Department:	Utilization Management	**Original Approval:**	07/13/2000
Policy No:	UM203	**Last Approval:**	08/19/2026
Policy Title:	Authorization and Certification Policy		
Approved By:	Clinical Services Leadership Team		
Dependencies:	Application of UM Criteria (UM218) Denial Process policy (UM204) Timeliness of Utilization Management Decision Making (UM205) Tribal Claims and Provider Data Requirements Policy and Procedure (OP661)		

Purpose

The purpose of this policy is to demonstrate the commitment of Community Health Plan of Washington (CHPW) to make utilization management decisions in compliance with relevant contracts and Federal and State regulations.

Policy

Utilization review, including pre-service, concurrent, and retrospective review, is required from CHPW for certain services, items, or supplies through the Utilization Management (UM) department. Since utilization management aims to proactively impact quality and value, authorization for many routine and urgent services must take place before the service is provided. For emergency services, no prior authorization is necessary.

Delegated entities who assume responsibility for UM must adhere to CHPW's UM Policies. The delegate's programs, policies, and supporting documentation are reviewed by CHPW at least annually. CHPW UM policies and procedures comply with 42 C.F.R. § 438.210, WAC 284-43-2000(6)(b), Chapters 182- 538 and 182-550 WAC, WAC 182-501-0160 and 182-501-0169, and all applicable state and federal regulations.

Authorizations for contracted services and supplies that are needed on an ongoing basis shall not be required any more frequently than every six (6) months. Services and supplies needed on an ongoing basis include, but are not limited to, insulin pens, incontinence supplies, and medications for chronic conditions.

When there is insufficient information needed to make an organizational determination, CHPW will contact the provider and/or member to obtain the information to evaluate the request and make the appropriate organizational determination. If no response is received or

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additional information is not complete, a determination decision will be made based on the information at hand to support the time frame for decision making. *See UM Policy UM205, Timeliness of Utilization Management Decision Making.*

Utilization Review
CHPW's UM Criteria are used for all UM medical necessity decisions. All pre-service, concurrent, and post-service review decisions reference the relevant UM Criteria and indicate which criteria are met and, if any, which criteria are not met and why. *See UM Policy UM218, Application of UM Criteria.*

The decisions in all appeals of clinically based decisions reference the appropriate UM Criteria and indicate which criteria are not met and why. External appeals conducted by an Independent Review Organization include consideration of CHPW's UM Criteria or equivalent as determined by the UM Committee unless a specific process is required by regulation payer mandate.

Decision-Making Authority
The first-level reviewers have the authority to approve services based on medical necessity. If first-level reviewers are unable to authorize the requested care, the case is referred to a second-level reviewer for review and determination. Second-level reviewers are the only CHPW representatives with the authority to deny service provision or payment for services based on medical necessity and clinical appropriateness.

Administrative Approval Determination
To support timely access to care and efficient utilization management operations, CHPW may approve select authorization requests through an Administrative Approval process. Requests may be approved through the Administrative Approval process when:

- Historical utilization management data demonstrates an approval rate of at least 95% for the requested service as determined by UM Leadership.
- Member eligibility and benefit coverage have been verified.
- The requested service can be clearly identified from the information submitted.
- The request is complete and accurate.
- The request does not require Medical Director review or an individualized clinical review under applicable federal, state, contractual, accreditation, or CHPW requirements.
- The request is not expected to result in adverse determination.

Administrative Approval does not eliminate the requirement to verify member eligibility, benefit coverage, completeness of the request, or that the requested service matches

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the authorization submitted.

UM Leadership may designate, modify, or remove services eligible for Administrative Approval based on approval rates, utilization patterns, quality concerns, audit findings, regulatory requirements, or operational needs. Documentation shall reflect verification of member eligibility, benefit coverage, and approval through the CHPW Administrative Approval Process.

Alternatives for denied care/services may be given to the requesting provider, and the member based on the criteria set used, the individual case circumstances, and the capabilities of the local delivery system. In making determinations based on contract benefit exclusions/limitations, the Member Handbook and posted benefit grids are used as references. The Member Handbook and benefit grids are also posted on the CHPW website as a resource for members (www.chpw.org).

No Reward or Penalty For Utilization Management Decisions
CHPW staff members and contractors are not rewarded or penalized for issuing authorizations or denials. Each authorization decision is made on its own merit, according to the review of the submitted information and in accordance with established clinical coverage criteria. Utilization Management decision-making is based only on the appropriateness of care and service and the existence of coverage. CHPW does not use incentives to encourage barriers to care and/or service.

Submission Of Prior Authorization Requests
Providers shall notify CHPW of a service request by fax, mail, or direct entry in the Care Management Portal (preferred). Amendments or other changes may be made telephonically or by fax.

CHPW Prior Authorization Request Form
When making a determination of coverage based on medical necessity, CHPW obtains relevant clinical information and consults with the treating provider.

For Medicare patients, all requests for information must be documented and maintained within the case file. As a Medicare Advantage Organization (MAO), CHPW must clearly identify the records, information, and documents it needs when requesting information from a provider. If a contracted provider makes the coverage request on behalf of the member, and the provider does not respond to CHPW's requests for information, a CHPW staff should conduct the outreach to the contracted provider.

Documentation should include the following:

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- A specific description of the required information;
- The name, phone number, fax number, e-mail, and/or mailing address, as applicable, for the point of contact at the plan; and
- Each request is documented by date and time stamps on copies of a written request, call record, facsimile transmission, or e-mail. Call records should include specific information about who was contacted, what was discussed and requested, and what information was obtained by CHPW.

Best practice recommendations and diligent efforts to obtain information include a minimum of 3 attempts, when possible, during normal business hours in the provider's time zone according to CMS defined times. Methods for requesting information can include Telephone; Fax; E-mail; and/or Standard or overnight mail with a certified return receipt.

1. Standard Organization Determinations – first request is made within 2 calendar days of receipt of the coverage request.
2. Expedited Organization Determinations – first request is made upon receipt of the coverage request.
3. Standard Reconsiderations – first request for information is made within 4 calendar days of receipt of the appeal request.
4. Expedited Reconsiderations – first request is made upon receipt of the coverage request.

Timeliness Of Decisions

The UM leadership team is responsible for monitoring the timeliness of the UM decision-making and notification of the decision to providers and members. When UM services are delegated to a subcontractor, oversight of the timeliness of UM decisions is done by CHPW's Performance Management team.

Documentation Of UM Decisions

UM decisions shall be consistently, completely, and accurately documented. Documentation includes:

- Accurate entry into the care management system
- Documentation of the UM criteria used to make the decision.
- The clinical information provided to make a decision is attached to the episode in the care management system.
- Evidence of sending the request to Second Level Review, if appropriate.
- Correct rationale for any denial in letters to members and provider
- Include the reviewer's name, credentials, and specialty in the notes

Continuity Of Care

CHPW shall ensure Continuity of Care for members in an active course of treatment for a

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chronic or acute physical or behavioral health condition, including children receiving Wraparound and Intensive Services (WISe) and Transitional Age Youth (TAY) who have a current plan and members who are being released from correctional facilities. CHPW will ensure continued access to services during a transition between Fee For Service (FFS) and the Health Plan or BHSO program, or from one Managed Care Organization or BHSO to another, in compliance with HCA's Transition of Care Policy (42 C.F.R. § 438.62). Medically necessary care and integration of services will be made available through contracted providers or non-contracted providers to ensure uninterrupted care for members and that transitions from one setting or level of care to another are supported with continuity of care period that is no less than ninety (90) days for all new members. CHPW will honor service authorizations made by other systems such as FFS and Apple Health Managed Care Organizations (42 C.F.R. § 438.208).

When a new member is already established on a prescription drug, the prescription will be approved for coverage for the first ninety (90) calendar days. During this continuity of care period, CHPW will initiate the authorization process with the prescribing Provider and make the authorization determination before the 90-day approval ends.

CHPW will strive to preserve the relationship between members and providers by promoting continuity of care. However, where the preservation of provider relationships is not possible and reasonable, CHPW shall facilitate transitions to a provider who will provide equivalent, uninterrupted care as expeditiously as the member's medical and/or behavioral condition requires.

CHPW will collaborate with the appropriate managed care organization(s) (MCO) in situations where contractual changes lead to sizable member transitions between organizations. CHPW partners with MCOs and HCA to promote the identification of a standard authorization data format to ensure the continuation of care for our members.

Enrollee Right to Privacy

CHPW Medical Management staff members ensure that members' rights to privacy and confidentiality are protected. Only information applicable to the condition being treated/service being requested is sought and retained. Organizational and departmental policies established for HIPAA compliance are followed.

Special Provision for American Indians And Alaska Natives

CHPW considers all Indian Health Care Providers (IHCP) as in-network. No additional authorization requirements are required from an IHCP outside of what is required for all networked providers. If an American Indian/Alaska Native member indicates to CHPW that they

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wish to have an IHCP as their PCP, CHPW will treat the IHCP as an in-network PCP regardless of whether or not such IHCP has entered into a subcontract with CHPW. CHPW will honor the referral of an out-of-network IHCP to refer an AI/AN member to a network provider. (42 C.F.R. § 438.14(b)(6)). For Tribal Claims and Provider Data Requirements refer to Policy and Procedure OP661.

Definitions:
Service Authorization: Request for services from a provider or member that requires prior authorization or notice.

First Level Reviewer: Utilization Management (UM) staff members who have been appropriately trained in the principles and standards of utilization and medical necessity review may make authorization decisions but not medical necessity denial decisions. First-level reviewers include UM Intake Coordinators, UM Nurse Reviewers, Behavioral Health clinicians, Social Workers, and UM Clinical Supervisory staff.

Second Level Reviewer: Appropriate licensed practitioners who are able to make authorization and denial decisions consistent with their licensure. Second level reviewers include Physicians, Clinical Ph.D., Psychologists (PsyD), or registered pharmacists. If the request is for Behavioral Health (BH) services, a board-certified or board-eligible physician in General Psychiatry, Child Psychiatry, Addiction Medicine, a subspecialty in Addiction Psychiatry, or other recognized behavioral health specialty can perform the BH medical necessity determinations.

Continuity of Care: Is the provision of continuous care for chronic or acute medical and behavioral health conditions to maintain care that has started or been authorized in one setting as the member transitions between facility to home; facility to facility; providers or service areas; Managed Care Contractors; and/or Medicaid fee-for-service (FFS) and Managed Care arrangements.

List of Appendices

A. Detailed Revision History

Citations & References

CFR	42 C.F.R. § 438.210; 42 C.F.R. § 438.14(b)(6); 42 C.F.R. § 438.62; 42 C.F.R. § 438.208
WAC	182-550; 182-501-0160; 182-501-0169
RCW	

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LOB & Contract Citation	☒ **WAHIMC** ☐ **BHSO** ☐ **Wraparound** ☐ **SMAC** ☐ **HH**	IMC Section 1.79: Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Database; IMC Section 14.1: CARE COORDINATION - Continuity of Care
	☐ **AHE**	
	☒ **MA/DSNP**	Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
	☐ **CS**	
Other Requirements		
NCQA Elements	UM 5	
References		

Revision History

SME Review:	07/13/2000; 09/28/2005; 10/25/2006; 11/13/2007; 04/03/2009; -4/14/2009; 08/14/2009; 10/14/2009; 11/09/2009; 08/13/2010; 03/22/2011; 07/26/2012; 03/26/2013; 05/15/2014; 07/21/2015; 05/18/2016; 10/25/2016; 11/03/2016; 11/22/2017; 06/21/2018; 06/19/2019; 02/07/2020; 05/29/2020; 11/11/2020; 09/08/2021; 08/22/2022; 07/14/2023; 07/25/2024; 06/24/2025; 06/03/2026
Approval:	10/14/2009; 10/27/2010; 04/27/2011; 08/08/2012; 03/27/2013; 07/22/2015; 05/20/2016; 11/03/2016; 11/30/2017; 06/25/2018; 06/21/2019; 06/16/2020; 11/20/2020; 09/28/2021; 08/31/2022; 08/22/2023; 08/12/2024; 07/30/2025; 08/19/2026

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Appendix A: Detailed Revision History

Revision Date	Revision Description	Revision Made By
07/13/2000	Original	UM/CM Manager
09/28/2005	Update	UM Manager
10/25/2006	Update	Georgette Cortel
11/13/2007	Formatting, add reference to Care Coordinators	Georgette Cortel
04/03/2009	Added additional language regarding non-physician reviewers	Tracey Gunderson
04/14/2009	Added language regarding appropriate UM professionals per NCQA	Sandra Hewett
08/14/2009	Revised for NCQA Compliance	Marcia Bush, Mike Hays, Christa Lilienthal
10/14/2009	No changes	Verni Jogaratnam
10/14/2009	Approval	MMLT
11/09/2009	Moved to new template; edited for style and clarity; requested form	Jennifer Carlisle
08/13/2010	Added WHP citation	Jason Horne
10/27/2010	Approval	MMLT
03/22/2011	Revised to meet NCQA compliance; title change from “Prior Authorization and Certification” to Authorization and Certification”	Verni Jogaratnam
04/27/2011	Approval	MMLT
07/26/2012	Added Care Management Portal; minor edits	Lucy Sutphen, MD, FACP, Jane Daughenbaugh,, Georgette Cortel
08/08/2012	Approval	MMLT
03/26/2013	Added statement to policy to identify outreach to member/provider to obtain additional information when needed to make a determination decision. Included statement that a determination decision will be made based on information at hand when no additional information or insufficient additional information is	Jane Daughenbaugh
03/27/2013	Approval	MMLT

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05/15/2014	Updated LOB for 2014	Andrew Boe
07/21/2015	Updated definitions to accurately reflect terms used by CHPW and its subcontractors. Removed Information for Decision Making section and replaced with NCQA requirement on obtaining relevant clinical information needed to make medical necessity decisions. Included a statement about timeliness oversight by Delegated Healthcare Services.	Kelly Force
07/22/2015	Approval	MMLT
05/18/2016	Removed 'scope section', moved definitions section, added one definition to meet contract language	Melissa Shilipetar
05/20/2016	Approval	MMLT
10/25/2016	Added CMS outreach guidelines of requirements	Jane Dubbe
11/03/2016	Reviewed – No changes	Cyndi Stilson
11/03/2016	Approval	MMLT
11/22/2017	Added reviewer documentation includes name, credential, and specialty as applicable. Updated approver of policy and committee that approves criteria.	Justin Fowler
11/30/2017	Approval	Patty Jones
06/21/2018	Minor editing	Drew Breuckman
06/25/2018	Approved	Patty Jones, RN, MBA
6/19/2019	Changed UM Nurse Coordinator to UM Nurse Reviewer. Update correct WAC per AH contract. Updated UM policy 205 title.	Yves Houghton, RN, BSN
06/21/2019	Approval	MMLT
02/07/2020	Updated citations and regulatory references	Yves Houghton, RN, BSN
05/29/2020	Added definition for continuity of care per WAH IMC contract. Update first level and second level reviewer definitions. Removed all references to BHO. Added UM 205 under policy dependencies	Yves Houghton, RN, BSN

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06/12/2020	Approved	Ma'ata Hardman, RN, MBA, CCM
06/16/2020	Approval	CMO Cabinet
11/11/2020	Updated LOB and C&R. Added section clarifying tribal providers are treated as network needed per HCA updates	Yves Houghton, RN, BSN
11/20/2020	Approval	CMO Cabinet
09/08/2021	Minor edits, no content changes. Added UM218 under dependencies	Yves Houghton, RN, BSN
09/24/2021	Approved	Ma'ata Hardman, RN, MBA, CCM
09/28/2021	Approval	CMO Cabinet
08/22/2022	Reviewed, minor edits.	Yves Houghton, RN, BSN
08/30/2022	Approval	Ma'ata Hardman
08/31/2022	Approval	CMO Cabinet
07/14/2023	Updated Continuity of Care section and the citation section.	Yves Houghton, RN, BSN
08/08/2023	Approval	Ma'ata Hardman
08/22/2023	Approval	Clinical Services Leadership Team
7/25/2024	Updated the definition of Second Level Reviewers and replaced "authorization for Medicaid members" with "medical necessity determination" to apply to all lines of business.	Yves Houghton, RN, BSN
08/05/2024	Approval	Ma'ata Hardman
08/12/2024	Approval	Clinical Services Leadership Team
06/24/2025	Reviewed, no content changes made	Yves Houghton, RN, BSN
07/24/2025	Approval	Ma'ata Hardman
07/30/3025	Approval	Clinical Services Leadership Team
06/03/2026	Added Administrative Approval Determination	Yves Houghton, RN, BSN
08/03/2026	Approval	Angie Davis, RN, MSN
08/19/2026	Approval	Ma'ata Hardman
08/19/2026	Approval	Clinical Services Leadership Team

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