blue california
Promise Health Plan

Policy Title: Benefit/Preventative Health Algorithms for Authorizations		POLICY #: 10.2.37 Line of business: MCAL	
Department Name: Utilization Management	**Original Date** 1/00	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 10/22**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 10/22**	

PURPOSE

To establish and define mechanisms for the Blue Shield of California Promise Health Plan (Blue Shield Promise) Utilization Management (UM) Department to review, approve or deny, monitor, control, account for, and report member utilization of preventive health and auto-benefit services.

POLICY

Blue Shield Promise members may access preventative health services and pre-established auto benefits based on the periodicity as well as other benefits both within and outside of the Blue Shield Promise provider network on a self-referral basis as mandated per Title 10, California Code of Regulations (CCR), Chapter 5.8 for Healthy Families members and Title XIX of the Federal Social Security Act, Title XXII, California Code of Regulations (CCR) for Medi-Cal, and Center for Medicare Services for Medicare Recipients. The algorithms are based on benefits that do not require any clinical decision. They consist of preventative health services, health education services and mandatory regulatory entitlements that members may access without the prior approval of Blue Shield Promise Health Plan.

PROCEDURE

1. Algorithms are approved at the coordinator level
2. The Utilization Management (UM) coordinators are non-clinical employees who have had either medical terminology training, medical office experience or other related experience. They report to the Manager of UM.
3. These personnel are not involved in any decision-making that requires clinical judgment.
4. All incoming referrals are screened an triaged by the UM Manager or a clinical designee in his or her absence
5. Auto benefit referral requests are forwarded to the UM Coordinators
6. The coordinators verify eligibility
7. The member history is reviewed in the MHC system to ascertain that the benefit appropriately falls within the periodicity of the request, meets the demographic specifications and other applicable criteria to qualify for the benefit.

8. If the provisions are met the coordinator completes the data entry portion of the authorization and processes it per the standard policy and procedure for the handling of Treatment Authorization Requests
9. If the request does not satisfy the auto benefit criteria it will be forwarded to a licensed nurse for clinical review.

REFERENCES