blue california
Promise Health Plan

Policy Title: Prior Authorization Review and Approval Process		POLICY #: 90.2.50 Line of business: CMC	
Department Name: Utilization Management	**Original Date** 3/13	**Effective Date** 6/19	**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

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 involves the 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 Medical Services committee.

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

POLICY

Decisions to approve, deny, delay, or modify will be based on medical necessity, benefit determinations, or eligibility. These decisions will reflect appropriate application of Blue Shield Promise approved criteria/guidelines. All decisions to deny, modify, or delay a treatment authorization request will 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.

Services requiring prior authorization are as follows:

- Initial specialty consultation with the exception of OB/GYN consults
- All follow-up specialty care
- Inpatient and outpatient hospital care
- SNF and rehabilitation
- Ambulatory and surgical care
- Diagnostic services
- Physical, occupational and speech therapy
- Home Health
- Infusion therapy
- Hospice Care
- Transplants

Services that do not require prior authorization are as follow:

- Emergency services
- Post-stabilization services, including emergency behavioral health care
- Urgent care
- Crisis stabilization, including mental health
- Urgent care for home and community service-based recipients
- Preventive services
- Basic pre-natal care
- Family Planning
- Communicable disease services, including sexually transmitted infections and HIV testing
- Out of area renal dialysis services

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.

Blue Shield Promise members will be referred to culturally and linguistically appropriate community services and/or providers who can meet the member's religious and ethical needs. The UM Department will redirect the member to another provider in the network if the current provider has an objection to perform certain services that are against his religious and ethical beliefs.

PROCEDURE

1. The provider will complete the Treatment Authorization Request (TAR) and submit it to Blue Shield Promise UM Department via fax. 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. Procedure requested with CPT Codes
    k. Reason for request
    l. Classification (Urgent, Routine, Retrospective)
2. Upon receipt of the TAR, the UM Coordinator will:
    a. Date-stamp the TAR
    b. Verify eligibility and benefits
    c. Determine if authorization request is a duplicate of a previous request
    d. Enter the TAR into the MHC Authorization Tracking system
        i. UM Coordinators are non-clinical personnel and are authorized to approve the following types of requests when no determination of medical necessity is required;
    e. Optometry services
    f. Screening mammograms
    g. Well woman exams
    h. Outpatient Facility Services when professional services authorized by IPA

3. If the authorization request does not meet the conditions described in #2 above, the UM Coordinator will forward it to an UM Case Manager for review. The UM Case Manager will evaluate the request using approved criteria/guidelines. If the requested service falls within the approved criteria/guidelines, the UM Case Manager will approve it and return to the UM Coordinator for processing. If the requested service does not meet approved criteria/guidelines, the UM Case Manager will forward it to the Chief Medical Officer or physician reviewer.

4. The Chief Medical Officer 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 Coordinator for processing. If denied, modified, or pended, the request will be returned to the UM Coordinator 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 Making)

Denial Notice:

1. The written notification of healthcare denials provided to the members and their treating practitioners are made in a timely manner 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, guidelines, protocol or other similar criterion on which the denial decision is based. 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.
    c. For Medi-Cal Notice, a citation of the California Code of Regulation that supports the denial determination
    d. A description of the appeal rights
        i. For Medi-Cal
            1. Right to file an appeal with Blue Shield of California Promise
            2. Right to file a State Fair Hearing
            3. Right to file a grievance with Blue Shield of California Promise and Department of Managed Health Care (DMHC)
        ii. For Medicare:
            1. Right to file an appeal with Blue Shield of California Promise
        iii. Second level appeals shall go to external review organizations
        iv. Appeals are processed within the required timeframes, as mandated by regulatory agencies, and are not unduly delayed for medical conditions requiring time sensitive services
        v. Members have the right to be represented by a representative to act for the member
        vi. Members have the right to submit written comments and information relevant to the appeal
    e. 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.

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 requests will be responded to within 30 minutes of the request or the request is deemed approved

- Expedited requests will be processed in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours if all necessary information is received at the time of the request. 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.
    - The written Notice of Action shall be mailed no later than the 72 hours 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 including:
            - Method by which hearing may be obtained
            - Member may either self-represent or be represented by a third party
            - Time limit for 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 may be deferred and the time limit extended to additional 14 calendar days, only where the member or the member's provider requests an extension or the organization can provide justification upon request and how it will benefit the member.
    - 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 the initial request.
    - 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.

- 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 quest 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.

- In-Patient Hospice requests will be processed within 24 hours of the request. Notification will take place within the 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.

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

- Pharmaceutical requests are processed within 24 hours or one business day on all drugs that require prior authorization.

REFERENCES

Health & Safety Code Section 1367.01
Title 22, 53261 and 53894
NCQA UM 7, Denial Notices
Welfare and Institutions Code, Section 14185