



Promise Health Plan

# POLICY & PROCEDURE

## Medical Services

<b>Policy Title: Utilization Management Delegation and Monitoring</b>			
<b>Policy No: 70.2.44</b>		<b>Original Date: 12/97</b>	
<b>Effective Date: 12/18</b>	<b>Revision Date: 1/01, 12/01, 3/03, 12/18</b>	<b>Revision No: 4</b>	
<b>Department Head:</b>	<b>Date:</b>	<b>Medical Services/P&amp;T Committee:</b>	<b>Date:</b>
<b>P&amp;P Committee:</b>	<b>Date:</b>	<b>Department(s): UM</b>	

### PURPOSE:

To establish mechanisms, policies, and procedures for Blue Shield Promise to delegate specific Utilization Management (UM) functions to capitated Participating Provider Groups (PPGs) who, by contract, refrain financial risk for member care management. To establish data reporting standards and mechanisms in order to monitor delegation UM activities.

### POLICY:

Blue Shield Promise Health Plan is responsible for maintaining a monitoring system for delegation of specific UM functions to PPGs.

The Blue Shield Promise Medical Services Committee (MSC) is responsible for performing evaluation of UM Program objectives and progress on an annual basis with as directed by the Blue Shield Promise Governing Board. All contracted PPGs must have a UM Program, UM Work Plan, UM Policies and Procedures, and perform UM activities in a manner that meets Blue Shield Promise Health Plan, the Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) standards.

#### Review and Approval Process

Blue Shield Promise Health Plan may delegate authorization requests, reviews and approvals to the PPGs. While PPGs have some degree of latitude in establishing review and approval processes, they must contain the following provisions:

- Appropriately licensed health professionals conduct the supervision of all review decisions and processes.
- An appropriate licensed and trained medical professional shall review all cases where a potential for modification or denial is raised during the review.
- A qualified physician shall conduct a review where medical appropriateness is in question

- A physician shall conduct a review for all denial of service requests, including denials for non-covered services.
- Physician consultants from the appropriate specialty areas of medicine and surgery who are certified by the applicable American Board of Medical specialties shall be utilized as necessary.
- UM decisions are made independent of financial incentives or obligations.

### **Standards for Review and Approval of Authorization, Exceptions to Authorization**

The delegated structure of Blue Shield Health Plan allows the PPGs to establish prior authorization requirements. Federal and State Regulations require certain services to be available without a need for prior authorization. These requirements shall be reviewed by the Blue Shield Promise Health Plan's CMO or designee, and the UM Director and presented to Blue Shield Promise Health Plan's Medical Policy Subcommittee and the Medical Services Committee for adoption. Member eligibility verification and benefit determinations will be secured or all elective services prior to authorization approval.

Services requiring prior authorization generally include:

- Inpatient and outpatient hospital care
- Ambulatory and other surgical care
- All infusion therapy
- Physical, occupational and speech therapy
- MRIs and CT scans
- Transplants (may also be a carve-out service)
- Custom made durable medical equipment
- Cataract spectacles
- Hearing aids and services
- Home health care.

Exceptions to prior authorization requirements include:

- Emergency services (medical screening and stabilization)
- Family Planning Services including abortions
- Preventive health services
- Sensitive and confidential services including HIV testing and STD diagnosis and treatment
- Basic prenatal care
- OB/GYN referrals and consultations (in-network)
- Annual well woman care

### **Referral Review Process and Turn around Times (TAT)**

The referral process is a function that may be delegated to the PPGs. When this function is delegated, Blue Shield Promise Health Plan monitor the PPGs' referral process to ensure that

prior authorization guidelines, clinical practice guidelines and medical necessity criteria are utilized appropriately. The following standards must be enforced.

The referral is processed in a timely manner as follows:

Emergency pot-stabilization services – within 30 minutes of verbal request

Urgent requests – within 72 hours

Routine requests – 5 working days

Pended requests – 14 working days

Retrospective review requests – 30 days

Expedited review requests – 72 hours (review and notification)

## **PROCEDURE:**

1. General Standards for Delegation: PPG must use recognized UM standards when making decisions related to medical care. Criteria sets approved by Blue Shield Promise include Milliman Care Guidelines, the American College of Obstetrics and Gynecology, the American Academy of Pediatrics, the United States Preventative Services Task Force Standards. Other criteria sets used are Medi-Cal Health Care Guidelines and Benefit Interpretation, the Department of Health and Human Services Health Care Guidelines and requirements.
2. Pre-authorization and concurrent review decision processes are in place, are consistent with Blue Shield Promise Health Plan standards, and are supervised by an appropriately qualified professional such as the following:
  - a. A physician conducts medical review on any denial
  - b. Board-certified physician specialists are used as consultants to assist in determining medical necessity. Documentation is maintained to support their decisions.
3. Non-physician UM staff with any level of utilization decision-making authority will be clinical nurses licensed to practice in California (RN or LVN) and staff ratios are to be appropriate to the level of review.
4. When applying criteria, individual factors such as age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment are taken into consideration. Additionally, criteria applied takes into consideration the issues of whether services are available within the service area, benefit coverage, and other factors that may impact the ability to implement an individual member's care plan.
5. PPGs must disclose to network providers, members, or the public, upon request, the clinical guidelines or criteria used for determining health care services specific to the medical service requested. The following statement must be accompanied with the disclosure of criteria:
  - a. "The materials provided to you are guidelines used by (IPA name) to authorize, modify, or deny care for persons with similar illness or conditions."

6. Written decision protocols are based on reasonable and appropriate medical standards. Written documentation of the application of decision protocols must contain the elements below.
  - a. Criteria are clearly documented and communicated to participating physicians and available to the physician upon request.
  - b. A mechanism exists for checking the consistency of the application of criteria across reviewers.
  - c. A mechanism exists for evaluating and updating, as indicated, review criteria periodically (at least annually).
7. Efforts are made and documented to obtain pertinent clinical information during the UM decision-making process, including consultation with the treating physician.
8. Reasons for authorization denials are clearly documented and include the following elements:
  - a. Name of the individual who recommended denial and why this recommendation was made
  - b. Evidence that an explanation was provided to the provider, including a description of appeal processes
  - c. Evidence that written notification of denial was provided to the member, including a description of appeal processes.
9. Decisions are made in a timely manner and policies include maximum time frames and meet all established state and federal guidelines.
10. Staff and procedure are in place to meet the provision to the various clinical programs and services as required by Blue Shield Promise Health Plan as well as any related policies, procedures, or directives which may be issued in the future.
11. PPG UM Medical Director with a unrestrictive California licensed physician must be responsible for reviewing and monitoring the UM process including but not limited to the following activities:
  - a. Review UM data to assess potential over and under utilization services
  - b. Sign-off on all internal policies and procedures related to UM
  - c. Chairing the UM committee, or designating a chair
12. Performance measures and adherence to established procedures are determined by Blue Shield Promise and incorporated into Blue Shield Promise's or the PPG's UM Program:
  - a. Use of non-contracted non-emergency providers
  - b. Average hospital length of stay
  - c. Patient satisfaction survey results
  - d. Emergency visits are reported monthly Blue Shield Promise
  - e. Audit results are compliant with Blue Shield Promise standards, policies, and procedures.
13. IPA UM Committee: Committee membership must include a minimum of three practice physicians from the PPGs representing the appropriate specialties including OB/GYN, Pediatrics, Family Practice and other specialists as needed. The UM Committee meets at least quarterly and its responsibilities including, but are not limited to the following activities:

- a. Review and approve UM Program, UM Work Plan, UM Policies and Procedures annually
  - b. Review and evaluate UM statistics and make recommendations for improvement
  - c. Review complex referrals requiring input beyond the expertise of the Medical Director or committee physicians input
  - d. Coordinating educational opportunities for physicians regarding UM procedures and processes.
14. Once approved for full or conditional delegation the PPGs agree to:
- a. Make available to Blue Shield Promise any requested data, documents, and reports
  - b. Allow at least annual site visits, evaluations, and audits by Blue Shield Promise other agencies authorized.
  - c. Blue Shield Promise UM staff, in partnership with the Medical Services Committee will monitor data submitted by PPGs on an ongoing basis. Corrective action plans will be requested and monitored whenever data analysis, report and document review, and/or site visits, evaluations, and audits indicate less than full compliance with the standards for UM delegation.
15. When it is necessary for a corrective action plan to be implemented, PPGs will have 30 days to complete the necessary actions to bring it back into full compliance. If at the end of 30 days evidence of compliance is not clearly indicated, action may be taken. Refer to the Due Diligence Delegation Corrective Action and Delegated Oversight Sanction Policies and Procedures.
16. The Primary Care Physician (PCP) is to serve as the medical case manager and gatekeeper within each PPGs managed care system. As such, the PCP is responsible for making referrals and coordinating all medically necessary services a member needs, both inside and outside the Care1st provider network.

### **Outpatient Referral**

1. If the PCP is of the opinion a member requires treatment or examination outside of the standard primary care skill set, he/she will complete the following:
  - a. Authorize the referral or obtain authorization, when needed
  - b. Refer the member to the appropriate specialist or facility. The PCP, office staff, or member may arrange the referral appointment
  - c. Note the referral in the member's medical record and attach any authorization paperwork
  - d. Discuss the case with the member and the referral provider
  - e. Receive reports and feedback from the referral provider regarding the consultation and treatment. (A written report must be sent to the PCP by the referral provider or facility the member was referred to.)
  - f. Discuss the results of the referral and any plan for further treatment, if needed, and care coordination with the member.

2. Referrals will be tracked by the PCP's office and Blue Shield Promise or the PPG for follow-up through a tracking file, log or computerized tracking. The log or tracking mechanism should note the following for each referral:
  - a. Member name and identification number
  - b. Diagnosis
  - c. Date of authorization request
  - d. Date of authorization
  - e. Date of appointment, and
  - f. Date consult report received

### **Hospital Inpatient Care**

1. Hospital inpatient care may be pre-planned and pre-authorized or may be urgent or emergency admissions
2. The PCP is responsible for obtaining required pre-authorizations for inpatient care from Blue Shield Promise or PPG/IPA of an emergency admission.
3. While a member is hospitalized, the PCP must:
  - a. Coordinate care for members admitted to non-network facilities for emergency care or other reasons, with assistance from relevant UM staff. (after determination of the appropriateness of an emergency admission and a transfer assessment is made, the member will either be transferred to a network facility or care will be continuously monitored at the facility of admission until discharge or a transfer is appropriate)
  - b. Respond to the concurrent review process, including level of care, length of stay, and medical necessity elements, when he/she acts as the attending physician or works in conjunction with the attending physician for a hospital stay.
  - c. Assist with discharge planning by ordering and requesting authorization for appropriate elements of discharge.

### **Inpatient Concurrent Review:**

1. Inpatient concurrent review will begin within one day of admission and include an assessment of appropriateness of level of acute care using accepted criteria
2. Blue Shield Promise UM Case Manager conducts concurrent review for shared risk PPGs. These reviews will be performed periodically on or before dates assigned at the end of the initial and each subsequent review. These reviews will be conducted utilizing accepted guidelines for acute level of care, such as intensity of service, severity of illness criteria, Milliman Care Guidelines, or other guidelines and criteria developed and/or approved by Blue Shield Promise.
3. Concurrent quality issues noted during utilization review will be documented and reported to Blue Shield Promise Medical Director, PPG UM Case Manger and Blue Shield Promise Quality Management Department upon discovery. When appropriate, they will be discussed with the attending physician by UM staff for intervention. Discussion with service chiefs or administration may also be necessary, depending on the urgency or gravity of the situation.

4. Utilization review concurrent focus will be proactive and UM/Case Management levels of focus will be employed as appropriate.

#### Discharge Planning

1. UM staff will begin discharge planning within 24 hours of admission and facilitate the involvement of a multidisciplinary team of physicians, nursing, social work, and others, as appropriate.
2. Patient and family intervention will occur throughout the stay to assure discharge plans are in place and appropriate for each member. Discharge plans will consider the disease process, treatment requirements, the family situation, and available benefits and community resources.
3. Average length-of-stay guidelines will be used for discharge planning purposes. Discharge screens, lower level of care guidelines, or clinical decision-making by the physician is to be used for the final discharge date plan.
4. Questionable continued stay plans are to be discussed with the attending physician and then reviewed by a UM physician for further discussion with the attending physician.
5. A UM Case Manager will submit a discharge plan to the UM physician. If the attending physician disagrees with the plan and the UM physician's decision regarding it, he/she may follow the provider appeals process, beginning with reconsideration.

#### Services Requiring Prior Authorizations

1. Overview - the delegation of UM affords broad authority for the PPG's to establish prior authorization requirements. These requirements must be reviewed and approved by Blue Shield Promise through the delegation process.
2. Authorization Denial, Deferral, and/or Modification and Notification
  - a. Denials, Deferrals or Modification may occur:
    - i. A denial, deferral, and/or modification of a prior-authorization request may occur so that more information can be obtained or recommendation of alternative care may be made during the authorization process.
    - ii. At the request of the PCP or member such decisions may be referred to the MSC for additional review and determination.
  - b. Notification
    - i. PPG will send written notification of prior-authorization request denial, deferral, and/or modification to the member, the member's PCP, and/or attending physicians according to the provisions below:
      1. Within one working day of determination
      2. Before the denial, deferral, and/or modification is implemented, and
      3. When all the conditions below exist:
        - a. The request is made by a health care provider who has a formal arrangement with Blue Shield or the PPG to provide services to Medi-Cal members

- b. The request is made by the provider through the formal prior-authorization procedures operated by Blue Shield Promise or the PPG
      - c. The service for which prior authorization is requested is a Medi-Cal covered service for which Blue Shield Promise or the PPG has established a prior authorization requirement
      - d. The prior authorization decision is made at the highest level of responsibility within the delegated UM Program but prior to the point at which the member must initiate the compliant/grievance procedure to reverse the determination
3. Copies of the written notification are to be sent to the referral specialist, attending physician, hospital or other applicable provider(s) within one day of determination and before implementation. The notification must include elements listed below.
  - a. The notice to the member will inform the member that he/she may file a complaint/grievance concerning the determination using the complaint/grievance process prescribed in the UM Program prior to or concurrent with the initiation of a fair hearing process.
  - b. The member's right to, and method for obtaining, a fair hearing, DMHC, or IMR process to contest the denial, deferral or modification action
  - c. The member's right to represent himself/herself at the fair hearing or to be represented by legal counsel or other spokesperson
  - d. The name and address of the entity making the determination and the State's toll-free telephone number for obtaining information on legal service organization for representation
- 4. Reconsideration**
  - a. A provider requesting authorization may write or call to supply additional information for discussion with the Medical Director of Blue Shield Promise and/or the PPG. This early process is referred to as a reconsideration.
  - b. If the Medical Director or designated peer reviewer reverses the original determination based on additional information provided by the provider, the case will be closed.
  - c. Reconsideration should commence within one business day of the receipt of the provider's telephone call or written request
  - d. If reconsideration does not resolve a difference of opinion, the provider may then submit a grievance to the expedited grievance or standard grievance appeal process.

### **Grievance and Appeals Process**

1. The Grievance and Appeals Process is not delegated to PPGs. All grievance must be submitted to Blue Shield Promise for resolution. The PPG must maintain a monthly log grievances received.
2. The Clinical Grievance Coordinator will immediately investigate any grievance and may request information from the PPGs, the requesting provider, the PCP,

facility, and/or the member. This information will be forwarded to Blue Shield Promise Medical Director. An acknowledgement letter will be sent to the provider and PPG upon resolution.

### **Delegated Utilization Management Reporting Requirements**

The purpose of the reports is to provide ongoing monitoring for delegated UM functions and to ensure that services and decisions rendered by the delegated PPGs groups are appropriate and according to DHCS, DMHC, and Blue Shield Promise standards. All delegated PPGs must report and submit UM information to Blue Shield Promise as described below on a monthly, quarterly and annual basis.

Monthly reports are due to Blue Shield Promise by the 10<sup>th</sup> of the month following the month in which services were rendered or denials made, and include the following:

- a. Authorization Tracking Report- Include Authorization #, Member name, SSN#, requested date, approval date, Diagnosis, and requested services.
- b. Authorization Turnaround Time report
- c. Denials and Modifications – include all referral and denial/modification information and copies of all denial/modification letters.
- d. Case Management Log – include Member Name, SSN#, diagnosis, PCP, intervention, status of the case (open or close)
- e. Second Opinion Tracking log – include all authorizations, modifications and denial information for second opinion requests. The log must include the reason the second opinion was requested.
- f. Linked Services Logs – include Member name, SSN#, PCP name, diagnosis, and intervention

#### **Quarterly Reporting Requirements:**

- a. UM quarterly reports must be submitted to Blue Shield Promise by the 15<sup>th</sup> of the month following the end of the quarter (April, July, October and January). The report should include, at a minimum, UM activities, trending of utilization activities for under and over utilization, Member and provider satisfaction activities, and interrater reliability activities and improvement.

**Annual Reporting Requirements:** the following reports must be submitted annually to Blue Shield by the last day of February of each calendar year.

- a. UM Program Description: Reassessment of the UM Program Description must be done on an annual basis by the MSC
- b. UM Work Plan: submit an outline of planned activities for the coming year, including timelines, responsible person(s) and committee(s). The Work Plan should include planned audits, follow-up activities and interventions related to identified problem areas.

All reports must be submitted to Blue Shield Promise within the timeframes specified

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Persistent failure to submit required reports may result in action that includes, but is not limited to, request for Corrective Action Plan (CAP), freezing of new member enrolment or termination of Blue Shield Promise agreement.

Weekly inpatient bedday report: the inpatient report should include Member Name, SSN#, Diagnosis, facility, admit/discharge dates, and CCS status (if applicable). **This report applies to full risk contract only.**

## **REFERENCES/AUTHORITIES:**