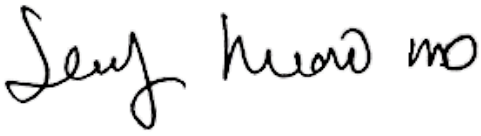
blue california
Promise Health Plan

Policy Title: Utilization Management Decision Making & Timeframes		POLICY #: 10.02.22 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 11/15	**Effective Date** 11/22	**Revision Date** 06/24
VP Approval: Tracy Alvarez, VP, Medical Care Solutions 		**Date of Approval: 6/12/2024**	
Medical Services/P&T Committee: (If Applicable) Jennifer Nuovo, MD 		**Date of Committee Review: 6/12/2024**	

A. PURPOSE

To provide guidance on how Blue Shield of California Promise Health Plan (Blue Shield Promise) will review, approve, modify, deny, and delay the provision of medical, mental health, and substance use disorder services to demonstrate compliance with mental health parity. The criteria apply to the prospective, concurrent, and retrospective review processes.

B. DEFINITIONS

1. Adverse benefit determination is defined as 1) the denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; 2) the reduction, suspension, or termination of a previously authorized service; 3) the denial, in whole or in part, of payment for a service; 4) the failure to provide services in a timely manner; 5) the failure to act within the required timeframes for standard resolution of grievances and appeals.

2. Concurrent review is a medical necessity review for the extension of an ongoing course of inpatient or outpatient treatment that was previously authorized. The concurrent review process is initiated by a request from a provider/facility and reviewed by the clinical team and is used to evaluate whether the member's condition continues to meet the medical necessity criteria for the level of care they are currently assigned. Concurrent review is a member-focused process that includes 1) medical necessity review, 2) discharge planning, 3) coordination of care.

The goal is to optimize the health outcomes of the member during the inpatient event.

3. Evidence of coverage or summary of benefits is a document that outlines care or service that could be considered either covered or non-covered, depending on the circumstances.
4. Medically necessary services are 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.

   Medical necessity of covered services for Medi-Cal beneficiaries under the age of 21 years is expanded to include the standards set forth in Title 22, California Code of Regulations (CCR) §51340 and §51340.1.

5. Notice of Action (NOA) is defined as a formal letter informing a member of an adverse benefit determination.

6. Pre-service review means reviewing a request for service for medical necessity prior to the service being rendered.
7. Post-service review means the review process after services have been rendered with a prior authorization.

8. Timeframe means the time allowed for a utilization management determination to be made once a request is received.

9. Urgent request is when the member's condition is such that the member 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 enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function.

C. POLICY

I. Blue Shield Promise applies California and federal regulatory requirements in making Utilization Management (UM) determinations. Determinations to approve, modify, deny, and delay are made as expeditiously as the member's condition requires. Authorizations are accepted from the member, the member's authorized representative, a provider, or the health plan on behalf of the member.

II. All UM referral requests, decisions, notifications, and all pertinent related actions are documented in the UM system: AuthAccel.

III. It is the policy of Blue Shield Promise to ensure that decisions are based on the medical necessity of proposed healthcare services and 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. These criteria and guidelines were developed pursuant to California Health and Safety Code (HSC) §1363.5.

IV. Blue Shield Promise discloses 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, and is located on UM & Clinical Practice Guidelines page of www.blueshieldca.com:

> *"The materials provided to you are guidelines used by this 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."*

V. Blue Shield Promise's Chief Medical Officer (CMO) is responsible for ensuring that medical necessity determinations are made by qualified medical personnel in accordance with HSC §1367.01. The CMO does not have any fiscal or administrative management responsibilities that would hinder his/her duties.

VI. Medical Necessity Determinations: Only appropriate, qualified medical professionals review for the medical necessity of services offered under Blue Shield Promise's medical benefit. Medical decisions are not influenced by fiscal or administrative management. Medical necessity determinations include the following:

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

VII. Benefit Determinations: Blue Shield Promise may cover or authorize a request for services that are specifically excluded from the benefit plan if a prior authorization request is submitted and the services are determined to be medically necessary.

a. A benefit determination would include the following:
    i. Decisions about services that are limited by number, duration, or frequency in the member's benefit plan
    ii. Decisions for extension of treatments beyond the specific limitations and

restrictions imposed in the member's benefit plan

iii. Decisions about care that do not depend on any circumstances

VIII. Documentation of Appropriate Professional Review: Documentation may consist of a handwritten signature, handwritten initials, or unique electronic identifier on the letter of 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.

IX. Monitoring for Consistent Review Criteria Application: The Medical Care Solutions Quality Audit Team performs ongoing monitoring of UM nurse/physician reviewer criteria/guideline application to:

a. Measure the reviewer's comprehension of the review criteria and guideline application process
b. Ensure accurate and consistent application of the criteria among staff reviewers
c. Ensure criteria and guidelines are utilized per policy and procedure
d. Ensure a peer review process for inter-rater reliability

See UM policy 10.02.57 Inter-Rater Reliability Process for additional information.

D. PROCEDURE

I. Blue Shield Promise applies a hierarchy of criteria for each UM review type to make medical necessity decisions . See Utilization Management Criteria and Guidelines Evidence-Based Medical Necessity Criteria Hierarchy document.

a. Blue Shield Promise has adopted MCG and other evidence-based utilization management criteria for use in making medical necessity determinations.
b. Guidelines are adopted with involvement from board-certified, actively participating health care providers; consistent with criteria or guidelines supported by sound clinical principles and processes; updated to the most current version available; and evaluated by the Medical Services Committee.

II. No individual other than a qualified licensed physician or licensed behavioral health practitioner (i.e., doctoral-level clinical psychologist) may deny or modify requests for medical necessity.

III. Application of criteria: In making medical necessity determinations, only information that is reasonably necessary to make a decision will be requested by the plan.

a. When appropriate, Blue Shield Promise will consult with providers as needed for prior authorization requests for the purposes of determining medical necessity for covered services unless doing so would lead to undue delay in care.
b. When appropriate, Blue Shield Promise's CMO may assemble a panel of board-certified independent experts to assist in a determination.
c. At the Blue Shield Promise level, adverse decisions may be appealed to the CMO or designee. Additional appeals may be pursued in accordance with Title 42, Code of Federal Regulations (CFR), Subpart F. 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
d. 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:
    i. Length of stay for in-patient or skilled nursing facility (SNF) stays that require condition-specific reviews
    ii. Complications of services that may affect co-morbidity
    iii. Complications of services that may affect age
    iv. Services that may affect unexpected complications
    v. Complications of services that may affect progress of treatment
    vi. Complications of services that may affect progress of psychosocial issues
    vii. Complications of services that may affect home environment education or support
    viii. Other factors that may impact the ability to implement an individual Member's care plan
e. Application of criteria also takes into consideration:
    i. Capabilities of the local delivery system, such as but not limited to:
        1. Whether services are available within the service area
        2. Benefit coverage

    Authorization requests shall be processed in accordance with the guidelines established in UM P&P 10.02.8 Authorization Denial, Pending/Deferral, and/or Modification Notification and UM P&P 10.02.38 Prior Authorization Review.

IV. 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.

V. 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 services that could be considered either covered or non-covered, depending on the circumstances. All UM activities are performed in accordance with HSC sections 1363.5 and 1367.01 and 28 CCR sections 1300.70(b)(2)(H) and (c).

VI. Procedures for UM processing timelines: 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 shall adhere to the following requirements:

a. Routine Requests: Blue Shield Promise UM will respond to routine requests for prior authorization as expeditiously as the member's condition requires, but no longer than five (5) business days from receipt of the information reasonably necessary and requested to render a decision, and no longer than fourteen (14) calendar days from the receipt of the request, in accordance with 42 CFR section 438.210 and HSC section 1367.01. Decisions to approve, modify, or deny requests will be communicated to the provider within 24 hours of the decision and to the member within two business days.

   i. Blue Shield Promise UM may extend the initial 14 calendar day authorization timeframe by up to 14 calendar days only if the member or the provider requests an extension, or if Blue Shield Promise UM justifies to DHCS upon request, a need for additional information and how the extension is in the member's interest, in accordance with 42 CFR section 438.210. Blue Shield Promise UM will notify the provider and the member in writing of any authorization request delayed beyond the five (5) business day timeframe, including the anticipated date on which a decision may be rendered, in accordance with H&S Code section 1367.01.

b. Expedited Requests: In instances where a provider indicates, or Blue Shield Promise UM determines, that the standard request timeframe may seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, Blue Shield Promise UM will approve, modify, or deny a prior authorization or concurrent request for health care services, and send the written NOA, in a timeframe which is appropriate for the nature of the member's condition, but no longer than 72 hours from receipt of the authorization request in accordance with 42 CFR section 438.210(d)(2)(i) and H&S Code section 1367.01(h)(2).

   i. Unless the member requests an extension of the initial 72 hour expedited authorization timeframe, Blue Shield Promise UM will either approve, deny, or modify the authorization request or document its justification of the need for an extension to obtain additional information and demonstrate how the extension is in the member's interest. Blue Shield Promise's justification must be documented in the member's record and provided to DHCS upon request in accordance with 42 CFR section 438.210(d)(2)(i),(ii).

ii. Blue Shield Promise UM will also send the written NOA to the member and the provider requesting the specific information it needs to determine if the requested service is medically necessary. The NOA must also advise the member of their right to file a grievance if they disagree with Blue Shield Promise's need for an extension. Following this notification and request for information, Blue Shield Promise will approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the member's condition, but no longer than 72 hours from the receipt of additional information requested to make a determination unless the member requests an extension or Blue Shield Promise can document justification of the need to extend the timeframe, not to exceed fourteen (14) calendar days in accordance with HSC sections 1367.01(h)(1) and (3).

c. Retrospective Requests: Retrospective authorization review requests will be accepted within a reasonably established time limit, not to exceed 365 calendar days from the date of service. Blue Shield Promise UM will communicate decisions to the provider and to the member who received the services or to the member's designee within 30 calendar days of the receipt of information that is reasonably necessary to make this determination, in accordance with 42 CFR section 438.404(a) and HSC section 1367.01(h)(1).

d. Extensions/Deferrals: 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 fourteen (14) calendar days from the receipt of the request to defer.

i. Examples of reasonably necessary information may include:
   1. Additional clinical information required
   2. Consultation by an expert reviewer
   3. Additional examination or tests to be performed

ii. If a deferral is required, Blue Shield Promise UM will notify the member and practitioner in writing of the decision to defer using the deferral NOA template.
   1. Deferral notifications must be made:
      a) For routine requests: Within 5 business days of receipt of request
      b) For urgent requests: Within 72 hours of receipt of request
   2. Blue Shield Promise UM will provide a total of up to fourteen (14) calendar days from the date of deferral to receive additional information.
   3. Upon receipt of additional information or at the end of the deferral period, notifications must be made:

1. For routine requests: Within five (5) business days of either receipt of the additional information or the end of the deferral period
2. For urgent requests: Within 72 hours of either receipt of the additional information or the end of the deferral period

e. Hospice Services: Blue Shield Promise UM only requires prior authorization for inpatient hospice care. Blue Shield Promise will respond to inpatient hospice care authorization requests in accordance with 22 CCR section 51003 and all applicable DHCS APLs within 24 hours of receipt of the information reasonably necessary and requested to render a decision.

f. Post Stabilization: Inpatient Post Stabilization Requests:
   i. If a provider requests authorization for post-stabilization care, Blue Shield Promise UM will render a determination on behalf of a member within 30 minutes of the request.
   ii. If not done within the required timeframe, the authorization request will be deemed approved, in accordance with Title 28, §1300.7.1.4. If the post-stabilization care received within or outside the network fails to be approved or disapproved within 30 minutes of a complete request submitted to Blue Shield Promise, the medical care will be deemed authorized, per 28 CCR §1300.71.4(b) and (d).

g. Physician Administered drug requests: Direct to pharmacy.

VII. Communications regarding decisions will be delivered to practitioners within 24 hours of the decision.
   a. Decisions will be available via interactive voice response (IVR) and provider portal.
   b. Notification of decisions will specify the specific health care service approved.
   c. Denial decisions, Notice of Actions (NOA) are made in accordance with state licensure requirements Health and Safety Code.
   d. Practitioner notification will include a statement indicating the availability of physician and behavioral health reviewers to discuss decisions and will ensure that practitioners receive information sufficient to understand and discuss with the member about appealing a decision to deny care or coverage.
   e. For all telephonic notifications, the practitioner/provider/member name, the time, date, and name of the UM representative who spoke with the practitioner/provider/member will be documented.

E. MONITORING

N/A

F. REPORTING

I. Turn-around-times tracking: To ensure compliance with turn-around-times (TAT), the UM department has implemented the following:

a. A tracking system that monitors all UM authorizations for documentation/identification of request status and time frames for processing.
b. A process to include periodic audits for UM referral timeframe compliance monitoring.
c. 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.

G. ATTACHMENTS

N/A

H. REFERENCES

1. 22 CCR §51340 and §51340.1
2. 22 CCR §51003
3. 28 CCR §1300.70(b)(2)(H) and (c)
4. 42 CFR, Subpart F
5. 42 CFR section 438.210
6. 42 CFR §2560.503 – 1(f)(2)(i), (f)(2)(ii)(B), (f)(2)(iii)(A-B), (g)(2)
7. HSC §§1363.5, 1367.01 and 1371.01 (h) (1-3,5)
8. DHCS APL 21-011
9. DHCS Contract, Exhibit A, Attachment 6, Provision 2
10. DHCS PL 14-003
11. BSCPHP Member Handbook
12. NCQA UM 2
13. NCQA UM 5.A-D
14. 2024 Utilization Management Criteria and Guidelines Evidence-Based Medical Necessity Criteria Hierarchy
15. 10.02.08 Authorization Denial, Pending/Deferral, and/or Modification Notification
16. 10.02.57 Inter-Rater Reliability Process
17. 10.02.38 Prior Authorization Review

I. REVISION HISTORY

Date	Modification (Reviewed and/or revised)	E-Filing Number
6/2024	Ad hoc update: • Removed medical necessity hierarchy information; added reference to PHP UM hierarchy document and updated evidence-based criteria statement • Removed therapeutic enteral formula content (now carved out to Medi-Cal Rx) • Updated definition of concurrent review • Updated information related to coverage of non-covered services based on medical necessity	
3/2024	2024 Annual Review • Updated regulatory requirements per DHCS • Updated criteria hierarchy for BH and non-BH • Formatting/grammatical updates • Updated references	
2/2023	Updated Regulatory Requirements DHCS	
10/22	Annual Review – updated regulatory requirements	