Policy Title: Utilization Management Decision Making Time-Frames (Medicare)			POLICY #: 70.2.94 Line of business: ALL
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: 3/21**

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 requests, decisions, notifications and all pertinent related actions are documented in the UM Information Technology files: Facets and Medhok Auth Accel.

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 **fourteen (14) calendar days** after receipt of request.

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 seventy-two (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 thirty (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. In cases when an Extension is indicated:
   - An Extension is allowed **only** if requested by member.
   - The provider and/or organization must justify the need for additional information.
     i. And is able to demonstrate how the delay is in the interest of the member
     ii. Example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny.
   - Extensions **must not** be used to pend organization determinations while waiting for medical records from contracted providers.

5. If an Extension is indicated Blue Shield Promise will notify the member by using the MA-Extension: Standard & Expedited to notify member and provider of an extension
   - And give notice **in writing** within 14 calendar days of receipt of request.

6. The extension notice must include:
   - The reasons for the delay.

   - The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension.

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

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

9. 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.

10. For all telephonic notifications, practitioners, providers. Member's name, the time, date, and UM representative name, who spoke with the practitioner, provider, and or member will be documented.

II. Turn- Around-Times Tracking

To ensure compliance with turn-around-times (TAT) the UM department has implemented the following:

1. A tracking system that monitors all UM Referrals for documentation and identification of request status and time frames for processing.

2. A process to include periodic audits for UM referral timeframe compliance monitoring.
   a. 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 Timeliness

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

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 - CMS