POLICY & PROCEDURE
UTILIZATION MANAGEMENT

Policy Title: Standard Pre-Service Organization Determinations		
Policy No: 50.2.22	**Original Date: 05/08**	
Effective Date: 12/18	**Revision Date: 2/13, 10/13, 4/14, 12/18**	**Revision No: 4**
Department Head: **Date:**	**Medical Services/P&T Committee:** **Date:**	
P&P Committee: **Date:**	**Scope of Coverage:** **UM**	

PURPOSE:

To establish and define a process for timely processing of a standard 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 Health Plan standard organization determination, in accordance with the guidelines outlined in CMS Managed Care Manual Chapter 13.

PROCEDURES:

Receipt of pre-service organization determination requests:

The request for a service can be received from either the member or the provider. The request from the member is received via his/her provider, per Blue Shield Promise protocol.

When a faxed request is received from the provider's office:

1. The UM Coordinator enters the information on the request into Authorization/Claims System and indicates in the system if request is expedited or standard.

2. The UM Coordinator notes in the system the date(s) of service requested
    a. If the date of service has already passed, the UM Coordinator checks the system to see if there is a current authorization present,
    b. If there is an approved authorization, the UM Coordinator notifies the provider that there is already an approval for this date of service.

If a new request is received, the UM Coordinator automatically approves the request, if the item/service requested is on the Coordinator's automatic approval list or if not on the automatic

approval list, the UM Coordinator sends the request to the Case Manager for approval. The Case Manager automatically approves the request if the item/service requested is on the Case Manager's automatic approval list. If not on the list of automatic approval, the Case Manager sends the request to the physician reviewer for a determination.

Review of Request:

Blue Shield Promise makes determinations based on the medical necessity that are consistent with criteria and guidelines supported by scientific-based medical evidence and principles. The physician reviewer of Medical Director reviews the request and the clinical information to determine if the requested services are covered by Medicare and/or Blue Shield Promise.

1. Blue Shield Promise's UM criteria shall use the following Medicare criteria to make the determination:
   a. National and Local Coverage Determination
   b. Medicare Benefit Interpretation Manual;

2. Other criteria or guidelines used are:
   a. Milliman Care Guidelines
   b. Apollo Medical Review Criteria
   c. Blue Shield Promise Health Plan's approved criteria
   d. Other evidence-based criteria consistent with nationally-acceptable standards of medical practice

3. If no criteria are available, Blue Shield Promise resorts to 2 peer-reviewed published articles for the condition in which a determination is requested.

4. Only physicians can deny or modify requests for medical necessity. The reviewing physician holds an unrestricted license to practice in the state of California.

5. Blue Shield Promise uses a panel of board-certified independent experts to assist in the determination, as appropriate.

Provider Outreach for Additional Information:

1. If the physician reviewer determines that additional information is needed and is in the best interest of the enrollee, the additional information is requested. Only the relevant information needed for the determination shall be requested.

2. Regardless of whether the additional information is needed from a contracting or non-contracting provider, the UM Coordinator will contact the provider by telephone within 24

hours of receiving the request for the standard organization determination, to request the necessary additional documentation. If the provider does not provide the requested documentation within 2 business days of the first telephone attempt, UM Coordinator will make attempts every two business days until the 13th day of receipt of the request.

3. If the additional information is not received by the 13th day, the Medical Director will determine if an extension is justified, or will make a determination based on the information provided with the request.

4. If an extension or the approval of the request cannot be justified, a denial letter will be issued (Attachment 1), stating that additional information was requested, but was not received. The determination will be rendered based on the available information submitted.

5. All telephone requests shall be documented in writing and maintained in the case file.

Timeframes for Review:

1. Standard requests are processed within 14 days of receipt of the request.

2. Blue Shield Promise may extend the review timeframe by up to additional 14 days if there is a justified need for additional information and Blue Shield Promise documents how the delay is in the member's best interest.

3. If Blue Shield Promise takes an extension under these circumstances, UM Coordinator sends a written notice (Extension for Additional Information Letter, Attachment 3) to the member and the requesting provider informing them of the extension. The notice to the member provides a description of the member's right to file a grievance if s/he disagrees with Blue Shield Promise's decision to grant itself an extension.

4. If the additional information is not received by the end of the 14-day extension period, the UM Coordinator forwards the case to the Physician Reviewer or Medical Director for a final determination with the information available.

5. The determination is rendered no later than the end of the extension period.

Member Notification:

1. Once a determination has been made by the Physician Reviewer or the Medical Director, the UM Coordinator sends the approval letter (Attachment 2) to the member and the requesting provider informing of the decision and the details of the approval.

2. For standard pre-service organization determinations that are denied in whole or in part, the Case Manager, with the guidance of the Physician Reviewer or Medical Director, formulates the denial reason, and sends it to the UM Coordinator. The UM Coordinator generates a CMS-approved Notice of Denial of Medical Coverage or Payment (NDMCP)

(Attachment 1) and mails the notice to the member, or the member's authorized representative, within 14 days of receipt of the request.

Denial Information:

The NDMCP (Attachment 1) provides the following:

1. The specific reason for the denial that takes into account the member's presenting medical condition, disabilities, and special language requirements, if any, including the denial reason written in clear, easily understood language;

2. Information regarding the member's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the members' behalf;

3. A description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;

4. If the decision is to deny some of the requested services (partial denial) or to modify the requested services (e.g., approve the requested services, but through a different type of provider than requested in the pre-service organization determination request), the NDMCP will explain which services are denied, or how the request has been modified, and will explain the member's right to file an appeal for the denied or modified services.

Approved Services:
Authorization Process

1. For approved standard pre-service organization determinations, the UM Coordinator generates a notice (Attachment 2) to the member, requesting provider, and requested provider, informing them that the requested services are approved. The approval notice includes the following information:
    a. Member name
    b. Name of requesting provider
    c. Description of the services requested
    d. Authorization dates for the approved service
    e. Instructions on how to obtain the approved services

2. The UM Coordinator adjudicates the authorization into Authorization/Claims System, including the date(s), the service(s) are authorized for. Additionally, communications with the member and provider are documented in the system. Documentation of all approvals is maintained in the system indefinitely.

3. The approved request is automatically faxed to the provider within 24 hours of the request.

Types of Beneficiary Notices:

1. Notice of Denial of Medical Coverage (NDMCP) (Attachment 1) – issued if the determination is to deny services, in whole or in part, or discontinue/reduce a previously authorized ongoing course of treatment.

2. Denial of Medical Coverage (NDMCP) 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, including the denial reason written in clear, easily understood language;

    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. A description of both standard and expedited reconsideration processes and timeframes, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;

    d. The beneficiary's right to submit additional evidence in writing or in person.

    e. Approval Notice Form (Attachment 2) – If the organization determination is fully favorable.

    f. Extension Needed for Additional Information Notice (Attachment 3) – If the member requests an extension, or Blue Shield Promise justifies a need for additional information and documents how the delay is in the interest of the enrollee.

Failure to Provide Timely Notice:

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

Misclassification of Files:

Complaints on organization determinations may be misclassified as grievances because no denial notice was issued. When such error happens, Blue Shield Promise shall notify the enrollee in writing that the complaint was misclassified and will be handled through the appeals process. The timeframe for processing the complaint begins on the date the complaint is received, not on the discovery of the error.

Monitoring the Effectiveness of the Process:

1. UM Data Analyst runs the prior authorization report on a quarterly basis

2. The UM Quality Manager ensures the compliance with the turn-around-time of all requests:
    a. Turn-around-time study is conducted.
    b. Blue Shield Promise maintains a threshold of 95% on turn-around-time of standard requests.
    c. Result is reported to Medical Services Committee.

Definitions:

Pre-Service Organization Determination – a determination made by Blue Shield Promise Health Plan with respect to:

- Refusal to authorize, provide for services, in whole or in part, including the type or level of services that the enrollee believes should be furnished or arranged for by the Medicare health plan.
- Reduction or premature discontinuation of a previously authorized ongoing course of treatment.
- Failure of the Medicare health plan 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.

Adverse Pre-Service Organization Determination – A decision not to provide a requested service, or to discontinue or reduce a previously authorized course of treatment.

Standard Pre-Service Organization Determination –A decision for routine pre-service requests which must be processed as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date Blue Shield Promise receives the request.

AUTHORITIES AND REFERENCES:

- CMS Managed Care Manual, Chapter 13, Section 40
- 42 CFR 422.568, 422.520, 422.566, 422,576

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