blue california
Promise Health Plan

Policy Title: Utilization Management Decision Making Time-Frames		POLICY #: 10.2.43 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 11/15	**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: 321**	

PURPOSE

To implement processes to ensure that Blue Shield of California Promise Health Plan's (Blue Shield Promise) Medical Management Department conducts utilization decisions in a timely manner in order to minimize disruption in the provision of health care to members.

POLICY

Requests for utilization management (UM) determinations are accepted from the member, the member's authorized representative, a provider, or the health plan on behalf of the member.

All UM referral request, decisions, notifications and all pertinent related actions are documented in the UM Information Technology files: Facets, Authaccel, MHC, and CITS.

PROCEDURE

I. Procedures for UM referral processing

In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to members, based in whole or in part on medical necessity, Blue Shield Promise Health Plan will adhere to the following requirements:

1. Shall be made in a timely fashion appropriate for the nature of the member's condition, not to exceed **five business days** from receipt of the information reasonably necessary and requested to make the determination.
    a. Practitioner will be initially notified within 24 hours of the decision
        i. Decision will be available via Interactive Voice Response (IVR) and Provider Portal

2. When the member's condition is such that the enrollee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process, would be detrimental to the member's life or health or could jeopardize the member's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the member's condition, **not to exceed 72 hours**.

3. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make the determination, and shall be communicated to the provider in a manner that is consistent with current law.

4. If an extension is needed to collect information reasonably necessary to make a determination that is based on medical necessity, the request will be deferred up to but no longer than 14 calendar days from the receipt of the request. Examples of reasonably necessary information may include:
    a. Additional clinical information required;
    b. Require consultation by an Expert Reviewer;
    c. Additional examination or tests to be performed

5. If a deferral is required Blue Shield Promise will notify the member and practitioner of decision to defer, in writing using the deferral Notice of Action template (NOA):
    a. Within 5 working days of receipt of request
    b. Provide a total of up to 14 calendar days from the date of receipt of the original request

6. Communications regarding decisions to approve requests by practitioners will specify the specific health care service approved.

7. Denial decisions are made in accordance with state licensure requirements Health and Safety Code.

8. Practitioner notification of the availability of physician and behavioral health reviewers to discuss decisions will ensure that practitioners receive information sufficient to understand and discuss with the member about appealing a decision to deny care or coverage.

9. For all telephonic notifications, practitioner/provider/member name, the time, date, and name of the UM representative who spoke with the practitioner/provider/member will be documented.

II. Turn-around-times Tracking

1. To ensure compliance with turn-around-times (TAT) the UM department has implemented the following:
    a. A tracking system that monitors all UM Referrals for documentation/identification of request status and time frames for processing.
    b. A process to include periodic audits for UM referral timeframe compliance monitoring.
        i. A process to include periodic audits for UM referral timeframe compliance monitoring.
            1. The timeframes adhered to are inclusive of the entire UM process, from the receipt of the request for a UM decision to the issuance of the decision to include sending of the written notification for adverse determinations.

III. Referral Process Timelines

Blue Shield Promise Health Plan will follow the current Medi-Cal ICE Timeliness Standards located on the ICE website at www.iceforhealth.org. See Attachment

To implement process to ensure that Blue Shield Promise Health Plan's Medical Management Department conducts utilization decisions in a timely manner in order to minimize disruption in the provision of health care to members.

REFERENCES

CA Health & Safety Code §1367.011371.01 (h) (1-3,5)
NCQA UM 5.A-D;29
CFR §2560.503 – 1 (f) (2) (i), (f) (2) (ii) (B), (f) (2) (iii) (A-B), (g) (2)

ATTACHMENTS:

ICE UM TAT – Medi-Cal