-Cal: DHCS criteria is primary source

  - Pharmaceuticals covered under medical or pharmacy benefits.
    - [Pharmacy benefits, other than those covered by the medical

benefit will be coordinated with the member's health plan]
- Authoritative Compendia
- Medi-Cal Approved Compendia pursuant to SSA 1927 (g)(1)(B) and(k)(6).

- For Commercial: DMHC - Knox Keene Act - Title 28 is the Primary Source

- World Professional Association for Transgender Health [WPATH]: Standards of Care for the Health of Transsexual, Transgender and Gender nonconforming people from WPATH will be utilized as primary source to provide clinical guidance in determination of coverage.

3. Health Plan specific criteria include benefits and services that do not require prior authorization.
    - Anthem Medicare members, referrals to in network providers for consultation are considered a pass through.
4. Evidenced based criteria: Apollo Medical Review Criteria Guidelines for Managed Care unless otherwise directed by a specific health plan. MCG Clinical guidelines will be utilized for clinical review for CalOptima, Aetna, CHP, and Molina, Alignment health plans.
    - No evidence-based criteria shall be more restrictive than the benefits of coverage of traditional Medicare.
5. Community Medical Standards per availability as appropriate by health plan and line of business: American Medical Association; American Academy of Pediatrics; American Board of Obstetrics and Gynecology; American Board of Internal Medicine/Family Practice, Hayes, UpToDate, InterQual, MCG, National Comprehensive Cancer Network Guidelines, Agency for HealthCare Research and Quality, Cochrane Review.
6. Practice Guidelines developed by the Quality Management Committee in conjunction with the UMC.

Statement of Rationale: Evidence based criteria are used when Medicare, Medi-Cal, and the Health Plan guidelines do not address the member's specific condition and/or medical service or item requests.

No evidence guideline replaces, modifies, or supersedes existing Medicare Regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). These supplemental medical necessity criteria are based upon evidence-based guidelines and clinical studies in the peer-reviewed published medical literature. Evidence-based criteria are used when medical necessity criteria for a service have not been fully established by the Centers for Medicare and Medicaid Services (CMS) to prevent delays in care when making medical necessity determinations. HealthSmart Management Services Organization, Inc., believes the benefits of using Apollo Care Guidelines and other evidence-cased criteria reduce the risk of delays in care or access to items or services by providing timely medical necessity determinations which ensure patients receive services that are appropriate, safe, and effective, which outweigh any clinical harms.

Utilization Management Clinical Criteria are available to the public on the site or upon request. Request for Utilization Management Clinical Criteria can be made by contacting the UM Department at (714) 947-8600.

Resources:

UM 2 Medical Criteria Policy, page 1-3

World Professional Associate for Transgender Health (WPATH) www.wpath.org/publications/soc

California Code of Regulations, Title 22
www.dhcs.ca.gov/services/adp/Pages/CA_Code_Regulations.shtml.aspx

DHCS All-Plan Letters and Other DHCS Regulatory Guidance regarding UM
www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

DMHC Regulatory Guidance regarding UM https://www.dmhc.ca.gov/LawsRegulations.aspx

Centers for Medicare and Medicaid Services (CMS) Guidelines National Coverage Determinations (NCD) https://www.cms.gov/medicare-coverage-database/reports/national-coverage-ncd-report.aspx?chapter=all&sortBy=title

Local Coverage Determinations (LCD) https://www.cms.gov/medicare-coverage-database/reports/local-coverage-final-lcds-alphabetical-report.aspx?lcdStatus=all