

AMENDED IN ASSEMBLY APRIL 11, 2002

CALIFORNIA LEGISLATURE—2001–02 REGULAR SESSION

ASSEMBLY BILL

No. 2795

Introduced by Assembly Member Salinas

February 25, 2002

An act to amend Section 14133.9 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 2795, as amended, Salinas. Medi-Cal: prior authorization.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

Existing law requires the department to secure a toll-free telephone number for the use of Medi-Cal providers to provide information regarding available services.

Existing law also provides that for major categories of treatment subject to prior authorization under the Medi-Cal program, the department shall publicize and continue to develop its list of objective medical criteria that indicate when authorization should be granted, and provides that any request meeting those criteria shall be approved or deferred, as specified.

This bill would revise that requirement to require *that for major categories of treatment subject to prior authorization for Medi-Cal fee-for-service acute inpatient hospital stays*, the department ~~to~~ *must adapt and use the same* medical necessity criteria used for the federal

Medicare Program, *Program's case management*, and would make conforming changes.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

1 SECTION 1. Section 14133.9 of the Welfare and Institutions
2 Code is amended to read:

3 14133.9. The implementation of prior authorization
4 permitted by subdivision (a) of Section 14133 shall be subject to
5 all of the following provisions:

6 (a) The department shall secure a toll-free phone number for
7 the use of providers of Medi-Cal services listed in Section 14132.
8 For providers, the department shall provide access to an individual
9 knowledgeable in the program to provide Medi-Cal providers with
10 information regarding available services. Access shall include a
11 toll-free phone number that provides reasonable access to that
12 person. The number shall be operated 24 hours a day, seven days
13 a week.

14 (b) For major categories of treatment subject to prior
15 authorization *for Medi-Cal fee-for-service acute inpatient hospital*
16 *stays*, the department shall ~~utilize the same medical necessity~~
17 ~~criteria used for the federal Medicare Program that indicate when~~
18 ~~authorization should be granted. Any request adapt and use the~~
19 *medical necessity criteria used for the federal Medicare Program's*
20 *case management. The resulting criteria shall not change the*
21 *scope of Medi-Cal program benefits or coverage. Any request*
22 *meeting these criteria, as determined by the department, shall be*
23 *approved, or deferred as authorized in subdivision (e) by specific*
24 *medical information.*

25 (c) The objective medical criteria utilized by the federal
26 Medicare Program required by subdivision (d) shall be adopted
27 and published in accordance with the Administrative Procedure
28 Act, and shall be made available at appropriate cost.

29 (d) When a proposed treatment meets the objective medical
30 criteria utilized in the federal Medicare Program, and is not
31 contraindicated, authorization for the treatment shall be provided
32 within an average of five working days. When a treatment
33 authorization request is not subject to objective medical criteria,



1 a decision on medical necessity shall be made by a professional
2 medical employee or contractor of the department within an
3 average of five working days.

4 (e) Notwithstanding the provisions of subdivisions (c) and (d),
5 the department shall adopt, by emergency regulations as provided
6 by this subdivision, a list of elective services that the director
7 determines may be nonurgent. In determining these services, the
8 department shall be guided by commonly accepted medical
9 practice parameters, including those used in the federal Medicare
10 Program. Authorization for these services may be deferred for a
11 period of up to 90 days. In making determinations regarding these
12 referrals, the department may use criteria separate from, or in
13 addition to, those specified in subdivision (c). These deferrals shall
14 be determined through the treatment authorization request
15 process. When a proposed service is on the list of elective services
16 that the director determines may be considered nonurgent,
17 authorization for the service shall be granted or deferred within an
18 average of 10 working days. The State Department of Health
19 Services may adopt emergency regulations to implement this
20 subdivision in accordance with the Administrative Procedure Act
21 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
22 Division 3 of Title 2 of the Government Code). The initial
23 adoption of emergency regulations and one readoption of the
24 initial regulations shall be deemed to be an emergency and
25 necessary for the immediate preservation of the public peace,
26 health and safety or general welfare. Initial emergency regulations
27 and the first readoption of those regulations shall be exempt from
28 review by the Office of Administrative Law. The emergency
29 regulations authorized by this subdivision shall be submitted to the
30 Office of Administrative Law for filing with the Secretary of State
31 and publication in the California Code of Regulations and shall
32 remain in effect for no more than 120 days.

33 (f) The department shall submit to the Legislature, every three
34 months, its treatment authorization request status report.

35 (g) Final decisions of the department on denial of requests for
36 prior authorization for inpatient acute hospital care shall be
37 reviewable upon request of a provider by a Professional Standards
38 Review Organization established pursuant to Public Law 92-603,
39 or a successor organization if either of the following applies:



1 (1) The original decision on the request was not performed by
2 a Professional Standards Review Organization, or its successor
3 organization.

4 (2) The original decision on the request was performed by a
5 Professional Standards Review Organization, or its successor
6 organization, and the original decision was reversed by the
7 department. The department shall contract with one or more of
8 these organizations to, among other things, perform the review
9 function required by this subdivision. The review performed by
10 the contracting organization shall result in a finding that the
11 department's decision is either appropriate or unjustified, in
12 accordance with existing law, regulation, and medical criteria. The
13 cost of each review shall be borne by the party that does not prevail.

14 The decision of this body shall be reviewable by civil action.

15 (h) This section, and any amendments made to Section 14103.6
16 by Assembly Bill 2254 of the 1985-86 Regular Legislative
17 Session, shall not apply to treatment or services provided under
18 contracts awarded by the department under which the contractor
19 agrees to assume the risk of utilization or costs of services.

