blue california
Promise Health Plan

POLICY & PROCEDURE
Medical Services

Policy Title: Expedited Organization Determinations		
Policy No: 50.2.20	**Original Date: 5/08**	
Effective Date: 12/18	**Revision Date:5/12, 2/13, 12/18**	**Revision No: 3**
Department Head: Date:	**Medical Services/P&T Committee: Date:**	
P&P Committee: Date:	**Department(s):** **UM**	

PURPOSE:

To define and establish a process to implement the requirements for Expedited Organization Determination, as set forth in Chapter 13 of the Medicare Managed Care Manual.

POLICY:

Blue Shield Promise Health Plan's Utilization Management Department provides a process for the timely processing of a Blue Shield Promise expedited organization determination, in accordance with the guidelines outlined in CMS Managed Care Manual Chapter 13.

DEFINITIONS:
CMS: Centers for Medicare and Medicaid Services

MAO: Medicare Advantage Organization

Determination: A request for service indicates the enrollee believes the organization should provide the service. The request constitutes a determination.

Organization Determination:

- The MAO's refusal to provide or pay for services that the enrollee believes should be furnished or arranged for by the MAO and the enrollee has not received outside the MAO.
- Reduction or premature discontinuation of a previously authorized ongoing course of treatment
- Failure of the MAO to approve, furnish, arrange for or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the enrollee.

Pre-service denial: Blue Shield Promise's refusal to pay for a service that the enrollee/requestor believes is covered, and has not been obtained elsewhere.

OPERATING PROTOCOL: Refer to P&P 50.2.22 Standard Organization Determination

RIGHT OF ENROLLEES: Refer to P&P 50.2.22 Standard Organization Determination

Expedited Organization Determination Process:
An enrollee or any physician (regardless of whether the physician is affiliated with the Medicare health plan), may request an expedited organization determination when the enrollee or his/her physician believes that waiting for a decision under the standard time could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

When asking for an expedited organization determination, the enrollee or the physician shall submit either oral or written request directly to Blue Shield Promise or the MAO responsible for making the determination. The physician need not to be the enrollee's representative in order to make a request Blue Shield Promise follows the Industry Collaboration Effort' (ICE) CMS UM Timeliness Standard.

- If the MAO decides to expedite the request, it shall render a decision as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the enrollee's request. the 72-hr period begins when request is received by the UM Department. The MAO shall notify the enrollee or in writing within the 72-hr time frame. The enrollee must receive the notice in the mail within 72 hours. When the determination is adverse, the MAO shall mail written confirmation of its determination within 3 calendar days after providing oral notification.
    - If the enrollee requests for extension or if the organization justified a need for additional information and documents how they delay is in the interest of the enrollee, the MAO shall extend the 72-hr time frame by up to 14 calendar days. When the extension is rendered, the MAO shall notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MAO's decision to grant an extension. The MAO shall notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.
    - If the medical information is required from non-contracted providers to make a determination, the MAO shall request the necessary information from the non-contract provider within 24 hours of the initial request for an expedited organization determination. All oral requests shall be documented in writing and maintain the documentation in the case file.
    - The MAO is responsible for meeting the same time frame and notice requirements as it does with contracting providers.

- If the MAO denies a request for an expedited organization determination, it shall automatically transfer the request to the standard time frame and make a determination within 14 calendar days (the 14 calendar day period starts when the request is received by MAO), and using the "Criteria Not Met Letter", gives the enrollee prompt oral notice of the denial including the enrollee's rights, and subsequently deliver to the enrollee, within 3 calendar days the notice that:
    - Explains that the organization will automatically transfer and process the request using the 14-day time frame for standard determinations;
    - Informs the enrollee of the right to file an expedited grievance if he or she disagrees with the organization's decision not to expedite the determination.
    - Informs the enrollee of the right to resubmit a request for an expedited determination and that if the enrollee gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, the request shall be expedited automatically; and
    - Provides instructions about the expedited grievance process and its time frames.
- Blue Shield Promise has a dedicated fax line for expedited cases and the requests are processed expeditiously according to its timeframe.

Acceptance of the Expedited Request:

If an organization grants a request for an expedited determination, the determination must be made in accordance with the following requirements:

- If the request for expedited determination is approved, the MAO shall make the determination and notify the enrollee and the physician involved, as appropriate, of its determination as expeditiously as the enrollee's health condition requires but no later than 72 hours after receiving the request. Although the MAO may notify the enrollee orally or in writing, the enrollee shall be notified within the 72 hour time frame. The enrollee must receive the notice in the mail within 72 hours.
- When the determination is adverse, the MAO shall mail written confirmation of its determination within 3 calendar days after providing oral notification.
- The MAO shall extend the 72 hour time frame by up to 14 calendar days if the enrollee requests the extension. The MAO also may extend the time frame by up to 14 calendar days if the organization justifies a need for additional information and documents how the delay is in the interest of the enrollee. When MAO extends the time frame, it shall notify the enrollee in writing of the reasons for the delay, and inform the enrollee of the right to file an expedited grievance if he or she disagrees with the MAO's decision to grant an extension. The MAO shall notify the enrollees of its determination as expeditiously as the enrollee's health condition requires, but no later than the expiration of the extension.

Notice Requirements for Expedited Organization Determinations:

If a decision is made to deny services, in whole or in part, or discontinue/reduce a previously authorized ongoing course of treatment, then a written notice of the organization's determination shall be issued (NDMC).

The notice shall be provided using the most efficient manner of delivery to ensure the enrollee receives the notice in time to act (e.g., via fax, hand delivery, or mail). If the enrollee has a representative, the representative shall be given a copy of the notice. The written notice of determination may be a separate document from the plan generated statement to the enrollee or provider.

1. Denial of Medical Coverage (NDMC) – shall be written in a manner that is understandable to the member and shall provide:
    a. The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;
    b. Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf (in compliance with 42 CFR 422.570 and 422.566(b)(3);
    c. For service denials, a description of both standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and other elements of the appeals process;
    d. The beneficiary's right to submit additional evidence in writing or in person.
2. If the organization determination is fully favorable, Blue Shield Promise and delegates shall use only the form approved by CMS for Blue Shield Promise Health Plan.
3. Carved-out services are not considered denials of service. Information Letter is issued to the member explaining that Blue Shield Promise's contracted vendor is providing the service and prior authorization is not needed, and the member is instructed to make arrangement with that specific vendor directly.

PROCEDURE: Outpatient Referral Workflow

1. When a Treatment Authorization Request (TAR) is received via right fax:
    a. Once the UM Coordinator receives an expedited request and member verification for eligibility is done, he/she immediately assesses if the approval can be done through the automatic approval system.
    b. If approval can be done on the Coordinator level, the request is processed and adjudicated in MHC Program. An approval letter is generated and sent to the enrollee on the same day. The approval is auto faxed to the requesting and referred provider; then the entire file and documentation are scanned and filed.
    c. If clinical review is required, the referral request is forwarded and reviewed by Outpatient Case Manager. If the case is approved, the Case Manager adjudicates and closes it in the MHC Program.

d. The Outpatient Case Manager forwards the adjudicated referral to the Outpatient UM Coordinator, who sends the approved auth to the requesting and referred providers via automatic fax, then scans and files the case on the same day.
e. If the Outpatient Case Manager deems the case needs further review, he/she prepares the case and reviews it with the Medical Director.
f. If the Medical Director approves the case, the Outpatient Case Manager follows Step D.
g. If the member or the non-contracted practitioner who sends the referral request for an extension, or the Medical Director deems that additional information can justify the approval of the request, then an Extension Needed for Additional Information letter is generated and sent to the member explaining the reason for the extension. Blue Shield Promise follows the UM Timeliness Standard from the Industry Collaboration Effort (ICE).
h. If the medical records are received and the request is approved, the Outpatient Case Manager follows step d.
i. If the request is modified or denied, the Outpatient Case Manager generates the denial letter and sends to the Outpatient UM Coordinator for processing.
j. The UM Coordinator notifies the member or the representative via telephone of the outcome of the determination
k. The UM Coordinator processes the denial letter and closes the case in the MHC Program, documents the time of the call, then faxes the denial letter to requesting provider, scans and files the entire documentation.

Failure to Provide Timely Notice
Failure to provide timely notice of an expedited organization determination constitutes an adverse organization determination and may be appealed.

Misclassified Organization Determinations
All organization determinations are subject to appeal process. Complaints that do not appear to involve organization determinations are sometimes classified as grievances because the organization did not issue written notice of adverse determination. Upon discovery of the error, Blue Shield Promise shall:

- Notify the enrollee in writing that the compliant was misclassified and will be handled through the appeals process;
- Process the complaint beginning on the date the complaint was received, as opposed to the date the error was discovered.

A system shall be in place to identify presence of errors in appeals and grievance systems and appropriate quality improvement action is implemented, as needed.

REFERENCES/AUTHORITIES:

CMS Managed Care Manual Chapter 13
42 CFR 422.566; 422.568; 422.570 and 422.572