blue california
Promise Health Plan

Policy Title: UM Prior Auth Review		POLICY #: 70.2.50 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 4/04	**Effective Date** 12/18	**Revision Date** 12/18, 1/20, 7/21, 11/21, 2/22
Department Head: Mirela Albertsen, UM Senior Director			**Date: 6/28/22**
Medical Services/P&T Committee: (If Applicable)			**Date: 6/30/22**

PURPOSE

The Blue Shield of California Promise Health Plan (Blue Shield Promise) Medical Services Committee (MSC) oversees the development and implementation of an effective referral/authorization process. This process and structure involve the Utilization Management (UM) Program's methods for reviewing and authorizing requested healthcare services. Responsibilities are assigned to the appropriate health care professionals. The process is evaluated, updated and approved annually by the MSC.

The UM Staff work within their scope of practice and in conjunction with the Chief Medical Officer (CMO) or physician designee to process authorizations appropriately. The CMO has substantial involvement in the authorization review and approval process. Appropriately licensed health professionals will supervise all review decisions.

POLICY

Blue Shield Promise will ensure that appropriate processes are used to review and approve the provision of medically necessary covered services. Blue Shield Promise shall authorize medically necessary in accordance with the regulations, even though the procedures or services may not be listed as covered by Medi-Cal. The "Treatment Authorization Request (TAR) and Non-Benefit List" published by the Department of Health Care Services shall be used as a guideline only.

Decisions to approve, deny, delay, or modify will be based on medical necessity. These decisions will reflect appropriate application of Blue Shield Promise approved criteria/guidelines. Any decision to deny, modify or delay a a request, shall be made by a physician. Physician consultants from appropriate specialty areas of medicine and surgery who are eligible for certification by the applicable American Board of Medical Specialties will be utilized as necessary. Blue Shield Promise does not compensate practitioners or other individuals for denials of coverage or service.

MSC performs quarterly reviews of UM reports to assure and improve quality of care for Blue Shield Promise members. Quarterly reports reviewed at the MSC include prior authorization denials, deferrals, modifications, over/under utilization, continuum of care, as well as appeals and overturns. Report reviews and associated quarterly workplan updates are then reported to the Quality Management Committee (QMC) as part of the Blue Shield Promise quality improvement oversight.

Services that require prior authorization are as follows: (except those listed on Direct Referral Form)

- Out of Network Specialty referrals
- Out of Network Initial specialty consultation with the exception of OB/GYN consults
- Out of Network all follow-up specialty care
- Inpatient and Outpatient hospital care
- Out of Network Diagnostic services
- Out of Network Physical, occupational and speech therapy
- Home Health
- Infusion Therapy
- MRIs and CT Scans
- In Patient and all Out of Network Hospice Care
- Transplants
- Post-stabilization emergency care
- Custom-made durable medical equipment
- Non-Emergency Medical Transportation
- Partial Hospital Program for mental health and substance use disorders
- Intensive Outpatient Program for mental health and substance use disorders
- Electroconvulsive Therapy (ECT)
- Transcranial Magnetic Stimulation (TMS)
- Psychological and Neuropsychological Testing
- Applied Behavioral Analysis (ABA)

Services that never require prior authorization:

- Emergency services
- Outpatient Mental Health therapy and medication management
- Minor consent services
- Preventative services
- Basic Pre-Natal Care
- Family Planning
- Sensitive and confidential services i.e., minor abortion, sexually transmitted disease, HIV testing and counseling.
- Communicable disease services
- Crisis stabilization (including mental health).
- Urgent care and support for home and community service-based recipients
    - Outside the service area
    - Within the service area under unusual or extraordinary circumstances when the contracted medical provider is unavailable or inaccessible
- Minor consent services for individuals under the age of (18) are available of these services. Minor consent services that do not require parental consent are:
    - Pregnancy
    - Family planning services
    - Diagnosis and treatment of STDs in children 12 years of age or older
    - Abortion
    - Medical Care relate to sexual assault or rape
    - Drug and Alcohol abuse for children 12 years or older
    - Outpatient Mental Health care for children 12 years of age or older who are mature enough to participate intelligently and where either: (1) there is a danger of serious physical or mental harm to the minor or other, or (2) the children are the alleged victims of incent or child abuse.
    - Routine Hospice
    - Out-of-area renal dialysis services
    - Other services, as specified in the CMS – California Memorandum of Understanding and UM Direct Referral Form

- A doctor of podiatric medicine shall not be required to submit prior authorization for podiatric services rendered in either an outpatient or inpatient basis if a physician and surgeon providing the same services would not be required to submit prior authorization to the department.

No authorization shall be rescinded or modified after the provider renders the health care service in good faith for any reason including, but not limited to, subsequent recessions, cancellations or modification of the member's contract or when the delegate did not make an accurate determination of the member's eligibility.

PROCEDURE

1. For Medi-Cal prior authorization requests, the provider will complete the request for all services required and submit it to Blue Shield Promise UM Department via fax, phone or web portal. The provider shall include:
    a. Member's Name
    b. Language
    c. Date of birth
    d. Member ID #
    e. Demographic information
    f. Date of request
    g. Requesting provider
    h. Referral provider with address & phone number
    i. Diagnosis including ICD-9 code
    j. Reason for request
    k. Classification (Urgent, Routine, Retrospective)
2. Upon receipt of the request, the UM Coordinator will:
    a. Verify eligibility and benefits for requested service
    b. Determine if authorization request is a duplicate of a previous request
    c. Enter the request into system of record
    d. UM Coordinators are non-clinical personnel who may collect data for preauthorization and concurrent review under the supervision of appropriately licensed health professionals. They may also have the authority to approve (but not to deny) services for which they are explicit criteria, as delineated by each product line.
    e. UM Coordinators may approve UM direct referrals and services that meet Blue Shield Promise's current lists of auto authorizations, as delineated by each product line.
3. For Medicare prior authorization requests, the UM Coordinator will forward these requests to the UM Clinician for review. The UM Clinician will evaluate the request using approved criteria/guidelines. If the requested service falls within the approved criteria/guidelines, the UM Clinician will approve if the requested service does not meet approved criteria/guidelines, the UM Clinician will forward it to the CMO or physician reviewer.
4. The CMO or physician reviewer shall review the request for medical necessity and make a determination to approve, deny, modify, or delay the requested service. If approved the request will be returned to the UM Clinician for processing. If denied, modified, or pended, the request will be returned to the UM Clinician to prepare a notification letter. The notification letter will be reviewed and signed by the physician making the determination before being sent to the provider and the member. The practitioner and the member will be notified of an approval denial, modification, or delay within the timeframes described below.

5. When considering approval of requested services, individual and local healthcare delivery system factors will be considered (see UM P&P 70.2.42 UM Standards for Medical Decision)

Processing Timeframes

- Emergency services are not subject to prior authorization
- Post-stabilization requests must be authorized in 30 minutes of less or they are deemed approved.
- Non-urgent care following exam in the emergency room request will be responded to within 30 minutes of the request or the request is deemed approved.
- Expedited or urgent requests will be processed in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours, regardless if all necessary information is received at the time of the request. An expedited request may be extended if:
    - Blue Shield Promise is unable to make a decision due to a lack of necessary information; the decision time frame may be extended once, for up to 48 hours.
    - Within 24 hours of receipt of the request, Blue Shield Promise shall notify the member or the member's authorized representative what specific information is necessary to make the decision.
    - Blue Shield Promise shall give the member or the member's authorized representative at least 48 hours to provide the information and notify the member or the member's authorized representative of this time period.
    - The 48-hour extension period, within which a decision must be made by Blue Shield Promise begins on either of the following:
    - The date on which the member's response is received (without regard to whether all of the requested information is provided), or at the end of the specified time period given to the member or the member's authorized representative to supply the information, if no response is received from the member or the member's authorized representative.
    - The practitioner will be notified orally or electronically as soon as the decision is rendered, but no longer than 24 hours of the decision to deny, defer, or modify the request.

Notice of Action:

The written Notice of Action shall be mailed to the member no later than 2 business days after the decision and shall specify the following:

- Action taken
- Reason for the action
- Citation of the specific regulation or procedure supporting the action
- Member's right to a fair hearing
- Routine requests will be processed within 5 working days if all the necessary information is received at the time of the request. The practitioner will be notified orally or electronically within 24 hours of the decision to approve, deny, defer, or modify the request. Members will be notified in writing within 2 working days of the decision.
    - The decision for Medi-Cal may be deferred and the time limit extended to a total of 14 calendar days.
- A notice of deferral shall be sent to a Medi-Cal member when the referral request is delayed. For routine authorization, the deferral letter shall be sent within 5 working days of the request, but the decision shall be made no longer than 14 calendar days from the receipt date of initial request.
- Any decision may be deferred, and the time limit extended an additional 14 calendar days only where the member or the member's provider requests an extension, or Blue

Shield Promise can provide justification upon request by the State the need for additional information and how it is in the member's interest.

DEFINITIONS:

Medicare definition of Medical Necessity

Medically necessary services are those that are responsible and necessary for diagnosis or treatment of illness or injury, or for the improvement of the functioning of a malformed body member, or otherwise medically necessary, under 42 U.S.C §1395y.

Medi-Cal Definition of Medical Necessity:

Medically necessary services are those services 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, as under Title 22 California Code of Regulations (CCR), Section 51303.

They are services for which there is no other medical service or site of service, comparable in effect, available and suitable for the enrollee requesting the service that is more conservative or less costly.

Medically Necessary services meet professionally recognized standards of healthcare substantiated by records, including evidence of such medical necessity and quality.

Benefit

A benefit is health care items or services covered under a health insurance plan. The covered services include a comprehensive set of health benefits which may be accessed as medically necessary.

Utilization Management (UM) Decision-making Criteria Sets:

UM Decision-making Criteria Sets are guidelines that are scientific and evidence-based, supported by sound clinical principles and processes, and are regularly reviewed and updated to the most current version available, including prescription drug coverage. Criteria may include nationally recognized criteria sets, locally developed criteria sets, or pre-determined criteria sets that are established in accordance with insurance coverage, i.e. Medicare and Medi-Cal.

The criteria sources utilized by Blue Shield Promise include but are not limited to:

1. CMS National Coverage Determination
2. CMS Local Coverage Determination
3. CMS Benefit Interpretation Manual
4. DHCS Medi-Cal UM Criteria
5. Milliman Care Guidelines
6. National Guideline Clearinghouse
7. Nelson's Textbook on Pediatrics
8. Optum 2019 Current Procedural Coding expert
9. Hayes Criteria
10. World Professional Association of 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

- Any decision delayed beyond the time limit is considered a denial and shall be processed as such.
- A notice of modification shall be provided to a Medi-Cal member when part of the authorization request is modified.

- For Medicare, the decision may be deferred, and the time frame extended to additional 14 calendar days, only when the member or the member's provider requests an extension, or the organization can justify how the extension will benefit the member. Refer to UM P&P 50.2.22 Medicare for authorization denials, deferrals & modification notification.

- Concurrent requests for ongoing ambulatory services (treatment regimen) will be processed within 5 working days or less consistent with the urgency of the member's medical condition. The practitioner will be notified orally or electronically within 24 hours of the decision to approve, deny, defer, or modify the request. Members will be notified in writing within 2 working days of the decision.

- Inpatient urgent concurrent review (acute hospital inpatient). A new request for inpatient care is considered urgent concurrent review and ongoing hospitalization requests are considered urgent concurrent review unless determined otherwise. A decision will be made within 24 hours of receipt of the request. The practitioner will be notified within 24 hours of the request for approvals and denials. The member and the practitioner will be notified within 24 hours of the request for approvals and denials. Written notification will be sent to the member and provider within 24 hours of the receipt of the request. Care shall not be discontinued until the patient's treating provider has been notified of Blue Shield Promise's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

- The request to extend urgent concurrent care was not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. The organization may make the decision within 72 hours.

- The request to approve additional days for urgent concurrent care is related to care not previously approved by Blue Shield Promise and Blue Shield Promise documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, the organization has up to 72 hours to make the decision.

- In-Patient Hospice requests will be processed within 24 hours of the request. Notification will take place within 24 hour timeframe. The practitioner will be notified orally or electronically within 24 hours of the decision to approve, deny, defer, or modify the request. Members will be notified in writing within 2 working days of the decision.

- Retrospective requests will be processed within 30 calendar days of receipt of the request. Notification will take place within the 30 calendar day timeframe. Practitioners will be notified in writing within 2 working days of the decision.

- Therapeutic Enteral Formula for Medical Conditions in Infants and Children

- Per plan contract requests for Therapeutic Enteral Formula (TEF) for members under 21 years of age BSC Promise will provide a response within 24-hours after receipt of the request for Prior Authorization and in accordance with PL 14-003.

Verbal or written notification for therapeutic enteral formula shall be provided to any provider requesting a service by prior authorization that is denied, approved, or modified in an amount, duration or scope that is less than that requested by provider.

Authorizations are valid for 30 days from the approval date as long as member is eligible with Blue Shield Promise. The provider should always verify member eligibility at the time of service.

Denial Notice:

1. The written notification of healthcare denials and appeals provided to the members and their treating practitioners are made in a timely manner, are not unduly delayed for medical conditions requiring time sensitive services and contain the following information:
    a. The specific reasons for the denial, clearly documented and in easily understandable language
    b. A reference to the provision, guideline, protocol or other similar criterion on which the denial decision is based
    c. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request. This is not applicable for Medicare members.
    d. For Medi-Cal Notice, a citation of the California Code of Regulation that supports the denial determination.
    e. A description of the members' rights in the denial letter and appeal process, including the right of member representation and timeframes for expedited appeals:
        i. For Medi-Cal
            1. Right to file an appeal with Blue Shield Promise within at least 60 days
            2. Right to file a State Fair Hearing and the method of obtaining it to contest the denial, deferral, or modification action and the decision Blue Shield Promise or its delegate has made.
            3. Right to file a grievance with Blue Shield Promise and Department of Managed Health Care (DMHC)
            4. Right to represent himself/herself at the fair hearing or to be represented by a legal counsel, friend, or other spokesperson.
            5. Right to submit written comments and information relevant to the appeal
            6. Right to call the State Medi-Cal Managed Care 'Ombudsman Office' for answering questions or help in appealing the decision
            7. Right to obtain the Blue Shield Promise's address and the State toll-free telephone number for obtaining information on legal service organization for representation.
        ii. For Medicare:
            1. Right to file an appeal with Blue Shield Promise within 60 days
            2. Right to be represented by a representative to act for the member
            3. Right to submit written comments and information relevant to the appeal
    f. A notification of free interpreting services or request for information in another language

2. Blue Shield Promise gives the requesting practitioners the opportunity to discuss healthcare UM denial decisions with a physician reviewer.

Receipt of Request:

- Procedures for receipt of requests take into consideration the nature or urgency of the request. Blue Shield Promise has the capability of accepting them outside of business hours.
- For urgent requests, Blue Shield Promise counts the date and time the request was received by fax, web portal or telephone, whether or not it is during business hours.
- If the request is received by telephone, it is usually followed by a faxed request. The date of receipt is when the telephone call or fax is received.
- Emergent requests are handled telephonically and discussed with the Case Manager and/or CMO in order to render an immediate decision.
- For routine requests received by fax, web portal or phone outside of normal business hours, the date of receipt shall be recorded as the next business day.

Specialty Referral Tracking:

Blue Shield Promise conducts focused audit on specialty referrals at least once a year to ensure meaningful and timely exchange of medical information pertinent to the treatment plan of the member. Blue Shield Promise shall ensure the provision of medically necessary services is appropriate and decisions are based on nationally recognized criteria or guidelines.

Referral Tracking and Monitoring System:

The system shall include authorized, denied, deferred or modified referrals.

1. Authorized – tracking shall include timeframe for the turn-around-time (TAT) of the referral, report sent by the consulting physician, documentation or follow-up of the referral made to a specialist, and follow-up for missed appointment.
2. Denied-tracking shall include TAT, documentation of notice of the denial to the provider, evidence of notice to the member, and the denial reason based on nationally recognized criteria, plus the offer of alternative treatment and follow-up.
3. Modified tracking shall include TAT, documentation of notice of the modification to the provider, evidence of notice to the member, and the modification reason.
4. Deferral-tracking shall include TAT, outcome of each deferral file, notice of the decision to the member and provider.
5. Frequency of monitoring may increase to 2x a year, up to quarterly basis, if a trend of non-compliance is identified.
6. A Specialty tracking report will be run on a monthly basis and shall be presented to appropriate committee on a quarterly basis.

NOTE: See Policy #10.2.11 – Medi-Cal or 50.2.22 – Medicare for authorization denials, deferrals & modification notification

REFERENCES

- Health & Safety Code Section 1367.01
- 22 CCR, Sections 5104.1, 51014.2
- Title 22, 53261 and 53894
- Welfare and Institutions Code, Section 14185
- DHCS Two-Plan and GMG Contracts, Exhibit A, Attachment 5