EVH Clinical Guideline 2739.CC for Utilization Review Process

Guideline Number: EVH_CG_2739.CC	Applicable Codes	
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Original Date: November 1, 2023	**Last Revised Date:** November 20, 2025	**Implementation Date:** December 1, 2025

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STATEMENT

General Information

- *It is an expectation that all members receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines, and state/national recommendations.*
- *The guideline criteria in the following sections were developed utilizing evidence-based and peer-reviewed resources from medical publications and societal organization guidelines as well as from widely accepted standard of care, best practice recommendations.*

Purpose

The purpose of this policy is to define medical necessity, how and by whom it is applied, and the turnaround times to render the determination.

Special Note

This policy documents the medical necessity review process. For determination of medical necessity, please refer to Evolent Clinical Guideline 2738.CC for Determination of Medical Necessity.

Services Requiring Prior Authorization

Covered Services that require prior authorization, including pharmacy services, shall be authorized or denied as expeditiously as the member's health condition requires. Ordinarily, requests for authorizations shall be reviewed and decided on within five (5) days after receiving the request for authorization from a Provider, with a possible extension of up to five (5) additional days, if the member requests the extension or CountyCare informs the Provider that there is a need for additional written justification demonstrating that the Covered Service is Medically Necessary and the member will not be harmed by the extension. If the Provider indicates, or CountyCare determines, that following the ordinary review and decision time frame could seriously jeopardize the member's life or health, CountyCare shall authorize or deny the Covered Service no later than forty-eight (48) hours after receipt of the request for authorization, unless CountyCare has not received clinical information sufficient upon which to make the determination. If that is the case, CountyCare shall notify the provider that additional clinical information is needed in order to make a determination, and CountyCare shall allow an additional twenty-four (24) hours for the provider to submit the requested clinical documentation. In no case shall CountyCare deny a request for authorization, due to lack of clinical documentation, prior to seventy-two (72) hours after the request was submitted. CountyCare

shall authorize or deny a prior authorization request for pharmacy services no later than twenty-four (24) hours after receipt of the request for authorization.

PROCEDURE

General

- Requests for authorization of healthcare services are reviewed by a Utilization Management (UM) reviewer against medical policy or licensed medical necessity criteria. If the policy or criteria are not met, if the request has no written policy or criteria or if by plan guidelines it requires physician review, the reviewer refers the case to the Medical Director. All available pertinent information (including requests with incomplete clinical information) and documentation are forwarded to the Medical Director for review and the reviewer remains available to discuss the case with a Medical Director, if necessary, to facilitate the exchange of information.
- Services supporting individuals with ongoing or chronic conditions, or who require Long-Term Services and Supports (LTSS), shall be authorized in a manner that reflects the member's ongoing need for such services.
- For authorizations for Managed Long-Term Services and Supports (MLTSS), members residing in a Nursing Facility (NF), if a response to the authorization is not provided within twenty-four (24) hours of the request and the NF is required by regulation to provide a service because a Physician ordered it, the authorization requirement is removed in order for the service to be paid as long as it is a Covered Service and consistent with the policies and procedures of County Care.
- Self-referrals to American Indian Health Services of Chicago for behavioral health services do not require an authorization.
- All requests for medical necessity review will be documented within the appropriate medical management system and will include date of receipt, date of decision, and date of notification.
- The Medical Director reviews requests according to Utilization Management requirements. Each case is reviewed to determine if the requested service is medically necessary and appropriate. A Medical Director can approve or deny services based on application of the medical necessity definition, clinical criteria, policy and procedures, coverage guideline, pertinent regional practice, and/or clinical judgment. Adverse determinations are made by a physician who has experience treating and managing members with the medical condition or disease for which authorization was requested.
- When applying the medical necessity definition to a service request, the Medical Director considers the individual's needs (member's age, comorbidities, complications, progress of treatment, psychosocial situation and home environment), the characteristics and the availability of the local delivery system (skilled nursing facilities, sub-acute facilities, homecare or an alternate level-of-services) and product/benefit design.
- The Medical Director consults, at his/her discretion, peer review consultants, a board-certified specialty physician with appropriate experience, to offer their expertise

regarding the appropriateness of a request, given the clinical presentation. Any consultation with a specialty physician is documented in the review.

- The Medical Director may consult, as necessary, the attending physician for additional clinical information. A consultation is also available upon request to discuss the case with the attending physician.
- The Medical Director notifies the UM reviewer of his/her decision with appropriate rationale.
- If the Medical Director denies the request, the adverse benefit determination letter includes:
    - Reasons for the determination.
    - Right of member to request and be provided, free of cost, access to and copies of all relevant information.
    - Right of member to request an Appeal and procedures to request an Appeal, including an expedited Appeal; and
    - Member's right to request and have benefits continue during the Appeal process.
    - Timeframes for filing and completing the appeal process.

Timeliness of Review Decisions

CountyCare shall authorize or deny covered services that require prior authorization as expeditiously as the member's health condition requires.

All levels of medical review are conducted within the required timeframes per 42 CFR §438.404(c) and outlined below:

Precertification Turnaround Times

- **Urgent**: Review and determination are completed within Forty-eight (48) hours of receipt of the request for a utilization management determination. However, an extension of an additional twenty-four (24) hours may be given for the provider to submit any additional requested clinical documentation.
- **Non-urgent**: Review and determination are completed within five (5) calendar days of receiving all necessary information, not to exceed ten (10) calendar days from receipt of request. Necessary information includes the results of face-to-face clinical evaluations, second opinions, or other clinical information required by the issuer/URO.
    - A possible extension of up to five (5) calendar days for non-urgent cases may be given if the following criteria are met:
        - If the member requests the extension, or CountyCare informs the provider that there is a need for additional written justification demonstrating that the covered service is medically necessary, and the member will not be harmed by the extension.
        - Notification is provided to the member, prior to the expiration of the review period and includes the circumstances requiring the extension and the date when the

plan expects to make a decision; and

- If a member fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the member must be given at least forty-five (45) calendar days from receipt of the notice to respond to the plan request for more information.

Concurrent Turnaround Times

- For reductions or terminations in a previously approved course of treatment, the determination is issued early enough to allow the member to request a review and receive a decision before the reduction or termination occurs.
- For requests to extend a current course of treatment received at least twenty-four (24) hours before the expiration of the current period, review and determination are completed within two (2) calendar days.
- For requests to extend a current course of treatment received less than twenty-four (24) hours before the expiration of the current period, review and determination are completed within seventy-two (72) hours.
- The practitioner/facility is notified via phone of the decision on the day of determination.

Retrospective Turnaround Times

The review, decision, and notification occur within thirty (30) days of receipt of request. Cases may be extended for up to fifteen (15) calendar days if the following criteria are met:

- It is determined that an extension is necessary because of matters beyond CountyCare's control; and
- Notification is provided to the member, prior to the expiration of the initial thirty (30) calendar day period of the circumstances requiring the extension and the date when the plan expects to make a decision; and
- If a member fails to submit necessary information to decide the case, the notice of extension must specifically describe the required information, and the member must be given at least forty-five (45) calendar days from receipt of the notice to respond to the plan request for more information.

Healthcare services are deemed authorized if the Health Plan fails to comply with these deadlines. A failure by the health plan to comply with the deadlines and other requirements shall result in any health care services subject to review to be automatically deemed authorized by the health plan.

Length of prior authorization approval

A prior authorization approval shall be valid for the lesser of 6 months after the date the health care professional or health care provider receives the prior authorization approval or the length of treatment as determined by the member's health care professional or the renewal of the plan, and the approval period shall be effective regardless of any changes. This does not apply to coverage of any care, treatment, or services for any health condition that the terms of coverage

otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Length of prior authorization approval for treatment for chronic or long-term conditions

If the health plan requires a prior authorization for a recurring health care service, the approval shall remain valid for the lesser of 12 months from the date the health care professional or health care provider receives the prior authorization approval, or the length of the treatment as determined by the member's health care professional. This does not apply to coverage of any care, treatment, or services for any health condition that the terms of coverage otherwise completely exclude from the policy's covered benefits without regard for whether the care, treatment, or services are medically necessary.

Follow-Up After a Mental Health Crisis Event.

The health plan promotes access to delivery of crisis stabilization and follow-up services by linking members who have been community stabilized following a Crisis event with an urgent appointment with a mental health provider within one (1) Business Day after the Crisis event, if deemed Medically Necessary.

The health plan shall not require prior authorization of outpatient mental health services for thirty (30) days post-Crisis.

Potential Quality of Care Issues

Any potential quality-of-care issues that are identified during the pre-service decision/prior authorization process by the UM Reviewer (UM RN Care Advisor, BH Care Advisor, UM Medical Director and/or UM Letter Writer) are referred to the Quality Department for investigation and resolution.

Use of Algorithmic Automated Process

Only a Clinical Peer shall make any Adverse Determination based on medical necessity.

Any subsequent appeal shall be processed in accordance with CountyCare's contract with the State of Illinois Department of Healthcare and Family Services and in compliance with 215 ILCS 134/45 including the restriction that only a Clinical Peer may review an appeal.

Utilization Management Programs that use automated processes shall have the accreditation and policies and procedures required by 215 ILCS 134/85 (b)(10).

Nothing in this subsection prohibits an accredited algorithmic automated process from being used to refer a case to a Clinical Peer for a potential Adverse Determination.

Nothing in this subsection prohibits either a Clinical Peer or an accredited algorithmic automated process, or both in combination, to certify the medical necessity of a health service in accordance with accreditation standards.

CODING AND STANDARDS

Codes

N/A

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

BACKGROUND

Definitions

- **Adverse Benefit Determination**: The denial or limitation of authorization of a requested service; the reduction, suspension, or termination of a previously authorized service; the denial of payment for a service, not including a denial solely because the claim does not meet the definition of a "clean claim" at 42 CFR §447.45(b); the failure to provide services in a timely manner; the failure to respond to an Appeal or Grievance in a timely manner; solely with respect to an MCO that is the only Contractor serving a Rural Area, the denial of an Enrollee's request to obtain services beyond the travel time and distance standards established for an Enrollee who lives in a Rural Area as set forth in section 5.8.1.1; or, the denial of an Enrollee's request to dispute a financial liability, including cost sharing.
- **Adverse Determination**: As it relates to Utilization Review and Peer Review, adverse determination is defined as follows: (1) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit; (2) the denial, reduction, or termination of or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization that a preexisting condition was present before the effective date of coverage; or (3) a rescission of coverage determination, which does not include a cancellation or discontinuance of coverage that is attributable

to a failure to timely pay required premiums or contributions towards the cost of coverage.

Per Section 140.76 Managed Care Utilization Review Standardization and Transparency Practices

"Adverse benefit determination" means the denial or limited authorization of a service authorization request for coverage of a health care service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized health care service; or the denial, in whole or in part, of payment for a service (unrelated to whether the claim is submitted timely or properly coded).

- **Clinical Peer**: A health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.
- **Health care services**: Any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury including home health and pharmaceutical services and products.
- **Investigational/Experimental Procedures**: Defined as a procedure, device or pharmaceutical agent that is still undergoing pre-clinical or clinical evaluation, and/or has not yet received regulatory approval. It is the use of a service, procedure or supply that is not recognized by the Plan as standard medical care for the condition, disease, illness or injury being treated. A service, procedure or supply includes but is not limited to the diagnostic service, treatment, facility, equipment, drug or device. When basic safety and efficacy have been demonstrated by the experimental scientific process, the investigational phase begins.
- **Long-Term Care (LTC) Facility or Nursing Facility (CNF) means**: A facility that provides Skilled Nursing or intermediate long-term care services, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the DPH under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and (ii) a part of a hospital in which Skilled Nursing or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act are provided.
- **Managed Long-Term Services and Supports (MLTSS)**: Program for seniors and persons with disabilities who have full Medicaid and Medicare benefits and opt-out of the Medicare-Medicaid Alignment Initiative. The Managed Long-Term Services and Supports program started in Illinois in 2016. It operates in the Greater Chicago Region.
- **Medically necessary (medical necessity)**: As per Illinois 215 ILCS 200 section 15, (HB711), medically necessary is defined as a health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that are:
  - in accordance with generally accepted standards of medical practice;

- clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and
- not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member, or other interested party, but focused on what is best for the patient's health outcome.

Per the STATE OF ILLINOIS MCCN CONTRACT Section 1.1.127

Medically Necessary means services that, when recommended by a Provider for an Enrollee, are: for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms; to assist in the Enrollee's ability to attain, maintain, or regain functional capacity; for the opportunity for an Enrollee receiving LTSS to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of the Enrollee's choice; or, for an Enrollee to achieve age-appropriate growth and development. Medically Necessary services are requested in accordance with applicable policies and procedures, and provided in a manner that is: (1) in accordance with generally accepted standards of good medical practice in the medical community; (2) consistent with nationally recognized evidence-based guidelines; (3) clinically appropriate, in terms of type, frequency, extent, site, and duration; and (4) not primarily for the economic benefit of the Contractor or for the convenience of the Enrollee or Provider.

A Medically Necessary service is a service that is appropriate, as indicated in State statutes and regulations for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease; to assist in the Enrollee's ability to attain, maintain, or regain functional capacity; have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of the Enrollee's choice; or for Enrollee to achieve age-appropriate growth and development.

Medically Necessary determinations for substance use disorders shall be made using care guidelines with appropriate patient placement criteria established by the American Society of Addiction Medicine. No additional criteria may be used to make Medically Necessary determinations for substance use disorders. In conducting utilization review of Covered Services for the diagnosis, prevention, and treatment of substance use disorders, Contractor shall use care guidelines with the most recent edition of the patient placement criteria established by the American Society of Addiction Medicine. Contractor shall provide evidence that its care guidance is in compliance with these requirements.

Per Section 140.76 Managed Care Utilization Review Standardization and Transparency Practices

"Medically necessary" or "medical necessity" means (a) that a service addresses the specific needs of an enrollee for the purpose of (i) screening, preventing, diagnosing, managing, or treating an illness, injury, or condition and disorder that results in health impairments and/or disability or its symptoms and comorbidities; (ii) minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities; (iii) achieving age-appropriate growth and development; (iv) attaining, maintaining, or regaining functional capacity and (b) in a manner that is all of the following: (i) in accordance with generally accepted standards of care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) not primarily for the economic

benefit of the MCO or for the convenience of the enrollee or provider.

- **Medical Director-Behavioral Health**: CountyCare Medical Director of Behavioral Health is an Illinois-licensed physician who oversees the behavioral health aspects of the CountyCare utilization management program, the ongoing clinical training and education of the behavioral health clinical staff and setting policy. Licensed doctoral-level clinical psychologists (or certified addiction medicine specialists when appropriate) may oversee behavioral healthcare UM decisions within the scope of their license to practice, as permitted under state and federal law. The Medical Director of Behavioral Health holds an unrestricted physician license and reports to the Senior Vice President of Clinical Operations. Reference UM 548 UM Department Staffing.
- **Medical Director Physical Health**: CountyCare Medical Director of Physical Health is an Illinois licensed physician without restriction with a minimum of 5 years of experience in direct practice for making review determinations for cases that do not meet the evidenced base clinical resources applied by clinical review staff. Licensed doctoral-level clinical psychologists (or certified addiction medicine specialists when appropriate) may oversee behavioral healthcare UM decisions as long as it is within the scope of their license to practice.

  A CountyCare Health medical director and/or designee (e.g., IRO) can apply CountyCare's medical necessity definition for the purposes of rendering an organizational determination. This position shall be actively involved in all delegated clinical program components.

  A CountyCare Medical Director may be responsible for the above functions and additionally oversees daily utilization management and serves in a supporting role as medical/behavioral manager and policy advisor to the company and clients.
- **Urgent health care service**: A health care service with respect to which the application of the time periods for making a non-expedited prior authorization that in the opinion of a health care professional with knowledge of the enrollee's medical condition:
  - could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or
  - could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review.
- **Utilization Management Reviewer (Reviewer)**: The review staff consists of RNs, Physicians, Physician assistants, or licensed practical nurses who are experienced in inpatient reviews and who operate under the direct supervision of a Registered Nurse, Physician, or Physician assistant. Non-physician reviewers i.e., Utilization Management (UM) Inpatient Care Advisor (ICA), Behavioral Health (BH), Care Advisor, Behavioral Health (BH) Utilization Manager (UM), UM Care Managers (UM CM), UM RN, who review the available clinical information for a requested authorization against client medical policy, licensed medical necessity criteria, benefit structure and plan rules. If medical necessity criteria, et al are met, and the service is to be provided within the County Care Health's network of participating providers, the reviewer approves the case. If the guidelines and/or criteria are not met, or provided outside the network, the reviewer refers the case to a Medical Director.

General Information

It is the policy of CountyCare Health (CountyCare), to promote the delivery of high-quality care in the most appropriate setting and to authorize payment for covered services that are Medically Necessary, as otherwise required by government program requirements, federal and state law, and regulation.

It is the policy of CountyCare, not to prohibit providers from advocating on behalf of members within the utilization process and supports open provider-member communication regarding appropriate treatment alternatives. CountyCare does not penalize health care providers for discussing medically necessary appropriate care for a member.

All adverse decisions are made by reviewers who are not compensated by CountyCare and are handled in a manner that does not violate any law or that deters the delivery of medically appropriate care.

POLICY HISTORY

Date	Summary
November 20, 2025	• This guideline replaces PA.253.CC Utilization Review Process • Annual Review - Editorial changes to match the formatting and layout of the new template, updated enrollee/patient to member and Contractor to CountyCare where appropriate

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider

agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

This guideline is the proprietary information of Evolent. Any sale, copying, or dissemination of said policies is prohibited.

REFERENCES

1. Centers for Medicare & Medicaid. 42 CFR 438 MMC Service. Authorization and Appeals. §438.404 Notice of action (c) Timing of Notice. **https://www.medicaid.gov/sites/default/files/2020-02/managed-care-regulations-42-cfr-part-438.pdf**
2. Illinois General Assembly. Insurance. Prior Authorization Reform Act. 215 ILCS 200. Section 15 (HB711). **https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=4201&ChapterID=22**
3. Illinois Healthcare and Family Services (HFS). Medicaid Managed Care Manual. Appendix II (Rev. 2) Definitions, Abbreviations and Acronyms. 1.1.127. **https://hfs.illinois.gov/content/dam/soi/en/web/hfs/info/medicaidmanagedcarerfp/documents/2018-24-001-appendix-II-rev2.pdf**
4. Illinois Register, Emergency Amendment: TITLE 89: SOCIAL SERVICES CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES SUBCHAPTER d: MEDICAL PROGRAMS- SUBPART B: MEDICAL PROVIDER PARTICIPATION- Section 140.76 Managed Care Utilization Review Standardization and Transparency Practices- a) Definitions. As used in this Section **https://team-iha.org/getmedia/5789ff70-d722-4170-94c9-01ca99c737c0/Standardization-Rules.pdf?utm_campaign=Daily%20Briefing&utm_source=hs_email&utm_medium=email&_hsenc=p2ANqtz-_QRPlneUP34o-V0-ovdTztP9lF0Bh65o0oj2p-oPQOJG8vX6uVN5MHYCK9AZjlZbpoOE5K**