

California Department of Insurance
Instructions for Utilization Review Policies and Procedures Filings
[Updated May 2026]

I. Filing Deadline(s)

Filing Requirement/Report	Due Date
Utilization Review Policies and Procedures	August 1, 2026 and when modified thereafter

If you have any questions or need to request additional time, please contact Andrea Doria at (916) 492- 3181 or andrea.doria@insurance.ca.gov or Christopher Citko at (916) 492-3187 or Christopher.Citko@insurance.ca.gov.

II. General Information

Insurance Code section 10123.135 requires a disability insurer, or entities with which it contracts for services, that covers hospital, medical, or surgical expenses that include any utilization review or any utilization management functions to comply with specified requirements. This includes specialized health insurers, including dental-only and vision-only insurers, that perform utilization review.

Utilization review policies and procedures required by Insurance Code section 10123.135 must be submitted to the Department of Insurance (Department) via SERFF for review and retention. If an insurer updates or modifies its policies and procedures, it should submit a new version via SERFF and reference any previous SERFF filing numbers in the filing description.

Please ensure your forms reflect required changes due to recently enacted laws. Some laws included below are for informational purposes and do not necessarily require compliance language to be added to your policies and procedures. However, any preexisting language that conflicts with a new law must be revised for consistency. Please note this is not a comprehensive list of new legal requirements or new legislation that may be applicable. Each insurer should undertake its own review to ensure its policies and procedures are compliant.

- CIC § 10123.135 [amended by Stats. 2024, Ch. 879 (S.B. 1120), Sec. 2, effective 1/1/2025]: An artificial intelligence, algorithm, or other software tool may not be used to deny, delay, or modify health care services based, in whole or in part, on medical necessity. If an artificial intelligence, algorithm, or other software tool is used for other utilization review or utilization management functions, insurers must ensure compliance with specified requirements. Please refer to the Department’s May 5, 2025 [Guidance SB 1120:1 Use of Artificial Intelligence, Algorithms and Other Software Tools in Utilization Management](#).
- CIC § 10144.5 (repealed and replaced by Stats. 2020, ch. 151 (S.B. 855 §§ 6, 7), effective 1/1/21): Specify that medically necessary treatment of mental health and substance disorders is covered under the same terms and conditions applied to other medical

conditions and in accordance with the federal Mental Health Parity and Addiction Equity Act. Include basic health care services, intermediate services, all statutory definitions, and network access standard. Disclose that all medical necessity determinations concerning service intensity, level of care placement, continued stay, and transfer or discharge are made using the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty, including the ASAM Criteria for substance use disorders, and for mental health conditions, LOCUS, CALOCUS/CASII, and ECSII. Disclose that WPATH's Standards of Care is used to determine the medical necessity of services for gender dysphoria (if applicable). Please refer to the Department's December 10, 2025 [Guidance SB 855 Notice to Health Insurers Re: Requirements of Senate Bill 855](#).

III. Guidance for Submission of Reports/Filings

The Department requests that all disability insurers subject to Insurance Code section 10123.135 submit current utilization review policies and procedures via SERFF by August 1, 2026. When you file, please note in the Filing Description in the General Information tab "Utilization Review Policies and Procedures" along with reference to any previously submitted utilization review policies and procedures via SERFF. Please use TOI code H21 Health – Other.

If an insurer uses a contracted entity to perform utilization review, a policies and procedures filing is still required to be filed by each insurer. Please submit all necessary information pursuant to Insurance Code section 10123.135.

Utilization Review Policies and Procedures are available to insureds, providers, and the public upon request and are made public within SERFF.

Compliance with Insurance Code section 10123.135 is mandatory, and if an insurer fails to meet any of the requirements of this section, the commissioner may assess, by order, administrative penalties for each failure. Cal. Ins. Code § 10123.135(h)(6).

IV. Components of Utilization Review Policies and Procedure Reports/Filings

The policies and procedures must include all requirements set forth in Insurance Code section 10123.135. Below are submission instructions:

- Under "Project Name" in the SERFF filing, please include a description, such as "2026 Utilization Review Policies and Procedures," or "Updated Utilization Review Policies and Procedures," to facilitate review and track submissions.
- Submit policies and procedures under the "Supporting Documents" tab.
- Do not simply re-state the provisions of Insurance Code section 10123.135 in your

submission but describe the specific procedures whereby you adhere to each subdivision. For example, delineate how exactly your company's policies and procedures determine that decisions are based on medical necessity, and describe in detail the criteria or guidelines that are supported by clinical principles and processes.

- Describe your company's compliance with subdivisions (c), (d), and (e), including specific information about the identity of the medical or clinical director, and the manner in which requests are communicated to providers.
- Describe the company's processes to ensure that all time period requirements in subsection (h) are met.
- As a formatting guide, it is helpful to include at least general headings that correspond to each requirement of Cal. Ins. Code section 10123.135, including each subsection, and reflect the processes of your company, such as the following:
 - a. Policies and Procedures (include procedures for prospective, retrospective and concurrent reviews, and for decisions based on medical necessity; include details of all criteria and guidelines used)
 - b. Medical Director or a statement that the insurer is not subject to this requirement
 - c. Communication of approvals
 - d. Communication of denials or modifications
 - e. Process to authorize, delay, modify, or deny services (include specific details of criteria and guidelines; include date last evaluated or modified)
 - f. Requests for medical information (include description of limitation to information reasonably necessary to make a determination)
 - g. Time limits (include description of policies and procedures used to ensure compliance with all required time limits)
- In all re-submissions, please disclose any unsolicited changes (changes that are not in response to any comments) in redlines and note such changes in the response letter.

NOTE: The Department is providing these instructions to assist insurers in submitting a complete filing and expedite review and authorization. Insurers and individuals are advised to review all applicable legal requirements and may not rely upon this information as legal authority or as a defense against disapproval of a filing or regulatory enforcement by the Department. These instructions and information may be subject to change at any time.