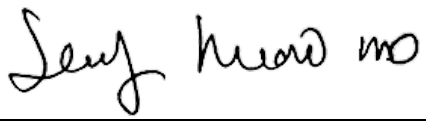
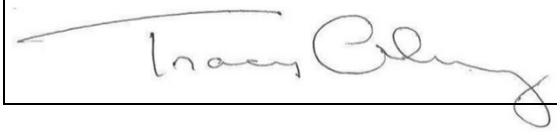
blue california
Promise Health Plan

Policy Title: Benefit/Preventative Health Algorithms for Authorizations		**POLICY #:** 10.02.37	
		Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 1/00	**Effective Date** 5/19	**Revision Date** 9/24
Governing Committee: Medical Services Committee			
Governing Committee Approval: Jennifer Nuovo, MD, Blue Shield Promise Chief Medical Officer 		**Date: 9/9/24**	
Vice President (VP) Approval: Tracy Alvarez, VP, Medical Care Solutions 		**Date: 9/9/24**	

A. 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.

B. DEFINITIONS

N/A

C. 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; Title XIX of the Federal Social Security Act and Title XXII, CCR for Medi-Cal; and Centers for Medicare and Medicaid 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.

D. PROCEDURE

I. Algorithms are approved at the UM coordinator level.
    a. The UM coordinators are non-clinical employees who have had either medical terminology training, medical office experience or other related experience. They report to the Senior Manager of UM Intake and Operations.
    b. These personnel are not involved in any decision-making that requires clinical judgment.

I. All incoming referrals are screened and triaged by the UM Manager or a clinical designee in his or her absence.

II. Auto benefit referral requests are forwarded to the UM Coordinators.

III. The coordinators verify eligibility.

IV. The member history is reviewed in the MHC system to ascertain that the benefit:
    a. appropriately falls within the periodicity of the request,
    b. meets the demographic specifications,
    c. and other applicable criteria to qualify for the benefit.

V. 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. See UM P&P 10.2.22 Utilization Management Decision Making & Timeframes.

VI. If the request does not satisfy the auto benefit criteria, it will be forwarded to a licensed nurse for clinical review.

E. MONITORING

N/A

F. REPORTING

N/A

G. ATTACHMENTS

N/A

H. REFERENCES & ATTACHMENTS

1. Title 10, California Code of Regulations (CCR), Chapter 5.8 – Managed Risk Medical Insurance Board Healthy Families Program
2. Title XIX, Federal Social Security Act
3. Title XXII, CCR
4. 10.2.22 Utilization Management Decision Making & Timeframes

I. REVISION HISTORY:

Date	Modification (Reviewed and/or revised)	E-filing Number
9/24	2024 Annual Review • Formatting updates • Reviewed regulatory requirements/updated references	
10/23	Annual review	