blue california
Promise Health Plan

Policy Title: Authorization, Denial, Pending/Deferral, and/or Modification Notification (MediCare)		POLICY #: 50.2.11 Line of business: Medicare Adv	
Department Name: Utilization Management	**Original Date** 9/06	**Effective Date** 5/19	**Revision Date** 12/18
Department Head: Sr. Director, UM		**Date: 3/21**	
Medical Services/P&T Committee: (If Applicable)		**Date: 3/21**	

PURPOSE

To establish a standardized internal process for the Blue Shield of California Promise Health Plan (Blue Shield Promise) Utilization Management Department that outlines the appropriate procedure for denying, pending, and/or modifying authorization requests for our Medicare members and subsequent notification to contracted providers and members in accordance with NCQA UM 8 standards and Title 22, CCR, Sections 510141.1 and 53894.

POLICY

Decisions to deny, pend/defer, or modify a Treatment Authorization Request based upon medical necessity or benefit determinations will only be made by a physician. The signature of the Chief Medical Officer or the reviewing physician is required on the denied authorization request from the denial/modification/deferral notification. Practitioners and members, and/or their authorized representative, will be notified in writing of a denial, deferral, or modification of a request for approval to provide health care service determinations and members informed of their rights as per Title 22, CCR, sections 51014.1, 51014.2, 53894, and Health & Safety Code Section 1367.01. Notifications to beneficiaries and the representatives are in accordance with timeframes set forth in Title 22, CCR, Sections 51014.1 and 53894.

PROCEDURE

Post Stabilization:

1. A decision will be made within 30 minutes or less or the service is deemed approved.

Non-Urgent Care in an Emergency Department

1. A decision will be made within 30 minutes or less or the service is deemed approved.

Standard:

1. A decision will be made within 5 working days, if all the necessary information is received at the time of request. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below.

2. If additional clinical information is required, or a consultation by an expert reviewer is necessary, or an additional examination or test is to be performed, a written deferral notice will be issued to the provider and the member. The provider will be notified of the additional information requested, additional examination or test to be performed or the need for a consultation by an expert reviewer. Within 14 calendar days, if the additional

information has not been submitted by the provider within 2 working days of the determination (but within the 14-day timeframe). Providers will be notified verbally or electronically within 24 hours of the determination.

If the requested information is received, a decision will be made within 24 hours of receipt of the information. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below. NOTE: Any decision delayed beyond the time limits is considered a denial & must be processed immediately as such.

A member or their designated representative may request an additional 14 days to provide medical information necessary to render a medical determination.

Expedited

1. Where a provider requests or Blue Shield Promise/Provider Group determines that standard timeframes could seriously jeopardize a member's life or health, or ability to attain, maintain, or regain maximum function and all necessary information is received at the time of the request, a decision will be made within 72 hours of the request. The practitioner will be notified, in writing, within 2 working days of the decision following the guidelines below.

2. If additional clinical information is required, or a consultation by an expert reviewer is necessary, or an additional examination or test is to be performed, a written deferral notice will be issued to the provider and the member. The provider will be notified in writing of the additional information requested, additional examination or test is to be performed or the need for a consultation by an expert reviewer. If, within 14 calendar days, the additional information has not been submitted by the provider, Blue Shield Promise will issue a written denial notification to the member and the provider within 2 working days of the determination (but within the 14-day timeframe). Provider will be notified verbally or electronically within 24 hours of the determination.

If the requested information is received, a decision will be made within 24 hours of receipt of the information. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below. NOTE: Any decision delayed beyond the time limits is considered a denial & must be processed immediately as such.

Concurrent

1. A decision will be made within 5 working days or less consistent with the urgency of the patient's medical condition and upon the receipt of all information necessary to make the decision. The treating provider will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below.

NOTE: In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient

In-Patient Hospice

1. A decision will be made within 24 hours of the request. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below.

Retrospective

1. A decision will be made within 30 calendar days from the receipt of the request. The Practitioner will be notified in writing within 2 working days of the determination not to exceed 30 calendar days from receipt of the request.
2. If additional clinical information is required, or a consultation by an expert reviewer is necessary, the request will be deferred, and the practitioner notified. This determination will be made as soon as the reviewer is aware that additional information is needed but not more than 30 days from the receipt of the request.

If the requested information is received a decision will be made within 5 working days not to exceed 30 calendar days from receipt of the request. The Provider will be notified within 2 working days of the determination not to exceed 30 calendar days from receipt of the request.

If the requested information is incomplete or not received, a decision will be made based upon the information that is available by the end of the 30th calendar day from receipt of the request. The practitioner will be notified in writing within 30 calendar days from receipt of the request.

If the requested information is incomplete or not received, a decision will be made based upon the information that is available by the end of the 30th calendar day from receipt of the request. The practitioner will be notified in writing within 30 calendar days from receipt of the request.

Provider Notification

- The communication to the provider shall include the name and telephone number of the health care professional responsible for the determination. The rationale is to afford the provider the opportunity to discuss the denial determination with him/her if the denial was based on medical necessity
- A disclosure of the specific utilization review criteria/guideline or benefit provision used as a basis for the denial will be included.
- Criteria/guidelines will be disclosed upon request to the public, provider, or member. The disclosure shall be accompanied by the following notice: ***The guidelines that were used by Blue Shield Promise Health Plan for your case are used by the Plan to authorize, modify or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need.***

Written Member Notification

- The written response to the member has to include clear and concise explanation of the reason for the denial or modification of requested service(s), and the specific clinical criteria used for the determinations to the denial or modification letters.
- The notice to the member will inform the member that he/she may file an appeal concerning the determination using the appeal process (as proscribed by the statute), prior to or concurrent with the initiation of a State Fair Hearing process.
- How to initiate an expedited appeal at the time they are notified of the denial.
- The member's right to request an Independent Medical Review (IMR)
- The name and address of the entity making the determination
- The State's toll-free telephone number for obtaining information on legal service organizations for representation.
- The Department of Managed Health Care's toll-free telephone number to receive complaints regarding a grievance against the Plan that has not been satisfactorily resolved by the Plan to the member's satisfaction.
- Possible alternative treatments or care

- Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the decision is made, not to exceed 14 calendar days from receipt of the original request.

Pended treatment authorization requests:

1. Upon receipt of a treatment request it will be triaged and processed
    a. Routine
    b. Expedited
    c. Concurrent
    d. Hospice
    e. Retrospective
2. When a determination has been made to pend the authorization request the following information will be entered into the MHC system:
    a. The reason for pending
    b. Any attempts to request information
    c. Any communication that has transpired with the provider to date
3. During the pending process, a hard copy of the request will be filed into a separate pending accordion file system within the UM Department. This will afford staff convenience in accessibility in the event that an inquiry about the request occurs or further information is submitted.
4. A Request for Medical Information Form will be faxed to the provider. The form will specify what information is required. (see attached)
5. Pended authorizations are flagged in the MHC System
6. An aging report of the pended authorizations will be generated from the MHC system each business day for turnaround timeframe compliance.
7. If the Medical Director makes the determination to approve or deny the request it will be processed per the standard UM procedures for processing an authorization.

Medicare Member Notification templates are used in accordance with CMS standards as noted below:

REFERENCES