

	Policy & Procedure	
	Policy Name:	UM Criteria
	Policy Number:	MM – 2006
	Department:	Medical Management Compliance
	Applicable States: (Check all that apply)	CA <input type="checkbox"/> TX <input type="checkbox"/> RI <input type="checkbox"/> CT <input type="checkbox"/> PA <input type="checkbox"/> _____
	Effective Date:	07/24/2000
	Last Reviewed Date:	04/08/2024

I. **PURPOSE:** (This applies to standard/expedited and behavioral health referrals.)

- A. Prospect maintains current versions of MCG for use by UM Registered Nurse (RNs), Licensed Vocational Nurses (LVNs), Physician Reviewers, and Pharmacists in determining the appropriateness of UM determinations. Denials are performed by Medical Directors and pharmacists only. Criteria are objective, measurable, and based on sound clinical evidence. Nurse Review may deny non-covered benefit (never covered).
- B. Physicians and the file types they are qualified to review include:
 1. Physicians, all types: Medical, behavioral health, pharmaceutical, dental, chiropractic and vision denials
 2. Doctoral-level clinical psychologists or certified addiction-medicine specialists – Behavioral healthcare denials.
 3. Pharmacists – Pharmaceutical denials.
 4. Dentists – dental denials.
 5. Chiropractor – Chiropractic denials.
 6. Physical Therapists – physical therapy denials

II. **SCOPE:**

III. **DEFINITIONS:**

IV. **RESPONSIBLE PARTIES:**

- A. Patient Care Coordinator
- B. Medical Director
- C. Referral Nurse
- D. Case Manager
- E. UM Manager

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V. POLICY:

A. It is the policy of Prospect Medical (Prospect) that referrals will be processed using the following criteria:

1. Commercial Hierarchy:

- a. Eligibility and benefits (EOC)
- b. State-specific and Federal guidelines or mandates
- c. Health Plan specific Guidelines or mandates referenced in Coverage Determination Guidelines and Benefit Interpretation Policies
- d. Other evidence-based criteria such as MCG
- e. Other evidence-based criteria such as Hayes or evidence-based literature.

2. Medicare Hierarchy:

- a. Plan Eligibility and Coverage (benefit plan package or EOC)
[Member Materials and Forms | Medicare \(molinahealthcare.com\)](#)
- b. CMS Criteria
 - i. National Coverage Determination (NCD)
[National Coverage NCD Report Results \(cms.gov\)](#)
 - ii. Local Coverage Determination (LCD) used only for the area specified in the LCD
[Local Coverage What's New Report Results \(cms.gov\)](#)
 - iii. Local Coverage Medical Policy Article (LCA)
[Local Coverage Articles Alphabetical Report Results \(cms.gov\)](#)
 - iv. Medicare Benefit Policy Manual (MBPM)
[Molina Clinical Policy](#)
 - v. Or Hierarchy defined or required by Individual Health plan per Health plan Hierarchy policy.
[Molina Clinical Policy](#)
 - vi. Medicare Managed Care Manual, Medicare Program Integrity Manual, and Medicare Claims Processing Manual.
[Internet-Only Manuals \(IOMs\) | CMS](#)
- c. UHC or Health Plan criteria (e.g. Coverage Summary, Medical Policy)
[Molina Clinical Policy](#)
- d. Evidence based criteria such as MCG
[Molina Clinical Policy](#)

3. D-SNP

- a) Medicare Delegation:
 - i. Medicare National Coverage Determination (NCD)

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- ii. [National Coverage NCD Report Results \(cms.gov\)](#)
Medicare Local Coverage Determination (LCD)
[Local Coverage What's New Report Results \(cms.gov\)](#)
- iii. CMS Benefit Policy Manual/Medicare Managed Care Manual
[Internet-Only Manuals \(IOMs\) | CMS](#)
- iv. MCG
[Molina Clinical Policy](#)

b) Medi-Cal Delegation:

- i. Medi-Cal Guidelines
- ii. MCG
- iii. NCCN
- iv. Blue Shield Promise Health Plan Evidence of Coverage (EOC)

4. Medi-Cal Criteria

- a. Medi-Cal Criteria
- b. Evidence based criteria such as MCG
- c. Community Standard

For Part B Drug and Biologicals Only:

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)

Organization Specific Guidelines for Part B Drug Step Therapy or organization Specific Guidelines for Device Preferred Products. Step therapy guidelines can only be applied to drugs not used within the last 365 days.

- Standards utilized for prior authorization, admissions, and concurrent review includes (including behavioral health), Plan Eligibility and Coverage, CMS Criteria, National (Medicare) Coverage Determination (NCD), Local Coverage Determination (LCD), Local Coverage Medical Policy Article, Medicare Benefit Policy Manual, Health Plan Specific Criteria, and MCG. Medi-Cal criteria is DHCS Medi-Cal UM Criteria, MCG, other approved Criteria, and evidence-based Community Standards. Pharmacy criteria used is all of the above and Micromedex/Drug Dex, Food & Drug Administration

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(FDA), Centers for Disease control & Prevention (CDC), and the Department of Health Care Services (www.medical-cal.ca.gov).

- Prospect takes into account cultural considerations in addition to medical necessity and benefits. Such considerations include but are not limited to members with diverse cultural and ethnic backgrounds, religious beliefs, limited English proficiency or hearing incapacity. They also include consideration of gender as it relates to the above examples if member requesting same sex provider.
- Criteria will be objective, measurable, and based on sound clinical evidence. Annually or as needed, Criteria and Guidelines will be reviewed and approved by UM and QM Committees to include USPSTF Guidelines. These will be distributed to providers via the Provider Portal and PMG Website.
- All physician offices receive a provider manual at the time of their orientation, which indicates developed practice appropriateness and application of review criteria. The review criteria are updated on an annual basis or as needed and also available to providers/members/representative and public upon request for approvals, denials and modifications. Care Plans will be included in manual with description of programs.
 - CMS Criteria/Manuals
 - National (Medicare) Coverage Determination (NCD),
 - Written coverage decision of local Medicare contractors.
 - Local Coverage Medical Policy Article,
 - Local (LCD) articles,
 - American College of Obstetrics and Gynecology
 - American College of Pediatrics
 - The United States Preventive Services Task Force
 - Centers for Disease Control
 - Food and Drug Administration
 - Child Health Disability and Prevention Program (CHDP)
 - Comprehensive Perinatal Services Program (CPSP)
 - Department of Health and Human Services health Care Guidelines and Requirements
 - National treatment guidelines through www.guidelines.gov and professional organizations such as,
 - American Diabetes Association
 - American College of Rheumatology
 - American Association of Clinical Endocrinologists
 - American Academy of Neurology
 - American College of Gastroenterology
 - American Academy of Dermatology
 - American Association for the Study of Liver Diseases

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- American College of Obstetrics & Gynecologists
 - American Society of Clinical Oncology (ASCO)
 - National Comprehensive Cancer Network (NCCN)
 - National Kidney Foundation
 - Kidney Disease Outcomes Quality Initiative (KDOQI)
 - www.chemoregimen.com
- Health Plan policy
 - When the above indicates that UM Criteria are not appropriate, decision makers will use alternative criteria.
 - Health Plan Specific Criteria/Guidelines and will not interfere with or abuse delay in service or preclude delivery of services. Established UM criteria will be utilized in the referral process. When the above indicates that UM Criteria are not appropriate decision makers will use alternative criteria.
 - Where there is an overlap between Medicare and Medicaid benefits, Prospect will apply the definition of medical necessity that is the more generous.
- B. Criteria used to determine appropriate of medical services by this plan will be consistent with criteria utilized by the Health Plans. All approved criteria will be transmitted and utilized throughout the physician networks.
- C. Criteria utilized for commercial inpatient are Eligibility and Benefits (EOC); State and Federal mandates; Health Plan criteria; and other evidence-based criteria, e.g. MCG.
- D. Criteria used to determine appropriateness of medical services will include the needs of the individual members. The following criteria may include, but are not limited to, areas to consider when evaluating individual member needs:
1. Age
 2. Co-morbidities
 3. Complications
 4. Home environment, if applicable
 5. Progress of treatment
 6. Psychosocial needs (schizophrenia disorder, panic disorder, bipolar disorder, panic disorder, etc.)
 7. Home environment, when applicable
 8. Other factors that may impact the ability to implement an individual member's care plan.
- E. Application of criteria also takes into consideration the capabilities of the local delivery system, such as but not limited to:
1. Whether services are available within the service area
 2. Benefit coverage

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Prospect also considers characteristics of the local delivery system available for specific patients such as:

- a. Availability of skilled nursing facilities, sub-acute care facilities or home care in Prospect's service area to support the patient after hospital discharge.
 - b. Availability of inpatient outpatient and transitional facilities.
 - c. Coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care where needed.
 - d. Availability of outpatient services in lieu of inpatient services such as surgery centers vs. inpatient surgery.
 - e. Availability of highly specialized services, such as transplant facilities or cancer centers.
 - f. Local hospital's ability to provide all recommended services within the estimated length of stay.
- F. PCP to manage the members condition within the scope of PCP practice. If no active or new events documented, PCP can continue to evaluate and determine treatment plan. MD Reviewer may deny or approve based on medical documentation from the specialist if continued care must be rendered by the specialist.
- G. UM Procedures/Processes and review criteria used by Prospect are also available for disclosure to providers, members and their representatives, and the public upon request in accordance with established regulatory and contractual agreements. UM Staff shall relay the request to the Medical Director (or designee) for response. All requests for UM Criteria are logged in the UM Criteria Tracking log and are processed upon request. Disclosure will be accompanied by the following notice:
- "The materials provided to you are guidelines used by Prospect to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual needs and the benefits covered under your contract"*
- H. Disclosure will include policies, procedures, and criteria used to authorize, modify, or deny healthcare to contracted healthcare practitioners and providers.
- I. Prospect will provide paper copies of the information upon request.
- J. Prospect will:
1. Copy criteria for each practitioner
 2. Read them over the phone
 3. Make them available for review at its offices
 4. Distribute via the internet, and

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5. Notifies the practitioners of its policy for making an appropriate practitioner reviewer available to discuss any UM denial decision and how to contact the reviewer.
- K. It is the policy of Prospect to evaluate new technology and the new application of existing technology for inclusion in the HP benefit plan. Evaluation will be referred to the HP for review and approval. Evaluation includes:
1. Medical procedures
 2. Behavioral health procedures
 3. Pharmaceuticals
 4. Devices
- L. It is the policy of Prospect to evaluate UM requests for appropriateness and medical necessity.
- M. Review criteria are updated on an annual basis or as needed and made available to providers upon request. Procedures for applying criteria are also reviewed annually. Updates are made when appropriate. Will use evidence-based Community Standards and USPSTF if other Criteria not available, and appropriate specialty Physician Reviewer for denials if no Criteria.
- N. Except as specified in 422.318 (for entitlement that begins or ends during a hospitalization stay) and 422.320 (with respect to hospice care), the following requirements shall be met:
1. Comply with CMS's national coverage determinations.
 2. General coverage guidelines included in original Medicare manuals and instructions unless superseded by regulations in this part or related instructions, and.
 3. Written coverage decisions of local Medicare contractors with jurisdiction for claims in the geographical area in which services are covered under the Medicare Advantage plan.
 4. CMS contracts with outside vendors, called contractors, who process Medicare fee-for-service claims. The contractors who process Part A claims are called intermediaries, the contractors who process Part B claims are called carriers, the contractors who process Part B DME claims are called DMERC's, etc. CMS has broken the country into intermediary, carrier, DMERC, etc. regions and each region is services by different contractors. Each contractor has the right to set their own coverage criteria in CMS has not issued a national determination. The coverage criteria is set by the contractors are called local coverage determination.
- O. UM Committee

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1. The UM committee shall appropriately and actively participate in the review process of giving advice, commenting on development or adoption of criteria, and on the instructions for applying the criteria.
 2. The UM Committee reviews the 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.
 3. The UM committee is chaired by the Medical Director who is Board Certified with an unrestricted license to practice in the state of California or designee and includes PCP's, and Board-Certified Specialists. Specialists who sit on the committee may include but is not limited to; Cardiology, Internal Medicine, Nephrology, Pulmonology, Urology, General Surgery, GI, Ophthalmology, Mental Health, and Pediatrics.
 4. The UM Committee will act on any opportunity to improve determinations for the benefit of the member.
 5. Board Certified Physicians, with clinical expertise in the area of being reviewed, assist in making decisions for medical appropriateness by either participating in the development of the criteria, UM plan, practice guidelines, referral process, disease management, or as a case expert.
 6. Behavioral Health Care Practitioners are available to review cases pertaining to their specialty.
- P. Applied Behavioral Analysis (ABA) is a behavioral health service, requests for ABA for treatment of Autism Spectrum Disorders are included in the treatments that should be referred to the health plan for medical necessity determinations. All medical services for the diagnosis and treatment of Autism Spectrum Disorders and other Pervasive Developmental Disorders, including Occupational, Physical and Speech Therapy remain the responsibility of PMG.
- Q. **Anthem Blue Cross** requires Prospect to use available Anthem Blue Cross adopted criteria when making utilization management decisions for Anthem members. Other adopted criteria or guidelines are only to be used in situations when an Anthem Medical Policy or Clinical UM Guideline does not exist. Other guideline sets adopted by anthem: AIM Specialty health Guidelines for diagnostic imaging and sleep studies; MCG care guidelines as licensed and modified by Anthem should be used first, and where no modification has been made, MCG care guideline as licensed by Prospect. In the absence of medical policy or an applicable UM guideline, at least one published reference source must be documented in support of the denied service, i.e., textbook, peer reviewed article, etc. This will be clearly documented in the denial reason and criteria.
- R. **All Medi-Cal Managed Health Plans**

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Wheelchairs and applicable seating and positioning components.

A wheelchair is medically necessary if the beneficiary's medical condition(s) and mobility limitations are such that without the use of the wheelchair, the beneficiary's ability to perform one or more mobility related activities of daily living (ADL) or instrumental activities of daily living (IADL) in or out of the home, including access to the community, is impaired and the beneficiary is not ambulatory or functionally ambulatory without static supports such as a cane, crutches or walker.

When a member presents for a medical evaluation for wheelchair and SPC, the sequential consideration of the questions below by ordering and treating providers offers clinical guidance for the ordering of an appropriate device to meet the medical need of treating and restoring the beneficiary's ability to perform one or more mobility related ADLs or IADLs. ADLs include dressing/bathing, eating, ambulating (walking), toileting, hygiene and activities specified in a medical treatment plan completed in customary locations in or out of the home. IADLs allow an individual to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within one's community.

1. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs? A mobility limitation is one that:
 - a. Prevents the beneficiary from accomplishing the ADLs or IADLs entirely, or,
 - b. Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in ADLs or IADLs, or,
 - c. Prevents the beneficiary from completing the ADLs or IADLs within a reasonable time frame.

2. Are there other conditions that limit the beneficiary's ability to participate in ADLs or IADLs?
 - a. Some examples are impairment of cognition or judgment and/or vision.
 - b. For these beneficiaries, the provision of a wheelchair and SPC might not enable them to participate in ADLs or IADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with wheelchair and SPC.

3. If these other limitations exist, can they be ameliorated or compensated such that the additional provision of wheelchair and SPC will be reasonably expected to improve the beneficiary's ability to perform or obtain assistance to participate in ADLs or IADLs?

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- a. If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair and SPC coverage if it results in the beneficiary continuing to have a limitation.
 - b. It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of wheelchair and SPC.
4. Does the beneficiary demonstrate the capability and the willingness to consistently operate the wheelchair and SPC safely and independently?
- a. Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
 - b. A history of unsafe behavior may be considered.
5. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane, crutches or walker?
- a. The cane, crutches or walker should be appropriately fitted to the beneficiary for this evaluation.
 - b. Assess the beneficiary's ability to safely use a cane, crutches or walker.
6. Does the beneficiary's typical environment support the use of wheelchair and SPC?
- a. Determine whether the beneficiary's environment will support the use of medically necessary types of wheelchairs and SPC.
 - b. Keep in mind such factors as physical layout, surfaces, and obstacles, which may render wheelchair and SPC unusable.
7. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair to participate in ADLs or IADLs during a typical day? The manual wheelchair should be optimally configured ((SPC), wheelbase, device weight, and other appropriate accessories) for this determination.
- a. Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
 - b. A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e., light weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
 - c. The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.

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- d. Assess the beneficiary's ability and willingness to safely and effectively use a manual wheelchair.
8. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
 - a. A covered POV is a 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation without additional SPC (a 3-wheeled device is not covered).
 - b. The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a POV.
 - c. Assess the beneficiary's ability to safely use a POV/scooter.
 9. Are the additional features provided by a power wheelchair or powered SPC needed to allow the beneficiary to participate in one or more ADLs or IADs?
 - a. The pertinent features of a power wheelchair compared to a POV are typically controlled by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
 - b. The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
 - c. The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
 - d. Assess the beneficiary's ability to safely and independently use a power wheelchair and powered SPC.
 10. Wheelchairs are not covered when:
 - a. Not medically necessary.
 - b. Not used by the beneficiary.
 - c. Used as a convenience item.
 - d. Used to replace private or public transportation such as an automobile, bus or taxi.
 - e. Not generally used primarily for health care and are not regularly and primarily used by persons who do not have a specific medical need for them.
 - f. Used in a facility that is expected to provide such items to the beneficiary.

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- g. Used in a skilled nursing facility, unless the beneficiary demonstrates the need for a custom wheelchair under Title 22 of Code of Regulation section 51321(h).
- h. Not prescribed by a licensed practitioner, or, in the case of a custom wheelchair, a licensed practitioner and a QRP.

11. A prescription for a wheelchair may not be denied on the grounds that it is for use only outside of the home.

VI. PROCEDURE:

VII. REFERENCES/ATTACHMENTS:

VIII. REVISION HISTORY:

Version	Version Date	Policy Number	Policy Name
1	01/23/2024	MM-2006	UM Criteria
2	04/08/2024	MM-2006	UM Criteria