Utilization Management
Delegation Oversight Audit Tool
2025 NCQA Standards

Utilization Management (UM)
Delegation Oversight Annual Audit

IPA:	
Date:	
UM Total Score:	

NCQA UM 1: Utilization Program Structure

The organization's UM program has clearly defined structures and processes, and assigns responsibility to appropriate individuals.

	Element A: Written Program Description	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	The organization's UM program description includes the following:				
1	NCQA - A written description of the program structure. DMHC - UM 001 Element 1 - CA Health and Safety Code section 1367.01(b) UM 001- 1.1 Do policies and procedures describe the process by which the Delegate reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for delegate enrollees? UM 001- 1.2 Do policies and procedures include utilization review processes such as prospective review, concurrent review and retrospective review?				
2	NCQA - Involvement of a designated senior-level physician in UM program implementation. DMHC - UM 001 Element 2 - CA Health and Safety Code section 1367.01(c) 2.1 Is a Physician designated to provide clinical direction to the UM Program and ensure compliance with the requirements of 1367.01? 2.2 Does the designated individual hold a current unrestricted license to practice medicine in California? 2.3 Is there evidence that the individual is substantially involved in UM Program operations through significant time devoted to UM activities, clinical oversight and guidance to UM staff? 2.4 Is there evidence that the individual is substantially involved in UM Program operations through active involvement in UM Committee and subcommittees?				
3	NCQA - The program scope and process used to determine benefit coverage and medical necessity.				
4	NCQA - Information sources used to determine benefit coverage and medical necessity.				
5	NCQA - Allows for a second opinion from a qualified health professional at no cost to the Member. DMHC - UM-005 Element 2 and Element 3 - CA Health and Safety Code section 1383.1(a) 2.1 Does the Delegate have a written policy filed with the Department that describes the manner in which the delegate determines if a second medical opinic is medically necessary and appropriate 3.1 Does the Plan's EOC provide all enrollees with notice of the policy regarding the manner in which an enrollee may receive a second medical opinion? 3.2 Does the Plan's EOC provide all enrollees with information regarding the manner in which an enrollee may receive a second medical opinion? 3.3 Does the Delegate's written policy describe how the delegate reviews requests for a second medical opinion? DMHC - UM 005 Element 4 - CA Health and Safety Code section 1383.15(a), (b), (c,) (f), and (i) 4.1 Does the Delegate provide or authorize a second opinion by an appropriately qualified health care professional, if requested by an enrollee or participating health professional? 4.2 Does the Delegate allow for non-medically necessary second opinions for any of the following reasons? (List is non-inclusive): (1)The enrollee questions the reasonableness or necessity of recommended surgical procedures. (2)The enrollee questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition. (3)The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the enrollee requests an additional diagnosis. (4)The treatment plan in progress is not improving the enrollee's medical condition within an appropriate period of time given the diagnosis and plan of care, and the enrollee requests a second opinion regarding the diagnosis or continuance of the treatment. (5)The enrollee has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care. 4.3 When the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the enrollee's ability to regain maximum function, does the Delegate authorize or deny second opinion requests within 72 hours (or in a timely fashion appropriate for the nature of the enrollee's condition)? 4.4 When the enrollee's condition is non-urgent, does the Delegate authorize or deny second opinion requests in an expeditious manner? 4.5 If the enrollee requests a second opinion, then does the Delegate allow the enrollee to choose from any provider from any independent practice association or medical group within the network of the same or equivalent specialty to provide that opinion? 4.6 If the enrollee requests a second opinion from an out of network specialist, then does the Delegate incur the cost or negotiate the fee arrangement for the second opinion, beyond the applicable copayments paid by the enrollee? 4.7 If the Delegate denies the request for a second opinion, then are additional medical opinions not within the original physician organization the enrollee's responsibility? 4.8 If the Delegate denies an enrollee's request for a second opinion, then does the delegate notify the enrollee in writing of the reasons for the denial? 4.9 If the delegate denies an enrollee's request for a second opinion, then does the delegate notify the enrollee in writing of his or her right to file a grievance with the delegate? 4.10 If the delegate denies an enrollee's request for a second opinion, then does the delegate's written denial notice to the enrollee comply with CA Health and Safety Code section 1368.02(b)?				
6	NCQA - A established specialty referral system to track and monitor referrals requiring prior authorization. System shall include authorized, denied, deferred, or modified referrals, and the timeliness of the reviews.				
	Total Requirements Element A - Written Program Description		0	Score	
	Requirement Met	0	0		
	% of Requirement Met				

	Element B: Annual Evaluation	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
1	NCQA - The organization annually evaluates and updates the UM program, as necessary.				
	Total Requirements Element B - Annual Evaluation		0	Score	
	Requirement Met	0	0		
	% of Requirement Met				

NCQA UM 2: Clinical Criteria for UM Decisions

The organization uses written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria.

	Element A: UM Criteria	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	The organization applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.				
1	NCQA - Has written UM decision-making criteria that are objective and based on medical evidence.				
2	NCQA - Has written policies for applying the criteria based on individual needs.				
3	NCQA - Has written policies for applying the criteria based on an assessment of the local delivery system.				
4	NCQA - Involves appropriate practitioners in developing, adopting and reviewing criteria.				
5	NCQA - Annually reviews the UM criteria and the procedures for applying them, and updates the criteria when appropriate. DMHC - UM-003 Element 1 - CA Health and Safety Code sections 1363.5(a) and (b); CA Health and SafetyCode section 1367.01(f); CA Health and Safety Code section 1374.72 1.1 Does the Delegate utilize criteria/guidelines when determining the medical necessity of requested health care services? 1.3 Are criteria/guidelines developed with involvement from actively practicing health care providers? 1.4 Does the Plan have a mechanism to ensure that UM criteria/guidelines for making medical necessity decisions are updated annually? (Or more frequently if needed.) 1.5 Does the Delegate have a mechanism to ensure that UM criteria/guidelines for making medical necessity decisions are disseminated to all UM decision-makers? 1.6 Does the Delegate distribute clinical practice guidelines to primary care, specialty, and mental health providers as appropriate? 1.7 Is there supporting documentation to confirm the criteria/guidelines are consistent with accepted standards of practice? (For example, documented approval via minutes from Physician discussions; criteria/guidelines have been adopted by reputable Physician organizations; criteria/guidelines consistent with national standards from federal agencies.)				
	Total Requirements Element A - UM Criteria		0	Score	
	Requirement Met	0	0		
	% of Requirement Met				

	Element B: Availability of Criteria	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	The organization:				
1	NCQA - States in writing how practitioners can obtain UM criteria.				
2	NCQA - Makes the criteria available to its practitioners upon request.				
	Total Requirements Element B - Availability of Criteria		0	Score	
	Requirement Met	0	0		
	% of Requirement Met				

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	Element C: Consistency in Applying Criteria	Point Value			
	At least annually, the organization:	0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	NCQA - Evaluates the consistency with which health care professionals involved in UM apply criteria in decision making.				
2	NCQA - Acts on opportunities to improve consistency, if applicable.				
	Total Requirements Element C - Consistency in Applying Criteria	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				

NCQA UM 3: Communication Services

The organization provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

	Element A: Access to Staff	Point Value			
	The organization provides the following communication services for members and practitioners:	0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	NCQA - Staff are available at least eight hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.				
2	NCQA - Staff can receive inbound communication regarding UM issues after normal business hours.				
3	NCQA - Staff are identified by name, title and organization name when initiating or returning calls regarding UM issues.				
4	NCQA - TDD/TTY services for members who need them.				
5	NCQA - Language assistance for members to discuss UM issues.				
	Total Requirements Element A - Access to Staff	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				

NCQA UM 4: Appropriate Professionals

Qualified licensed health professionals assess the clinical information used to support UM decisions.

	Element A: Licensed Health Professionals	Point Value			
	The organization has written procedures:	0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	NCQA - Requiring appropriately licensed professionals to supervise all medical necessity decisions. DMHC - UM-002 Element 1 - CA Health and Safety Code sections 1367.01(e) and (g) 1.1 Does the Delegate have policies and procedures to ensure that only licensed Physicians or a licensed health care professional (competent to evaluate clinical issues related to requested health care services) make decisions to deny or modify requested services on the basis of medical necessity? 1.3 Do the Delegates's denial files validate that only licensed Physicians or a licensed health care professional (competent to evaluate clinical issues related to requested health care services) make decisions to deny or modify requested services on the basis of medical necessity? CMS - Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans - 40.9(1) Who Must Review an Initial Determination				
2	NCQA - Specifying the type of personnel responsible for each level of UM decision making.				
	Total Requirements Element A - Licensed Health Professionals	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				

Qualified licensed health professionals assess the clinical information used to support UM decisions.

	Element B: Use of Practitioners for UM Decisions	Point Value			
	The organization has a written job description with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have:	0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	NCQA - Education, training or professional experience in medical or clinical practice.				
2	NCQA - A current clinical license to practice or an administrative license to review UM cases. CMS - Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans - 40.9(2)(b) Who Must Review an Initial Determination				
	Total Requirements Element A - Use of Practitioners for UM Decisions	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				

	Element C: Practitioner Review of Nonbehavioral Healthcare Denials	Point Value			
	NCQA - The organization uses a physician or other health care professional, as appropriate, to review any nonbehavioral healthcare denial based on medical necessity. CMS - Addendum to the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for Applicable Integrated Plans - 40.9(2)(a) Who Must Review an Initial Determination	0	1	Include: Document Name, Page and Sections	Comment /Guidance
	Total Requirements Element C - Practitioner Review of Nonbehavioral Healthcare Denials	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				

	Element F: Use of Board-Certified Consultants	Point Value			
	The organization:	0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	NCQA - Has written procedures for using board-certified consultants to assist in making medical necessity determinations.				
2	NCQA - Provides evidence that it uses board-certified consultants for medical necessity determinations.				
	Total Requirements Element F - Use of Board-Certified Consultants	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				

NCQA UM 5: Timeliness of UM Decisions

The organization makes UM decisions in a timely manner to accommodate the clinical urgency of the situation.

	Element A: Notification of Nonbehavioral Decisions	Point Value			
	The organization makes UM decisions in a timely manner to minimize any disruption in the provision of health care.	0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	NCQA - For urgent concurrent decisions, the organization gives electronic or written notification of the decision to practitioners within 24 hours and member within 72 hours of the request. DMHC - UM-002 Element 2 - CA Health and Safety Code section 1367.01(h)(2) 2.5 Does the Delegate request information from the provider that is reasonably necessary to make a medical necessity decision in a timely fashion? (Appropriate for the nature of the enrollee's condition.) 2.6 Upon receipt of the requested information, does the Delegate make decisions to approve, modify, or deny the request within the required timeframe? DHCS D-SNP State Medicaid Agency Contract- 42 CFR section 422.631(d)(2)(iv)				
2	NCQA - For urgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners within 24 hours and members within 72 hours of the request. DMHC - UM-002 Element 2 - CA Health and Safety Code section 1367.01(h)(1) and (2) 2.5 Does the Delegate request information from the provider that is reasonably necessary to make a medical necessity decision in a timely fashion? (Appropriate for the nature of the enrollee's condition.) 2.6 Upon receipt of the requested information, does the Delegate make decisions to approve, modify, or deny the request within the required timeframe? DHCS D-SNP State Medicaid Agency Contract- 42 CFR section 422.631(d)(2)(iv)				
3	NCQA - For nonurgent concurrent decisions the organization gives electronic or written notification of the decision to practitioners within 24 hours of decisio and members within 2 business days from the date of the decision, not to exceed 14 calendar days from when the request was received DMHC - CA Health and Safety Code section 1367.01(h)(3)				
4	NCQA - For nonurgent preservice decisions, the organization gives electronic or written notification of the decision to practitioners within 24 hours of decision and members within 2 business days from the date of the decision, not to exceed 14 calendar days from when the request was received DMHC - CA Health and Safety Code section 1367.01(h)(3)				
	NCQA - For Medicare Part B urgent decisions, the organization gives electronic or written notification of the decision to members and practitioners within 24 hours of the request. CMS - Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance - 40.10 Processing Timeframes				
	NCQA - For Medicare Part B nonurgent decisions, the organization gives electronic or written notification of the decision to practitioners within 24 hours and members within 72 hours of the request. CMS - Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance - 40.10 Processing Timeframes				
5	NCQA - For postservice decisions, the organization gives electronic or written notification of the decision to practitioners within 24 hours of the decision and members within 2 business days from the date of the decision, not to exceed 14 calendar days from when the request was received				
6	NCQA - Process to provide notification to Members regarding denied, deferred or modified referrals. DMHC - UM-004 Element 2 - CA Health and Safety Code sections 1367.01(h)(1) and (5) 2.1 Does the Delegate have guidelines for communicating with the enrollee and provider if UM decisions do not meet the required timeframes? 2.2 If the Delegate is unable to make a UM decision within the required timeframe, does the Delegate notify the provider and enrollee of the anticipated decision date?				
	Total Requirements Element A - Notification of Nonbehavioral Decisions	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				

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	Element D: UM Timeliness Report	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	The organization monitors and submits a report for timeliness of:				
1	NCQA - Nonbehavioral UM decision making.				
2	NCQA - Notification of nonbehavioral UM decisions.				
	Total Requirements Element D - UM Timeliness Report	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				
	NCQA UM 6: Clinical Information				
	When determining coverage based on medical necessity, the organization obtains relevant clinical information and consults with the treating practitioner.				
	Element A: Relevant Information for Nonbehavioral Healthcare Decisions	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	NCQA - There is documentation that the organization gathers relevant clinical information consistently to support nonbehavioral healthcare UM decision making.				
	Total Requirements Element A - Relevant Information for Nonbehavioral Healthcare Decisions	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				
	NCQA UM 7: Denial Notices				
	The organization documents and communicates the reason for a denial.				
	Element A: Discussing a Denial With a Nonbehavioral Healthcare Reviewer	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	NCQA - The organization gives practitioners the opportunity to discuss nonbehavioral healthcare UM denial decisions with a physician or other appropriate reviewer. DMHC - UM-002 Element 3 - CA Health and Safety Code section 1367.01(h)(3) 3.1 Does the Delegate's policy and practice demonstrate that treating providers can readily access the Delegate Physician that made the adverse decision? 3.2 Does the Delegate document receipt of agreement by the treating provider? 3.3 What is the turnaround time for Delegate provider to respond to treating provider? How does the Delegate monitor it?				
	Total Requirements Element A - Discussing a Denial With a Reviewer	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				
	Element B: Written Notification of Nonbehavioral Healthcare Denials	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	The organization's written notification of nonbehavioral healthcare denials, provided to members and their treating practitioners, contains the following information:				
1	NCQA - The specific reasons for the denial, in easily understandable language. DMHC - UM -004 Element 1 - CA Health and Safety Code section 1363.5(b)(4); CA Health and Safety Codesection 1367.01(d), and (h)(3) and (4); CA Health and Safety Code section 1374.30(i) 1.1 For retrospective UM decisions, does the Plan communicate denials or modifications of health care services to providers in writing? 1.2 Do communications regarding decisions to approve requests by providers specify the specific health care service approved? 1.3 Do the Delegate's denial letters provide a clear and concise explanation of the reasons for the Delegate's decision to deny, delay, or modify health care services? 1.5 Do the Delegate's denial letters specify the clinical reasons for the Delegate's decision to deny, delay, or modify health care services? 1.6 Do written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the name of the health care professional responsible for the denial, delay, or modification? 1.7 Do written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them?				
2	NCQA - A reference to the benefit provision, guidelines, protocol or other similar criterion on which the denial decision is based. DMHC - UM -004 Element 1 - CA Health and Safety Code section 1363.5(b)(4); CA Health and Safety Codesection 1367.01(d), and (h)(3) and (4); CA Health and Safety Code section 1374.30(i) 1.4 Do the Delegate's denial letters specify a description of the criteria or guidelines used for the Delegate's decision to deny, delay, or modify health care services?				
3	NCQA - A statement that members can obtain a copy of the actual benefit provision, guidelines, protocol or other similar criterion on which the denial decision was based, upon request.				
	Total Requirements Element B - Written Notification of Nonbehavioral Healthcare Denials	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				
	Element C: Written Notification of Nonbehavioral Healthcare Notice of Appeal Rights/Process	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	The organization's written nonbehavioral healthcare denial notification to members and their treating practitioners contains the following information:				
1	NCQA - A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.				
2	NCQA - An explanation of the appeal process, including members' rights to representation and appeal time frames. DMHC - UM-004 Element 1- CA Health and Safety Code section 1363.5(b)(4); CA Health and Safety Codesection 1367.01(d), and (h)(3) and (4); CA Health and Safety Code section 1374.30(i) 1.8 Do written communications to an enrollee of a denial, delay, or modification of a request include information as to how he / she may file a grievance to the Delegate?				
3	NCQA - A description of the expedited appeal process for urgent preservice or urgent concurrent denials.				
4	NCQA - Notification that expedited external review can occur concurrently with the internal appeals process for urgent care. DMHC - UM-004 Element 1 - CA Health and Safety Code section 1363.5(b)(4); CA Health and Safety Codesection 1367.01(d), and (h)(3) and (4); CA Health and Safety Code section 1374.30(i) 1.9 Do written communications to an enrollee of a denial, delay, or modification of a request include information as to how he / she may request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Delegate, or by one of its contracting providers?				
	Total Requirements Element C - Written Notification of Nonbehavioral Healthcare Notice of Appeal Rights/Process	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				
	NCQA UM 12: UM Information Integrity				
	The organization has UM information integrity policies and procedures, audits UM information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues.				
	Element A: Protecting the integrity of UM Denial Information	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	The organization demonstrates its commitment to protecting the integrity of UM information used in in the processing of UM denials and UM appeals.				
1	NCQA - The scope of UM information.				
2	NCQA - The staff responsible for completing UM activities.				
3	NCQA - The process for documenting updates to UM information.				
4	NCQA - Inappropriate documentation and updates.				
5	NCQA - The organization audits UM staff and the process for documenting and reporting identified information integrity				
	Total Requirements Element A - Protecting the integrity of UM Denial Information	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				
	Element C: Information Intergrity Training	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	The organization annually trains UM staff on:				
1	NCQA - Inappropriate documentation and updates (Elements A, factor 4)				
2	NCQA - Organization audits of staff, documenting and reporting information integrity issues (Element A, Factor 5)				
	Total Requirements Element C - Information Intergrity Training	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				
	The organization demonstrates that it monitors compliance with its UM denial controls, as desribed in NCQA UM 12 Element A.				
	Element D: Audit and Analysis-Denial Information	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	The organization annually:				
1	NCQA - Audits for inappropriate documentation and updates to UM denial receipt and notification dates.				
2	Conducts qualitative analysis of inappropriate documentation and updates to UM denial receipt and notification dates.				
	Total Requirements Element D - Audit and Analysis-Denial Information	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				
	Element E: Improvement Actions-Denial Information	Point Value 0	Point Value 1	Include: Document Name, Page and Sections	Comment /Guidance
	The organization:				
1	NCQA - Implements corrective actions to address all inappropriate documentation and updates found in Element D.				
2	NCQA - Conducts an audit of the effectiveness of corrective actions (factor 1) on the findings 3–6 months after completion of the annual audit in Element D.				
	Total Requirements Element E - Improvement Actions-Denial Information	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				

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NCQA MED 9: UM Decisions About Payment and Services					
The organization makes decisions about utilization management request in a timely manner for Medicaid members					
Element E: Affirmative Statement about Incentives		**Point Value**			
The organization distributes a statement to all members and to all practitioners, providers and employees who make UM decisions, affirming the following:		**0**	**1**	**Include: Document Name, Page and Sections**	**Comment /Guidance**
1	**NCQA - UM decision making is based only on appropriateness of care and service and existence of coverage.**				
2	**NCQA - The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.**				
3	**NCQA - Financial incentives for UM decision makers do not encourage decisions that result in underutilization.**				
	Total Requirements Element E - Affirmative Statement about Incentives		0	**Score**	
	Requirement Met	0	0		
	% of Requirement Met				
UM 2: Sensitive Services					
Element A: Policy and Procedure					
		Point Value			
The written policy and procedure to (see below):		**0**	**1**	**Include: Document Name, Page and Sections**	**Comment /Guidance**
1	**Prior Authorization requirements shall not be applied to Emergency Services, urgently needed services, family delegatening services, preventive services, basic prenatal care, sexually transmitted disease services, and HIV testing.**				
	Total Requirements		0	**Score**	
	Requirement Met	0	0		
	% of Requirement Met				
UM 3: Over & Under Utilization					
Element A: Policy and Procedure					
		Point Value			
The written policy and procedure to (see below):		**0**	**1**	**Include: Document Name, Page and Sections**	**Comment /Guidance**
1	**Describe mechanisms to detect both under-and over-utilization of health care services.** **DMHC - UM 006 Element 1 - CA Health and Safety Code sections 1367.01(e), (h), and (j)** **1.8 Does the Delegate systemically and routinely analyze UM data to monitor for potential over and under-utilization?**				
	Total Requirements		0	**Score**	
	Requirement Met	0	0		
	% of Requirement Met				
UM 001: UM Program Policies and Procedures- Key Element 3					
Element 3: Policy and Procedure					
		Point Value			
The delegate ensures telephone access for providers to request authorizations for health care services.		**0**	**1**	**Include: Document Name, Page and Sections**	**Comment /Guidance**
1	**DMHC - UM 001 Element 3 - CA Health and Safety Code section 1367.01(i)** **3.1 Does the Delegate have policies and procedures that describe and ensure telephone access for requesting authorizations for health care services?** **3.2 Does the Delegate maintain telephone access for providers to request authorizations for health care services?**				
	Total Requirements		0	**Score**	
	Requirement Met	0	0		
	% of Requirement Met				
UM 005: Disclosure of UM Process to Authorize or Deny Services- Key Element 1					
Element 1: Policy and Procedure					
		Point Value			
The Delegate shall disclose to network providers, contractors and enrollees theprocess the Delegate uses to authorize, modify, or deny health care services underthe benefits provided by the Delegate.		**0**	**1**	**Include: Document Name, Page and Sections**	**Comment /Guidance**
1	**DMHC - UM-005 Element 1 - CA Health and Safety Code section 1363.S(a), (b)(4)-(5), and (c)** **1.1 Does the Delegate's policies and procedures provide for the disclosure of the process the Delegate uses to authorize, modify, or deny health care services?** **1.2 Does the Delegate disclose the UM process information to network providers?** **1.3 Does the Delegate demonstrate that it discloses UM processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request?** **1.4 Does the Delegate demonstrate that it discloses to the enrollee and provider the UM criteria used as a basis to modify, deny or delay services in specified cases under review?** **1.5 Are UM Criteria available to the public upon request, which may include the availability through electronic communication means?** **1.6 Is disclosure of UM criteria to the public accompanied by the following notice: "The materials provided to you are guidelines used by this Delegate 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."?**				
	Total Requirements		0	**Score**	
	Requirement Met	0	0		
	% of Requirement Met				
UM 006: UM Processes as Part of the QA Program- Key Element 1 and 2					
Element 1 and 2: Policy and Procedure					
		Point Value			
The Delegate has established and implemented a QA process to assess and evaluate their compliance with UM requirements. The scope of quality assurance monitoring includes assessment and evaluation of provider referral and specialist care patterns of practice.		**0**	**1**	**Include: Document Name, Page and Sections**	**Comment /Guidance**
1	**DMHC - UM-006 Element 1 - CA Health and Safety Code sections 1367.01(e), (h), and (j)** **1.1 Does the Delegate have a process in place to evaluate complaints and assess trends to identify potential quality issues in the UM process and regularly report this information to appropriate bodies?** **1.2 Does the Delegate have a process in place to monitor and assess compliance with timeliness of decision-making, timeliness of notification, and turnarour times for UM functions?** **1.3 Has the Delegate established and implemented policies and procedures to monitor and assess compliance with the use of appropriate licensed health care providers in making denial decisions and the appropriate use and application of criteria in making medical necessity decisions?** **1.4 Has the Delegate established and implemented policies and procedures to audit denial letters ensuring the required information is included, and communicated to the appropriate user, providers and/or enrollees?** **1.5 Does the Delegate systematically and routinely analyze its evaluation of the UM process to identify any potential quality issues in the UM process?** **1.6 Does the Delegate develop, communicate, and implement corrective action plans when potential quality issues are identified in the UM process?** **1.7 Does the Delegate evaluate the effectiveness of any corrective action plan (using performance measures, for example) and make further recommendations to improve the UM process?**				
2	**DMHC - UM-006 Element 2 - 28 CCR 1300.70(a)(1); 28 CCR 1300.70(b)(2)(G)(5)** **2.1 Does the Delegate's quality assurance/utilization review mechanism encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services (e.g., laboratory, radiology, pharmacy, physical therapy services)and appropriate preventive health services based on reasonable standards established by the Delegate and/or delegated providers?** **2.2 Does the Delegate have a process in place to routinely monitor and assess access to specialist care, ancillary support services (e.g., laboratory, radiology, pharmacy, physical therapy services) and appropriate preventive health services?** **2.3 Does the Delegate analyze its evaluation of access to specialist care, ancillary support services (e.g., laboratory, radiology, pharmacy, physical therapy services), and appropriate preventive health services?** **2.4 Does the Delegate have a process to routinely monitor and assess access to specialist care, ancillary support services(e.g., laboratory, radiology, pharmacy, physical therapy services), and appropriate preventive health services for any delegated providers?** **2.5 Does the Delegate identify, communicate, and implement corrective actions when potential access issues are identified in the UM process?** **2.6 Does the Delegate evaluate the effectiveness of any corrective actions (using performance measures, for example) and make further recommendations to improve potential access issues?**				
	Total Requirements		0	**Score**	
	Requirement Met	0	0		
	% of Requirement Met				

Utilization Management
Delegation Oversight Audit Tool
2025 NCQA Standards

UM 011: Standing Referrals- Key Element 1-5					
Element 1-5: Policy and Procedure					
		Point Value			
	The Delegate has established policies and procedures for standing referrals of: (a)enrollees who need continuing care from a specialist, and (b) enrollees whorequire specialized care over a prolonged period of time for the purpose ofhaving the specialist coordinate the enrollee's health care, including HIV/AIDS. CA Health and Safety Code section 1374.16(a) through (f)	0	1	Include: Document Name, Page and Sections	Comment /Guidance
1	DMHC - UM-011 Element 1 -CA Health and Safety Code section 1374.16(a) through (f) 1.1 Does the Delegate have established policies and procedures for standing referrals? 1.2 Does the Delegate disseminate those policies to primary care providers? (e.g., via provider manual)				
2	DMHC - UM-011 Element 2 - CA Health and Safety Code section 1367.01(h)(4); CA Health and Safety Codesection 1374.16(C) 2.1 Does the Delegate make a determination regarding requests for standing referrals within three (3) business days? 2.2 Once approved, does the Delegate make the referral in 4 (four) business days of the proposed treatment Delegate? 2.3 Do communications to approve standard referrals specify the specific services approved? 2.4 Do denial letters provide a clear and concise explanation of the reasons for the denial? 2.6 Do written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the following information: The name of the health care professional responsible for the denial, delay, or modification? 2.7 Do written communications to a Physician or other health care provider of a denial, delay, or modification of a request include the following information: The direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them? 2.8 Do written communications to an enrollee of a denial, delay or modification of a request include information as to how he / she may: File a grievance to the Plan? 2.9 Do written communications to an enrollee of a denial, delay or modification of a request include information as to how he / she may: Request an independent medical review in cases where the enrollee believes that health care services have been improperly denied, modified, or delayed by the Plan, or by one of its contracting providers?				
3	DMHC - UM-011 Element 3- CA Health and Safety Code sections 1374.16(a) and (b) 3.1 Does the Delegate approve a treatment Delegate or a current standing referral to a specialist or specialty care center when an enrollee requires specialized medically necessary care over a long period of time?				
4	DMHC - UM 011 Element 4 - CA Health and Safety Code sections 1374.16(a), (b), and (e); 28 CCR 1300.74.16(e) and (f) 4.1 Does the Delegate have a process for validating specialists and specialty care centers are accredited or designated as having special expertise? 4.2 Does the Delegate have a definition of and credentialing process for HIV/AIDS specialists? 4.3 Does the Delegate make listings of specialists and specialty care centers, including HIV/AIDS specialists available to PCPs to assist in the referral process? 4.4 Does the Delegate refer to a specialist or specialty care center that has demonstrated expertise in treating the condition or disease?				
5	DMHC - UM 011Element 5 - CA Health and Safety Code section 1374.16(b) 5.1 Does the Delegate demonstrate that it complies with section 1374.16(b) and approves the specialist to provide health care services within the specialist's area of expertise and training in the same manner as it approves the enrollee's primary care Physician's services, subject to the terms of the treatment Delegate?				
	Total Requirements	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				

Continuity of Care					
CY2025 D-SNP Policy Guide, section 5 - Medicare Continuity of Care Guidance for D-SNPS					
		Point Value			
	The written policy and procedure include the following:	0	1		
1	Describes process for Continuity of Care from a Non-contracted Provider.				
2	Describes process for Continuity of Care for completion of services from a terminated provider.				
	Total Requirements	0		Score	
	Requirement Met	0	0		
	% of Requirement Met				