blue california
Promise Health Plan

Policy Title: Utilization Management Decision Making Time-Frames		POLICY #: 10.2.22 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 11/15	**Effective Date** 5/19	**Revision Date** 12/18, 2/22, 9/22
Department Head: Sr. Director, UM		**Date: 10/22**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 10/22**	

PURPOSE

To establish criteria for the approval, denial, or modification of authorization requests for services. The criteria apply to the prospective, concurrent and retrospective review processes.

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: Authaccel

It is the policy of Blue Shield of California Promise Health Plan (Blue Shield Promise) to ensure that decisions are based on the medical necessity of proposed healthcare services that are consistent with criteria and guidelines supported by scientific-based medical evidence and principles and rendered in a method appropriate to the member's condition.

Blue Shield Promise will disclose the criteria or guidelines used to make medical necessity determinations upon request by a provider, member, or the public. The criteria or guidelines disclosed will be for the specific procedure or conditions requested. The following notice will accompany the disclosure:

"The materials provided to you are guidelines used by his 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."

A log of all requested disclosures of UM criteria or guidelines will be maintained by the UM Department. The log will summarize the number of disclosures to providers, members, or the public and the details of the disclosure such as date, criteria disclosed, etc.

Blue Shield Promise Health Plan's Chief Medical Officer is responsible for ensuring that medical necessity determinations are made by qualified medical personnel. The Chief Medical Officer does not have any fiscal or administrative management responsibilities that would hinder his/her duties.

Medical Necessity Determinations:
Only appropriate medical professionals review all medical necessity denials of service offered under Blue Shield Promise Health Plan's medical benefit, which include the following:

- Decisions about covered medical benefits, including hospitalization and emergency services;
- Decisions about pre-existing conditions when the member has creditable coverage;
- Decisions about services that could be considered either covered or non-covered, depending on the circumstances, including decisions on requests for care that maybe be considered experimental;
- Decisions about dental procedures that are covered under the member's medical benefits.
- Decisions about pharmacy-related requests regarding step-therapy or prior authorization cases.

Requests for experimental or investigational procedures are subject to review for medical necessity, unless the procedure is specifically excluded in the member's benefit plan.

Benefit Determinations:
Blue Shield Promise does not cover or authorize a request for benefits that are specifically excluded from the benefit plan, even when the member requests coverage based on medical necessity.

A benefit determination, a denial of service that is specifically excluded from the member's benefit plan includes the following:

- Decisions about services that are limited by number, duration, or frequency in the member's benefit plan;
- Denials for extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan;
- Decisions about care that do not depend on any circumstances.

Review of appropriate is not required for requests for medical services that are specifically excluded from the benefit plan.

Documentation of Appropriate Professional Review:
Documentation may consist of a handwritten signature, handwritten initials or unique electronic identifier on the letter of the denial or on the notation of denial in the file. For electronic signatures, appropriate controls are followed to ensure that only the individual indicated may enter a signature documentation of the denial may also consists of a signed or initialed note from a UM staff person who attributes the denial decision to the specific professional who reviewed and decided the case. This staff person documents her/his name, date, and time entry.

Monitoring for Consistent Review Criteria Application
The Quality Audit Team performs ongoing monitoring of UM nurse/physician reviewer criteria/guideline application to:
• Measure the reviewer's comprehension of the review criteria and guideline application process
• Ensure accurate and consistent application of the criteria among staff reviewers
• Ensure criteria and guidelines are utilized per policy and procedure
• Ensure a peer review process for inter-rater reliability

PROCEDURE

Blue Shield Promise adopted the use of Milliman Care Guidelines and other evidenced-based criteria for use in making medical necessity determinations. The term "Medically Necessary"

includes all Covered Services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury. {Title 22, CCR, Section 51303(a)}. It also means those services that are reasonable and necessary for the diagnosis or treatment of illness or injury, or for the improvement of functioning of a malformed body member, otherwise medically necessary, under 42 U.S.C §1395y.
Blue Shield Promise applies the UM Hierarchy for use of UM criteria;

1. CMS National Coverage Determination
2. CMS Local Coverage Determination
3. CMS Benefit Interpretation Manual
4. DHCS Medi-Cal UM Criteria (as available and updated on the DHCS website)
5. Milliman Care Guidelines
6. National Guideline Clearinghouse
7. Nelson Textbook Pediatrics
8. Optum Procedural Coding Expert
9. Hayes Criteria
10. World Professional Association for Transgender Health (WPATH)
11. AIM Specialty Health Radiology Guidelines
12. National Comprehensive Cancer Network Guidelines (NCCN)
13. Blue Shield Promise Health Plan approved criteria
14. Other evidence-based criteria consistent with nationally-accepted standards of medical practice

Blue Shield Promise also draws from and follows recommendations of a number of objective, nationally recognized sources in the development of medical policy and criteria related to preventive care, admissions, outpatient surgeries and diagnostic and therapeutic services. Examples of these organizations include:

- American academy of Pediatrics
- Centers for Disease control
- American College of Obstetrics and Gynecology
- Diagnostic and Treatment Technology Assessment (DATTA)
- Food and Drug Administration (FDA)
- US Preventive Services Task Force

Blue Shield Promise will also allow their contracted delegates to use any evidence-based criteria that are consistent with nationally accepted standards of medical practice to the health plan after it is submitted for approval before it is used for its members in making medical necessity determination.

Blue Shield Promise's UM criteria comply with Medicare Managed Care's National Coverage Determination, general Medicare coverage guidelines, and written coverage decisions of local Medicare contractors.

Determinations on decisions that are, or that could be considered covered benefits, are defined by Blue Shield Promise, including hospitalization and emergency services listed in the "Evidence of coverage" or summary of benefits and care or service that could be considered either covered or non-covered, depending on the circumstances.

These guidelines are adopted with involvement from board certified actively participating health care providers; are consistent with criteria or guidelines, supported by sound clinical

principles and processes, updated to most current version available, and are evaluated by the Medical Services Committee.

1. No individual other than a licensed physician may deny or modify requests for medical necessity.

2. In making medical necessity determinations, only information that is reasonably necessary to make a decision will be requested by the Plan.

3. When appropriate, Blue Shield Promise Health Plan's CMO may assemble a panel of board-certified independent experts to assist in this determination. At the Blue Shield Promise Health Plan level, adverse decisions may be appealed to the Plan CMO or designee. Additional appeals may be pursued in accordance with Blue Shield Promise notifies practitioners of its policy for naming a reviewer available to discuss any UM decision, and how to contact the reviewer. Information is available on the Blue Shield Promise website: https://www.blueshieldca.com/promise/index.asp

4. Criteria are applied in a consistent and appropriate manner based on available medical information and the needs of individual Members. The application of criteria takes into consideration individual factors, such as
    a. LOS for in-patient stays or SNF stays that require condition specific reviews
    b. Complications of services that may affect co-morbidity
    c. Complications of services that may affect age
    d. Services that may affect unexpected complications
    e. Complications of services that may affect progress of treatment
    f. Complications of services that may affect progress of psychosocial issues
    g. Complications of services that may affect home environment education or support
    h. Other factors that may impact the ability to implement an individual Member's care plan.

5. Application of criteria also takes into consideration:
    a. Capabilities of the Local Delivery System, such as but not limited to:
        i. Whether services are available within the service area
        ii. Benefit coverage

6. Authorization requests shall be processed in accordance with the guidelines established in P&P 10.2.8 Authorization Denial, Pending/Deferral, and/or Modification Notification and P&P 10.2.38 Prior Authorization Review & Approval Process.

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 business 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)
DHCS APL 21-011