



Promise Health Plan

POLICY & PROCEDURE

Medical Services

Policy Title: Utilization Management Standards for Medical Decision Making Process			
Policy No: 90.2.42		Original Date: 3/13	
Effective Date: 12/18	Revision Date: 7/13, 12/18		Revision No: 2
Department Head:	Date:	Medical Services/P&T Committee:	Date:
P&P Committee:	Date:	Department(s): UM	

PURPOSE:

To establish criteria for the approval, denial, or modification of authorization requests for services MMP enrollees. The criteria apply to the prospective, concurrent and retrospective review processes.

POLICY:

Blue Shield Promise Health Plan’s Chief Medical Officer Holds an unrestricted license to practice medicine in the State of California. He is responsible for the overall implementation and coordination of the Utilization Management Program and for ensuring that medical necessity determinations are made by qualified medical personnel.

Blue Shield Promise Health Plan ensures that decisions are based on the medical necessity of proposed healthcare services that are consistent with criteria and guidelines supported by scientific-based medical evidence and principles, and rendered in a method appropriate to the member’s condition.

Blue Shield Promise uses Milliman Care Guidelines and other evidenced-based criteria for use in making medical necessity determinations. The term “Medically Necessary” includes all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

Care1st’s UM criteria comply with Medicare Managed Care’s National and Local Coverage Determination, Benefit Interpretation Manual, general Medicare coverage guidelines, and written coverage decisions of local Medicare contractors.

Determinations on decisions that are, or that could be considered covered benefits, are defined by Care1st, including hospitalization and emergency services listed in the “Evidence of coverage” or

summary of benefits and care or service that could be considered either covered or non-covered, depending on the circumstances.

These guidelines are adopted with involvement from board certified actively participating health care providers, updated to the most current version available, and are evaluated annually by the Medical Services Committee.

1. No individual other than a licensed physician may deny or modify requests for medical necessity
2. In making medical necessity determinations, only information that is reasonably necessary to make a decision will be requested by the Plan.
3. When appropriate, Blue Shield Promise Health Plan's CMO may assemble a panel of board certified independent experts to assist in this determination. At Blue Shield Promise Health Plan level, adverse decisions may be appealed to the Plan CMO or designee. Additional appeals may be pursued in accordance with Blue Shield Promise policy, if there is disagreement with the plan. Blue Shield Promise notifies practitioners of its policy for naming a reviewer available to discuss any UM decision, and how to contact the reviewer. Information is available on the Blue Shield Promise website.
4. Criteria are applied in a consistent and appropriate manner based on available medical information and the needs of individual MMP members. The application of criteria takes into consideration individual factors, such as
 - a. LOS for in-patient stays or SNF stays that require condition specific reviews.
 - b. Complications of services that may affect co-morbidity
 - c. Complications of services that may affect age
 - d. Services that may affect unexpected complications
 - e. Complications of services that may affect progress of treatment
 - f. Complications of services that may affect progress of psychosocial issues
 - g. Complications of services that may affect home environment education or support
 - h. Individual needs of an MMP member
 - i. Other factors that may impact the ability to implement an individual Member's care plan.
5. Application of criteria also takes into consideration:
 - a. Capabilities of the Local Delivery System, such as but not limited to:
 - i. Whether services are available within the service area
 - ii. Benefit coverage

PROCEDURE:

Medical Necessity Determinations:

Only appropriate medical professionals review all medical necessity denials of service offered under Blue Shield Promise Health Plan's medical benefit, which include the following:

- Decisions about covered medical benefits, including hospitalization and emergency services;

- Decisions about pre-existing conditions when the member has creditable coverage;
- Decisions about services that could be considered either covered or non-covered, depending on the circumstances, including decisions on requests for care that may be considered experimental;
- Decisions about dental procedures that are covered under the member's medical benefits.

Requests for experimental or investigational procedures are subject to review for medical necessity, unless the procedure is specifically excluded in the member's benefit plan.

Benefit Determinations:

A benefit determination, a denial of service that is specifically excluded from the MMP member's benefit plan includes the following:

- Decisions about services that are limited by number, duration, or frequency in the member's benefit plan;
- Denials for extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan;
- Decisions about care that do not depend on any circumstances

Review of appropriate practitioner is not required for requests for medical services that are specifically excluded from the benefit plan.

Documentation of Appropriate Professional Review:

Documentation may consist of a handwritten signature, handwritten initials or unique electronic identifier on the letter of the denial or on the notation of denial in file.

Authorization requests shall be processed in accordance with the guidelines established in P&P 10.2.11 – MediCal or 50.2.11 – Medicare Authorization Denial, Pending/Deferral, and/or Modification Notification and P&P 70.2.50 Prior Authorization Review & Approval Process.

Disclosure of Criteria:

Blue Shield Promise will disclose the criteria or guidelines used to make medical necessity determinations upon request by a provider, member, or the public. The criteria or guidelines disclosed will be for the specific procedure or conditions requested. The following notice will accompany the disclosure:

“The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.”

A log of all requested disclosures of UM criteria or guidelines will be maintained by the UM Department. The log will summarize the number of disclosures to providers, members, or the public and the details of the disclosure such as date, criteria disclosed, etc.

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REFERENCES/AUTHORITIES:

Title 22, CCR, Section 51303 (a)
Medicare Managed Care Manual, Chapter 13
Health & Safety Code, Section 1367