blue california
Promise Health Plan

Policy Title: Authorization Denial, Pending/Deferral, and/or Modification Notification		POLICY #: 10.2.11 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 11/97	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 3/21**	

PURPOSE

To establish a standardized internal process for the Blue Shield of California Promise Health Plan ("Blue Shield Promise") Utilization Management (UM) Department that outlines the appropriate procedure for denying, pending, and/or modifying authorization requests and subsequent notification to contracted providers and members in accordance with NCQA UM 8 standards and within timeframes as set per Title 22, CCR, Sections 51014.1 and 53894.

POLICY

Decisions to deny, pend, defer or modify a Treatment Authorization Request (TAR) based upon medical necessity or benefit determination will only be made by a physician. The signature of the Chief Medical Officer (CMO) or the reviewing physician is required on the denied authorization request form and the denial/modification/deferral notification. Practitioners and members, and/or their authorized representative, will be notified in writing of a denial, deferral, or modification of a request for approval to provide health care service determinations and members informed of their rights as per Title 22, CCR, Sections 51014.1, 51014.2, 53894, and Health & Safety Code Section 1367.01. The member has the right to be represented by anyone the member chooses including legal counsel, friend, or other spokesperson and have that representative act of their behalf at all levels of an appeal.

PROCEDURE

Post Stabilization

1. A decision will be made within 30 minutes or less or the serve is deemed approved.

Non-Urgent Care in an Emergency Department

1. A decision will be made within 30 minutes or less or the service is deemed approved.

Routine/Standard

1. A decision will be made if all the necessary information is received at the time of the request. When making a determination of coverage based on medical necessity, relevant clinical information shall be obtained with a consultation with the requesting practitioner when necessary. Clinical information which is necessary will be requested by the UM coordination under the direction of the licensed staff (nurse and physician reviewer) to apply the appropriate UM Criteria, including at least:

    - Presenting problem and history, including patient, family and psychosocial history;
    - Clinical exam findings, diagnostic test results and photographs, as appropriate;

- Office and hospital records including treatment plans, progress notes, operative and pathological reports from the local delivery system;
- Information from consulting providers and practitioners including rehabilitation evaluations;
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.

The practitioner will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working of the decision following the guidelines below.

2. If additional clinical information is required, or a consultation by an expert reviewer is necessary, or an additional examination or test is to be performed, a written deferral notice will be issued to the provider and the member. The provider will be notified in writing of the additional information requested, additional examination or test to be performed or the need for a consultation by an expert reviewer. Within 14 calendar days, if the additional information has not been submitted by the provider, Blue Shield Promise will issue a written denial notification to the member and the provider within 2 working days of the determination (but within the 14 day timeframe). Providers will be notified verbally or electronically within 24 hours of the determination.

If the requested information is received, a decision will be made within 24 hours of receipt of the information. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below. NOTE: Any decision delayed beyond the time limits is considered a denial and must be processed immediately as such.

Expedited

1. Where a provider requests or Blue Shield Promise/Provider Group determines that standard timeframes could seriously jeopardize a member's life or health, or ability to attain, maintain, or regain maximum function and all necessary information is received at the time of the request, a decision will be made within 72 hours of the request. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below.

2. If additional clinical information is required, or a consultation by an expert reviewer is necessary, or an additional examination or test is to be performed, a written deferral notice will be issued to the provider and the member. The provider will be notified in writing of the additional information requested, additional examination or test to be performed or the need for a consultation by an expert reviewer. If, within fourteen (14) calendar days, the additional information has been submitted by the provider, Blue Shield of California Promise will issue a written denial notification to the member and the provider within two (2) working days of the determination, but within the fourteen (14) day timeframe. Providers will be notified verbally or electronically within twenty-four (24) hours of determination.

If the requested information is received, a decision will be made within 24 hours of receipt of the information. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below. NOTE: Any decision delayed beyond the time limits is considered a denial and must processed immediately as such.

Inpatient Concurrent/On-going Ambulatory Services

1. A decision will be made regarding inpatient continued stay/level of care within twenty-four hours of receiving updated concurrent clinical information on the patient's medical condition and need for continued acute stay. The treating provider and inpatient concurrent facility will be notified within twenty-four (24) hours of the decision either orally or electronically. If inpatient con-current/on-going ambulatory services are denied or modified, both member and provider will be notified within twenty-four (24) hours of receipt of the requests for services. If oral notification is given within twenty-four (24) hours, then written/electronic notification must be given no later than 3 calendar days after the oral notification. The member will be notified within 24 hours of receipt of the request for approval decisions.

NOTE: In the case of concurrent review, care shall not be discontinued until the enrollee's treating providers has been notified of the plan's decision, and a care plan has been agreed upon the treating provider that is appropriate for the medical needs of the patient.

In-Patient Hospice

1. A decision will be made within 24 hours of the request. The practitioner will be notified within twenty-four (24) hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below.

Retrospective

1. A decision will be made within thirty (30) calendar days from the receipt of the request. The Practitioner will be notified in writing within two (2) working days of the determination not to exceed 30 calendar days from the receipt of the request.

2. If additional clinical information is required, or a consultation by an expert reviewer is necessary, the request will be deferred, and the practitioner notified. The determination will be made as soon as the reviewer is aware that additional information is needed but not more than 30 days from the receipt of the request.

If the requested information is received a decision will be made within five (5) working days not to exceed 30 calendar days from receipt of the request. The Provider will be notified in writing within two (2) working days of the determination not to exceed 30 calendar days from receipt of request.

If the requested information is incomplete or not received, a decision will be made based upon the information that is available by the end of the thirtieth (30th) calendar day from receipt of the request. The practitioner will be notified in writing within thirty (30) calendar days from receipt of the request.

Notification Requirements

1. Provider Notification

Blue Shield Promise will provide written notification decision to deny, defer, modify requests to the member; member's authorized representative on a standardized form informing the provider of the following:

- The requesting provider will be notified of any decision to deny, approve, modify or delay a request, or to authorize a service in an amount, duration, or scope that is less than requested within twenty-four (24) hours of the decision. The notice to the provider may be orally or in writing.

- The communication to the provider shall include the name and telephone number of the health care professional responsible for the determination. The rationale is to afford the provider the opportunity to discuss the denial determination with him/her if the denial was based on medical necessity.
- A disclosure of the specific utilization review criteria/guideline or benefit provision used as a basis for the denial will be included.
- Criteria/guidelines will be disclosed upon request to the public, provider, or member the disclosure shall be accompanied by the following notice:

"The materials provided to you are guidelines used by Blue Shield of California Promise Health Plan to authorize modify or deny care for person within similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

Applies to Medi-Cal, Line of Business: *Refer to Medi-Cal LOB Denial Letter Template*

- Practitioners will receive sufficient information in the Notice of Action letter to understand and decide whether to an appeal a decision to deny, modify, or delay care or coverage.

2. Written Member Notification

Blue Shield of California Promise will provide written notification decision to deny, defer, or modify requests to the member or member's representative on a standardized form informing the provider of the following:

- The written response to the member must include clear and concise explanation of the reason for the denial or modification of requested services(s), and the specific clinical criteria used for the determinations to the denial or modification letters. (Member has a right to a request a written copy of the criteria or benefit provision used in the decision).

Applies to Medi-Cal Line of Business: *Refer to Medi-Cal LOB Denial Letter Template*

- Criteria/guidelines will be disclosed upon request to the public, provider, or member The disclosure shall be accompanied by the following notice:

"The material provided to you are guidelines used by Blue Shield of California Promise Health 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."

- Practitioners will receive sufficient information in the Notice of Action letter to understand and decide whether to appeal a decision to deny, modify, or delay care or coverage.
- The right to appeal to the Department of Managed Health Care (DMHC) if not satisfied with the appeal decision at the Health Plan level.
- The notice to the member will inform the member that he/she may file an appeal concerning the determination using the health plan's grievance/appeal process within at least 90 days of the decision (as prescribed by the statute), prior to or concurrent with the initiation of a State Fair Hearing process, and the right to submit a written comments, documents or other information relevant to the appeal.
- How to initiate an expedited appeal at the time they are notified of the denial including the member's right to call the State Medi-Cal Managed Care "Ombudsman Office" for answering questions or help in appealing the decision.
- The member's right to, and method for obtaining, a State Fair Hearing and the member's right to represent himself/herself at the State Fair Hearing or to be represented by Legal counsel or other spokesperson.
- The member's right to request an Independent Medical Review (IMR)

- The name and address of entity making the determination.
- The name and address of Blue Shield of California Promise and the State's toll-free telephone number for obtaining information on legal service organizations for representation.
- The Department of Managed Health Care's toll-free telephone number to receive complaints regarding a grievance against the Plan that has not been satisfactorily resolved by the Plan to the member's satisfaction.
- Possible alternative treatments or care.
- Blue Shield Promise shall provide notification to beneficiaries and representatives in accordance with the timeframes set forth in Title 22, CCR Sections 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third (3rd) working day after the decision is made, not to exceed fourteen (14) calendar days from receipt of the original request.
- Blue Shield Promise shall notify members of a decision to deny, delay, modify or terminate requests of Prior Authorization, in accordance with Title 22, CCR, Sections 51014.1 and 53894 by providing written notification to members, and or their authorized representative, regarding any denial, deferral, or modification of a request for an approval to provide a health care service.

Pending Treatment Authorization Requests:

1. Upon receipt of a treatment request it will be triaged and processed:
    - Routine/Standard
    - Expedited
    - Concurrent
    - Hospice
    - Retrospective

2. When a determination has been made to pend the authorization request the following information will be entered into the MHC system:
    - The reason for pending
    - Any attempts to request information
    - Any communication that has transpired with the provider to date.

3. During the pending process, a hard copy of the request will be filed into a separate pending accordion file system within the UM Department. This will afford staff convenience in accessibility in the event that an inquiry about the request occurs or further information is submitted.

4. A Request for Medical Information Form will be faxed to the provider. The form will specify what information is required. (See attached).

5. Pended authorizations are flagged in the MHC System.

6. An aging report of the pended authorizations will be generated from the MHC system each business day for turnaround timeframe compliance.

7. If the medical Director makes the determination to approve or deny the request it will be processed per the standard UM procedures for processing an authorization.

REFERENCES

NCQA UM 2 & 8
Title 22, CCR, Sections 51014.1, 51014.2, 53894

Health & Safety Code Section 1367.01

ATTACHMENTS:
UM Timeliness Standards – Medi-Cal UM TAT Grid (California)
UM Timeliness Standards – CMS
UM Denial Reason Grid and Medical Necessity Example