blue california
Promise Health Plan

POLICY & PROCEDURE
Medical Services

Policy Title: California Children's Services		
Policy No: 10.2.17	**Original Date: 11/97**	
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Department Head: **Date:**	**Medical Services/P&T Committee:** **Date:**	
P&P Committee: **Date:**	**Department(s):** **UM**	

PURPOSE:

To ensure children with special health care needs are referred to the local California Children's Services (CCS) program for evaluation and continue to receive medically necessary covered services whether or not they are covered by CCS.

POLICY:

CCS is carved out of the Blue Shield Promise Health Plan benefits agreement. The CCS program provides diagnostic and treatment services and treatment services, medical case management, and physical and occupational therapy services to children under the age of 21 with CCS eligible medical conditions.

Identified children with CCS eligible conditions are referred to CCS immediately upon identification.

Blue Shield Promise Health Plan will ensure a process which will include the following:

1. Providers are responsible for performing appropriate baseline assessments and diagnostic evaluations that provide sufficient clinical detail to establish or raise a reasonable suspicion, that a member has a CCS eligible medical condition.
2. Assure that contracting providers understand that CCS reimburses only CCS paneled providers and CCS approved hospitals within Blue Shield Promise Health Plan's network; and only form the date of referral.
3. Initial referrals of members with CCS eligible conditions are made to the local CCS program by telephone, same-day, or Fax. Followed by submission of supporting medical documentation, if available, to allow for eligibility determination by the local CCS program.

   a. Blue Shield Promise Health Plan providers are responsible for continuing to provide all medically necessary covered services to the member until CCS eligibility is confirmed.
4. Once eligibility for the CCS program is established for a member, Blue Shield Promise Health Plan providers shall continue to provide all medically necessary covered services that are not authorized by CCS. Blue Shield Promise Health Plan shall ensure the exchange of medical record information, coordination of services and joint case management between the PCP, the CCS specialty providers, and the local CCS program.
   a. If the local CCS program does not approve eligibility, Blue Shield Promise Health Plan remains responsible for the provision of all medically necessary covered services to the member. If the local CCS program denies authorization for any service, Blue Shield Promise Health Plan remains responsible for obtaining and paying for the services provided.

Blue Shield Promise or IPA/PPG Case Management shall assist in the coordination of care between PCP's, CCS Specialty Providers, and the local CCS program. All members who are referred to CCS or confirmed to have a CCS eligible condition shall be managed by Case Management.

The CCS program authorizes Medi-Cal Payments to Blue Shield Promise Health Plan network physicians who currently are members of the CCS panel and to other providers who provided covered CCS to the member during the CCS eligibility determination period who are determined to meet the CCS standards for paneling. Blue Shield Promise Health Plan shall submit information to the CCS program on all providers who have provided services to a member thought to have a CCS eligible condition.

Authorization for payment shall be retroactive to the date the CCS program was informed about the member through an initial referral by Blue Shield Promise Health Plan or a network physician shall be allowed until the next working day to inform the CCS program about the member. Authorization shall be issued upon confirmation of panel status or completion of the process described above.

PROCEDURE:

1. All authorization requests initially screened by the Utilization Management (UM) Coordinators for members age 21 and under will be forwarded directly to the case manager for review.

2. The Case Manager will determine if the request for authorization is a potential CCS eligible condition.
   a. If not, the authorization referral will be handled as outlined in the policies and procedures of processing an authorization requests.

3. If the condition is suspected to be an open CCS case based on the nature of the condition, the Child Health Liaison or CCS coordinator will contact the local CCS program and verify if the case is open/closed or never referred.

4. If the case is currently open, the Child Health Liaison or CCS Coordinator will prepare the denial letter to the provider, guardian, and member's primary care physician stating the condition is a "carve out" CCS benefit, and direct the requestor of the service to notify CCS through their specified authorization procedure.

5. If the case is not established or current, the case manager will direct the Child Health Liaison or CCS Coordinator to contact the member's PCP to assist the PCS or the designated PCP's office staff member with an initial consultation to an appropriate CCS provider for the condition.

6. If the PCP is a CCS paneled provider and is qualified to care for the specific condition, the provider will be asked to contact the local CCS program directly for authorization.

7. Initial CCS consultation referrals are documented as pending potential CCS case into comment section of the inpatient/outpatient authorization screen.

8. The Child Health Liaison or CCS Coordinator will attempt to directly contact the member or the member's responsible party to assist in coordinating the initial consultation appointment.

9. Once the consultation occurs, the Child Health Liaison or CCS Coordinator will request a copy of the consultation report and treatment plan from the specialist to determine if a referral will be sent to CCS for the condition.

10. When the treatment plan and consultation report are received, the information will be forwarded to the case manager for review.

11. A copy will be sent to the PCP to be entered as part of the member's medical record information.

12. If the information meets the specifications of the CCS criteria, it will be referred to the local CCS program for a case number.

13. All further requests for service that are received by Blue Shield Promise UM Department that are related to the member's CCS eligible condition will be referred to the local CCS program.

14. Upon determination that the requested service is related to a CCS eligible condition, a letter will be generated that states the condition as a carve-out CCS benefit.

15. If the case is denied by the local CCS program, Blue Shield Promise will ensure that the member continues to receive all medically necessary covered services and will be responsible for obtaining and paying for the service. If the local CCS program does not approve eligibility, Blue Shield Promise remains responsible for the provision of all medically necessary covered services.

16. All in-patient hospital stays are reviewed by Blue Shield Promise Case Managers daily. If a potential CCS eligible condition is identified through this procedure, he/she will advise the hospital, if it is CCS paneled, to make a referral to the local CCS program and proceed with the above applicable steps to facilitate the process.

    a. If the hospital is not CCS paneled and the patient medical qualifies for inpatient care stipulated in the CCS criteria, the Blue Shield Promise Case Manager will coordinate the transfer of the member to a CCS paneled hospital.

17. All members determined to have a CCS eligible condition will be evaluated for Case Management needs.

REFERENCES/AUTHORITIES:

- Welfare & Institutions Code Section 14094
- Health & Safety Code Section 123800