blue california
Promise Health Plan

Policy Title: Utilization Management (UM) Prior Auth Review		POLICY #: 10.02.38 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 4/04	**Effective Date** 11/22	**Revision Date** 6/24
VP Approval: Tracy Alvarez, VP, Medical Care Solutions			**Date of Approval: 6/12/24**
Medical Services/P&T Committee: (If Applicable) PHP CMO: Jennifer Nuovo, MD			**Date of Committee Review: 6/12/24**

A. PURPOSE

To provide guidance on how Blue Shield Promise Health Plan's (Blue Shield Promise) and the Medical Services Committee (MSC) will oversee the development and implementation of an effective referral/authorization process.

B. DEFINITIONS

1. "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.

2. "Biomarker Test" is a diagnostic test, such as single or multigene, of the cancer patient's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide patient treatment.

3. "Medi-Cal Definition of Medical Necessity" 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), §51303.

    a. 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.

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

C. POLICY

I. 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.

II. 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.

III. Blue Shield Promise will ensure that appropriate processes are used to review and approve the provision of medically necessary covered services within the DHCS required timeframes. Blue Shield Promise will authorize medically necessary covered services 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 will be used as a guideline only.

IV. 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 along with the requesting member's specific clinical and social needs and medical history. Decisions to deny or to authorize an amount, duration, or scope that is less than requested must be made by a qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition and disease or Long-Term Services and Supports (LTSS) needs. 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.

V. Qualified health care professionals supervise the review of decisions, including service reductions, and review all denials that are made, in whole or in part, based on Medical Necessity.

VI. 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, unused authorizations, 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.

VII. Prior authorization is required for non-emergency inpatient services as well as certain outpatient services. Additional information and instructions regarding the prior authorization process as well as the list of services for which prior

authorization is required (Prior Authorization List) is available at: https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/authorizations/overview

VIII. Services that never require prior authorization:
- a. Basic prenatal care
- b. Communicable disease services
- c. Crisis stabilization (including mental health).
- d. Emergency services/urgent care
- e. Family planning
- f. FDA approved biomarker testing for members with advanced or metastatic stage 3 or 4 cancer (includes progression/reoccurrence of the above mentioned)
- g. Initial assessment for mental health and substance use disorder (SUD)
- h. 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:
    - i. Abortion
    - ii. Diagnosis and treatment of sexually transmitted infections (STIs) in children 12 years of age or older
    - iii. Drug and alcohol abuse for children 12 years or older
    - iv. Family planning services
    - v. Medical care relate to sexual assault or rape
    - vi. Other services, as specified in the Centers for Medicare and Medicaid Services (CMS) – California Memorandum of Understanding and UM Direct Referral Form
    - vii. Out-of-area renal dialysis services
    - viii. 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 others, or
        2. the child is the alleged victim of incest or child abuse.
    - ix. Pregnancy
    - x. Routine Hospice
- i. Outpatient mental health therapy and medication management
- j. Podiatric medicine will 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.
- k. Preventative services
- l. Sensitive and confidential services e.g., abortion, STIs, HIV testing and counseling
- m. Support for home and community service-based recipients:
    - i. Outside the service area
    - ii. Within the service area under unusual or extraordinary circumstances when the contracted medical provider is unavailable or inaccessible

IX. No authorization will 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.

X. All Blue Shield Promise authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR §438.900, et seq. See UM P&P 10.26.3 Behavioral Health Care Services.

D. PROCEDURE

I. 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.

a. The provider will include:
   i. Member's Name
   ii. Language
   iii. Date of birth
   iv. Member ID #
   v. Demographic information
   vi. Date of request
   vii. Requesting provider
   viii. Referral provider with address & phone number
   ix. Diagnosis, including ICD-10 code(s)
   x. Reason for request
   xi. Classification (Urgent, Routine, Retrospective)

b. Upon receipt of the request, the UM Clinical Support Coordinator (CSC) will:
   i. Verify eligibility and benefits for requested service
   ii. Determine if authorization request is a duplicate of a previous request
   iii. Validation that the provider is not on the CMS/Medi-Cal Preclusion List or the Electronic Visit Verification (EVV) non-compliant List (for in Home Services)
   iv. Enter the request into system of record
   v. UM CSCs 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 there are explicit criteria, as delineated by each product line.
   vi. UM CSCs may approve UM direct referrals and services that meet Blue Shield Promise current lists of auto authorizations, as delineated by each product line.
   vii. If the request cannot be approved by the CSC, the request is forwarded to a UM clinician for review.

II. The UM clinician provides an initial assessment and evaluation of the services

requested. If the UM clinician is unable to make an authorization determination, he or she forwards the case to a Medical Director (MD)/Physician Advisor (PA) for further review and consideration.

III. The MD/PA will 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 delayed, the request will be returned to the UM Clinician to prepare a notification letter. The notification letter will be reviewed and signed by the MD/PA making the determination before being sent to the provider and the member. The provider and the member will be notified of an approval denial, modification, or delay within the timeframes described below.
    a. When considering approval of requested services, individual and local healthcare delivery system factors will be considered (see UM P&P 10.02.22 UM Decision Making & Timeframes)

IV. Timeframes
    a. Authorizations are valid for 30 days from the approval date as long as the member is eligible with Blue Shield Promise. The provider should always verify member eligibility at the time of service.
        i. For terminations, suspensions, or reductions of previously authorized services, Blue Shield Promise UM will notify Members at least ten calendar days before the date of the action pursuant to 42 CFR §431.211, with the exception of circumstances permitted under 42 CFR §431.213 and §431.214. For purposes of auditing, the postmark on Blue Shield Promise's notice to the Member will be used to confirm compliance with all authorization request timeframes and notice requirements set forth above.
    b. Routine/Standard 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.
    c. If Blue Shield Promise UM is unable to make a decision due to a lack of necessary information, the decision timeframe may be extended, for up to 14 calendar days.
        i. Blue Shield Promise UM will notify the member that the request requires an extension. Blue Shield Promise will send the written NOA deferring the authorization request, including justification of the need for the extension to obtain additional information and demonstrate how the extension is in the Member's interest in accordance with 42 CFR section 438.210(d)(2)(ii).
        ii. Blue Shield Promise will notify provider what specific information is necessary to make the decision.
        iii. Blue Shield Promise will give the provider at least 14 calendar days to

provide the information and notify the member or the member's authorized representative of this time period.

iv. A decision will be made by Blue Shield Promise within five (5) working days of the following:
    1. The date on which the additional information requested is received (without regard to whether all of the requested information is provided), or
    2. at the end of the specified time period given to supply the information if no response is received from the member or the member's authorized representative.

v. 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.

d. See UM P&P 10.02.22 UM Decision Making & Timeframes for detailed processing timelines for approvals, denials, deferrals, and modifications.

V. Denials, Modifications, & Deferrals
   a. For denials, modifications, or deferrals, Blue Shield Promise UM will provide a clear and concise written explanation of the reasons for denying, deferring, or modifying a service; a description of the criteria or guidelines used; and the clinical reasons for the decision based on medical necessity. Any written communication to a provider of a denial, delay, or modification of a request must include the name and telephone number of contractor's health care professional responsible for the denial, delay, or modification.
   b. See UM P&P 10.02.08 Authorization Denial, Pending/Deferral, and/or Modification Notification for procedures and regulatory requirements related to denial notices.

VI. Blue Shield Promise UM 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.

VII. Blue Shield Promise UM refers all services for moderate to severe impairment to the mental health plan (MHP). Behavioral health services are limited to age restrictions and frequency limitations via Medi-Cal guidelines.

E. MONITORING:

N/A

F. REPORTING:

I. Specialty Referral Tracking:
Blue Shield Promise conducts focused audits 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 will ensure the provision of medically necessary services are appropriate and decisions are based on nationally recognized criteria or guidelines. For additional information, see UM P&P 10.02.53 Specialty Care Referral Management.

II. Referral Tracking and Monitoring System:
The system will include authorized, denied, deferred, or modified referrals.

a. Authorized – tracking will 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.
b. Denied - tracking will 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.
c. Modified - tracking will include TAT, documentation of notice of the modification to the provider, evidence of notice to the member, and the modification reason.
d. Deferral - tracking will include TAT, outcome of each deferral file, notice of the decision to the member and provider.
e. Frequency of monitoring may increase to 2x a year, up to quarterly basis, if a trend of non-compliance is identified.
f. A Specialty tracking report will be run monthly and will be presented to the appropriate committee on a quarterly basis.

G. ATTACHMENTS

N/A

H. REFERENCES

1. 22 CCR, §5104.1, §51014.2, §51303, §53876
2. 42 CFR §438.10, §438.404, §438.408, §438.900
3. 42 CFR §438.420 and subsection 4.6.7
4. APL 22-014 Electronic Visit Verification
5. DHCS Two-Plan and GMG Contracts, Exhibit A, Attachment 5
6. DHCS Exhibit A, Attachment III, Section 5.1.3 (Member Information)
7. Health & Safety Code §1367.01
8. PL 14-003
9. 2024 Utilization Management Criteria and Guidelines Evidence-Based Medical Necessity Criteria Hierarchy
10. 10.02.08 Authorization Denial, Pending/Deferral, and/or Modification Notification

11. 10.02.22 Decision Making & Timeframes
12. 10.02.63 Specialty Care Referral Management
13. 10.26.3 Behavioral Health Services
14. Title 22, §53261 and §53894
15. Welfare and Institutions Code §14185
16. Welfare and Institutions Code §14029.91

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)	
3/2024	2024 Annual Review • Reviewed regulatory requirements per DHCS • Minor formatting/grammatical updates • Removed concurrent review content • Consolidated timeframes & denials content; referred to related P&Ps	
2/2023	Updated Regulatory Requirements DHCS	