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Line of business: Medicare Adv</td></tr>
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Utilization Management</td><td>Original Date
5/08</td><td colspan="2">Effective Date
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PURPOSE

To establish and define a process for timely processing of an expedited organization determination, as set forth in Chapter 13 of the Medicare Managed Care Manual.

POLICY

Blue Shield of California Promise Health Plan's (Blue Shield Promise) Utilization Management Department provides a process for the timely processing of a Blue Shield Promise Health Plan expedited organization determination, in accordance with the guidelines in CMS Managed Care Manual Chapter 13.

OPERATING PROTOCOL: Refer to P&P 50.2.22 Standard Organization Determination
RIGHTS OF ENROLEES: Refer to P&P 50.2.22 Standard Organization Determination

Expedited Organization Determination Process:
An enrollee or any physician (regardless of whether the physician is contracted with Blue Shield Promise Health Plan) may request that Blue Shield Promise expedite an organization determination. If it is determined by Blue Shield Promise Health Plan to expedite the request, a decision will be rendered as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request. Expedited requests apply to the following:

- The enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy;

- Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the enrollee has already received. However, if a case includes both a payment denial and a pre-service denial, the enrollee has a right to request an expedited appeal for the pre-service denial;

- When asking for an expedited organization determination, the physician must submit either an oral or written request directly to the organization, or if applicable, to Blue Shield Promise's delegate responsible for making the determination. A physician may also provide oral and written support for an enrollee's request for an expedited determination.

PROCEDURE

Receipt of Expedited Requests

During Business Hours:

- Blue Shield Promise has a dedicated fax line for expedited requests made by an enrollee, a representative, or any physician regardless of whether the physician is affiliated with Blue Shield Promise Health Plan.

- The UM Coordinator in receipt of the expedited request indicates the date and time of receipt of oral or written request into the Authorization/Claims System.

- The UM Coordinator scans the request and forwards it to the Case Manage, and immediately notifies the Case Manager by phone or e-mail.

During Weekends or After Business Hours:

1. Expedited requests after hours and during weekends are received and processed immediately by the nurse on call. The request is documented in the system with following information:
   a. Service being requested;
   b. Physician or provider to receive the service from;
   c. Provider or physician's phone number;
   d. Why the member/physician feels the request needs to be expedited;
   e. Name of the nurse processing the expedited request;
   f. Date and time of call in the particular case file;

2. The nurse contacts a Blue Shield Promise Physician Reviewer who is available after office hours and on weekends for clinical support as necessary.

Determining Whether to Process as Expedited:

Physician Request

If a request for an expedited organization determination is received from a physician, and the physician indicates in the request that using the standard timeframe could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request is automatically handled using the expedited process.

Member Request

If a request for an expedited organization determination is received from a member,

1. The case manager reviews the clinical information to determine if the request meets the criteria for expedited organization determinations. If the case manager determines the case needs further review, she prepares the case and reviews it with the Medical Director or physician reviewer. If the request does not have sufficient clinical information to support the request as expedited, the process for obtaining information is followed (see Insufficient Clinical Information below).

2. If the Physician Reviewer or Medical Director determines the case meets the criteria, the expedited process is followed (see Review of Request below).

3. If the Physician Reviewer or Medical Director determines the request does not meet the expedited criteria:
    a. The Physician Reviewer or Medical Director notifies Case Manager of this.

    b. The Case Manager transfers the request to the standard (14 day) organization determination process and sends the request back to the UM Coordinator.

    c. The UM Coordinator calls the member to notify him/her that the request is being transferred to the standard process and informs him/her of that process and the right to file an expedited grievance about the transfer decision.

    d. If UM Coordinator is unable to reach the member by phone, two more attempts are made within 24 hours of the decision to transfer. All telephone attempts are documented in the system.

    e. The Denial Coordinator generates a written notice (Expedited Criteria Not Met Notice, Attachment 1) that provides the following information:

        - That Blue Shield Promise is transferring the request to the 14-day timeframe for standard determinations;

        - That the member has the right to file an expedited grievance if he or she disagrees with Blue Shield Promise 's decision not to expedite the determination;

        - That the member has the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, the request will be expedited automatically; and

        - The UM Coordinator mails the letter within 24 hours of the decision to transfer to the standard process, in order to ensure that the member receives the notice within 3 calendar days of the request.

        - If the member grieves the transfer decision, the grievance will be processed according to Member Grievances' policy.

Insufficient Clinical Information

Determination

If the physician reviewer or Medical Director determines that there is insufficient clinical information to either determine whether the request should be handled as expedited, or whether the services requested can be approved, the Case Manager calls the provider requesting or providing the services, to request clinical information.

Request for Additional Information

1. If the provider's office does not respond to the request within 4 hours of initial contact, 2 additional attempts are made within 24 hours of receipt of the request. All attempts to contact the provider are documented in the system.

2. If the requested clinical information is not received within 24 hours of receipt of the request and the Medical Director determines that taking an extension to receive the clinical information is in the best interest of the member, an extension will be taken as follows:

   a. The Case Manager documents in the system that an extension is being taken and the justification for the extension.

   b. The UM Coordinator sends a written notice to the member within 24 hours of the decision to extend informing the member of the extension (Extension Needed for Additional Information Notice, Attachment 2). The notice provides an explanation of why Blue Shield Promise is taking the extension and the member's right to file a grievance if s/he disagrees with Blue Shield Promise decision to grant itself an extension.

Review of Request – Levels of Approval

Coordinator, Case Manager

1. The UM Coordinator automatically approves the request, if the item/service requested is on the Coordinator's automatic approval list (see Approved Determinations Section below).

2. If not on the automatic approval list, the UM Coordinator sends the request to the Case Manager for approval. The Case Manager automatically approves request if the item/service requested is on the Case Manager's automatic approval list (see Approved Determinations Section below).

3. If not on the list of automatic approval, the Case Manager sends the request to the physician reviewer for determination.

Physician Reviewer

1. The physician reviewer or Medical Director reviews the request and the clinical information to determine if the requested services are covered by Medicare and/or Blue Shield Promise.

   a. Blue Shield Promise makes determinations based on medical necessity that are consistent with criteria and guidelines supported by scientific-based medical evidence and principles.

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

   c. Other criteria or guidelines used are:
      - Milliman Care Guidelines
      - Apollo Medical Review Criteria

- Blue Shield of California Promise Health Plan's approved criteria
- Other evidence-based criteria consistent with nationally-acceptable standards of medical practice.

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

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

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

4. The physician reviewer or Medical Director determines if the services meet medical necessity criteria. If Blue Shield Promise intends to issue a partial or full denial of the requested service(s) based on lack of medical necessity (including a modification of the requested service), the decision is made by a Blue Shield Promise physician with sufficient medical and other expertise, using Medicare coverage criteria. Blue Shield Promise ensures that the physician making the denial decision has a current and unrestricted license to practice in California. The reviewing physician applies the prudent layperson standard in rendering the determination on emergency services.

5. The physician reviewer or Medical Director notifies Case Manager of the decision, including a specific and detailed reason if the decision is to modify or deny the requested services.

Approved Determinations

1. Upon notification from physician reviewer or Medical Director, the UM Coordinator enters the approval into the Authorization /Claims System. The UM Coordinator enters the following information into the system:
   a. Date and time of receipt of expedited request (if not already in system).
   b. Date and time the decision to approve was made.
   c. Date and time the provider was notified of the authorization.

2. The UM Coordinator calls the member (or member's authorized representative) to notify them of the approval. The date and time of the call and who the UM Coordinator spoke with are documented in the system.

3. If the member cannot be reached on the first attempt, two more attempts are made to verbally contact the member <u>within 24 hours of the decision</u>. These attempts are documented in the system.

4. If the member cannot be reached after 24 hours, the UM Coordinator then sends a written notice of the approval (Approval Notice, Attachment 3) within 24 hours of the decision **via overnight mail** to ensure the member receives the notice within 72 hours of receipt of the request.

Denied Determinations

1. Upon notification from the physician reviewer of Medical Director of a denied or modified request (which constitutes a partial denial), the UM Coordinator enters the denial into the system. The UM Coordinator enters the following information into the system:
    a. Date and time of receipt of expedited request (if not already in system);
    b. Date and time of the decision to deny or modify was made;
    c. Date and time of call to member or member's authorized rep (see below) and date and time the written notice was sent to the member;
    d. Date and time the provider was notified of the denial.

2. The UM Coordinator calls the member (or member's authorized representative) to notify them of the denial. The date and time of the call and who the UM Coordinator spoke with are documented in the system.

3. If the member cannot be reached on the first attempt, two more attempts are made to verbally contact the member within 24 hours of the decision. These attempts are documented in the system.

4. If the member cannot be reached by phone after **24 hours** of receipt of the request and decision, the UM Coordinator sends a written Notice of Denial of Medical Coverage or Payment (NDMCP)(Attachment 4) **via overnight mail** so that the member will receive the notice of the denial within 72 hours of the receipt of the request. The date and time of the **overnight mail** is documented in the system.

5. If the member is reached by phone within 24 hours of the request, the UM Coordinator informs the member of the denial, discusses the appeal process, then sends the NDMCP to the member within 24 hours, documenting in the system the date and time the notice was mailed.

6. The NDMCP provides the following:
    a. 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;

    b. 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 member's behalf;

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

7. 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 NDMC 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.

Types of Medical Beneficiary Notices

Attachments:

1. Expedited Criteria Not Met Notice – when the request for expedited determination is denied.

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

3. Approval Notice Form – If the organization determination is fully favorable.

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

   a. Denial of Medical Coverage (NDMCP) shall be written in a manner that is understandable to the member and shall provide:
      - The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any;

      - 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 CFT 422.570 and 422.566(b)(3);

      - 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;

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

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 Expedited Initial Organization Determination (EIOD) Process

The Outpatient and UM Quality Manager ensures the expedited process is followed:

1. The UM Data Analyst runs the urgent Medicare referral requests on a daily and monthly basis.

2. EIOD log is implemented, which reflect the date and time of decision, date and time of verbal notification of members, and date and time of mailing o the member and provide letters.

3. The UM Coordinator receives an attestation from the mailroom staff regarding the list of mails indicating the date and time the written notices for the organization determinations were sent out.

4. The Outpatient and UM Quality Manager reconciles the monthly report against the expedited log for the corresponding month.

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.

CMS – Centers for Medicare and Medicaid Services

MAO – Medicare Advantage Organization

Determination – A request for services indicates the enrollee believes the organization should provide the service. The request constitutes a determination.

REFERENCES

- CMS Managed Care Manual, Chapter 13
- 42 CFR 422.566, 422.568, 422.570 422,572
- UM P&P 70.2.72, Nurse Advice Line
- UM P&P 70.2.42, Standards for Medical Decision-Making
- Blue Shield of California Promise's UM Program