blue california
Promise Health Plan

Policy Title: Retrospective Review		POLICY #: 70.2.10 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 11/97	**Effective Date** 5/19	**Revision Date** 12/18
Department Head:		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable)		**Date: 3/21**	

PURPOSE

To establish and define mechanisms for the Blue Shield of California Promise Health Plan (Blue Shield Promise) Utilization Management (UM) Department to retrospectively review, approve, deny, or modify services.

POLICY

Blue Shield Promise reserves the right to perform retrospective review of care provided to its member for any reason. Care is subject to retrospective review when claims are received for services that were not authorized. All retrospective reviews are to be completed within 30 (thirty) calendar days of obtaining all necessary information. Notification of retrospective review determinations will be made in writing to the provider within 30 days of receipt of the information necessary to make a determination.

PROCEDURE

ER Claims:

Blue Shield Promise does not deny ER Claims. All ER Claims with Current Procedural Terminology (CPT) Codes 99284, or less, are automatically paid by the claims department. All ER Claims with CPT of 99285 are subject to retrospective review, to review the level of care given. The Claims Department shall request medical records for all 99285 claims and forward to the UM Department for review and adjudication. Claims with CPT Code 99285 are not denied, but, if after review they do not meet the severity of CPT Code 99285, they will be paid at CPT Code 99284.

Blue Shield Promise ensures reasonable reimbursement for covered emergency services as follows:

- Services obtained from both contracted and non-contracted providers up to the time the emergency condition of the member was stabilized.
- Services obtained from both contracted and non-contracted providers when the services were authorized by Blue Shield Promise
- Ambulance services dispatched through 911

Once medical records are received the claim is sent to UM for review. The case are sent to a physician reviewer for determination concerning the appropriateness of billed services and the level of care rendered. Based upon the physician reviewer's determination the claim may be authorized or modified.

Cases are then returned to the Claims Department for processing and filing.

NON-EMERGENT SERVICES:

The Claims Department will check non-emergent service claims for prior authorization. Non-emergent service claims include outpatient services, home health, DME, ancillary services etc. if prior authorization was obtained, the Medhok Auth Accel will contain information regarding the services authorized. If non-emergent service claims are for services other than those previously authorized, the claim will be sent to the UM department for review.

Once in UM the case will be logged in by a UM Coordinator and distributed to a Case Manager for review. The Case Manager may determine that a discrepancy exists between the services being billed and the services authorized. If the discrepancy does not involve a medical necessity determination, the case manager will resolve it making the appropriate notations in the Medhok Auth Accel system and return the case to the Claims Department for processing. If the case involves a medical necessity determination, the Case Manager will completely review the medical record comparing it to Milliman Care Guidelines. If the Case Manager determines Milliman Care Guidelines are satisfied, she/he will approve the case making the appropriate notations in Medhok Auth Accel and return the case to the Claims Department for processing.

Should the Case Manager determine that Milliman Care Guidelines are not satisfied, she/he shall summarize the case in the Medhok Auth Accel system and forward the case to the Chief Medical Officer or physician reviewer for a determination.

The Chief Medical Officer or the physician reviewer will review the medical record and the Case Manager's summary and make a determination to approve, deny, or modify the requested services. If approved, the case will be returned to the Claims Department for processing. If denied or modified, the UM Coordinator will prepare a denial or modification letter. Notification of the member and provider will occur as described above.

INPATIENTS STAYS:

Inpatient stays may be subject to retrospective review when they were not previously authorized or when there was insufficient information upon which an authorization determination could be made. When the Claims Department receives an inpatient claim that has not been authorized or has been pended/deferred, they will request a copy of the medical record from the provider. When the record is received, the case will be sent to the UM department for review.

Once in UM the case will be logged in by a UM Coordinator and distributed to a Case Manager for review. If the case involves a medical necessity determination, the Case Manager will completely review the medical record comparing it to Milliman Care Guidelines. If the Case Manager determines that Milliman Care Guidelines are satisfied, she/he will approve the case making the appropriate notations in Medhok Auth Accel and return the case to the Claims Department for processing. Should the Case Manager determine that Milliman Care Guidelines are not satisfied, she/he shall summarize the case in the Medhok Auth Accel system and forward the case to the Chief Medical Officer or physician reviewer for a determination.

The Chief Medical Officer or the physician reviewer will review the medical record and the Case Manager's summary and make a determination to approve, deny, or modify the requested services. If approved, the case will be returned to the Claims Department for processing. If denied or modified, the UM Coordinator will prepare a denial or modification letter. Notification of the member and provider will occur as described above.

REFERENCES

Health & Safety Code Section 1367.01