blue california
Promise Health Plan

Policy Title: Appropriate Professionals, UM Review and Support		**POLICY #:** 10.02.56	
		Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date:** 10/22	**Effective Date:** 11/22	**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 describe the process by which Blue Shield of California Promise Health Plan (Blue Shield Promise) approves, modifies, delays, or denies requests by providers of healthcare services for their members, based in whole or in part on medical necessity or benefits.

B. DEFINITIONS

1. "Medical Necessity" means covered services that are necessary and appropriate for the treatment of a member's illness or injury according to professionally recognized standards of practice.

C. POLICY

I. The Blue Shield Promise Utilization Management (UM) program uses qualified health professionals whose education, training, and experience are commensurate with the UM reviews and consultations they conduct. These professionals review prior authorization, concurrent review, and retrospective UM decisions. Blue Shield Promise promotes first-line UM decisions that are made by individuals who have the knowledge and skills to evaluate working diagnoses and

proposed treatment plans.

II. Blue Shield Promise UM decisions are based only on appropriateness of care and service, and existence of coverage (i.e., medical necessity within contracted benefits).

III. Qualified health professionals assess the clinical information used to support UM decisions, and appropriately licensed health professionals supervise all review decisions.

IV. A board-certified physician or pharmacist with a current unrestricted California license reviews and issues any non-behavioral healthcare or medication denial that is based on medical necessity or appropriateness. A board-certified psychiatrist or doctoral level clinical psychologist with a current unrestricted California license reviews and issues all behavioral health care denial decisions based on medical necessity or appropriateness.

V. For cases in which the clinical judgment needed for UM decisions is sufficiently specialized, Blue Shield Promise has a process to ensure that board-certified physicians in that specialty area (from a recognized American Board of Medical Specialists [ABMS]) are available to assist in making UM and/or Care Management (CM) determinations.

VI. Blue Shield Promise prohibits medical decisions to be influenced by fiscal and administrative management. Compensation of individuals or entities that conduct UM activities is not structured to provide incentives to deny, limit, or discontinue Medically Necessary services.

D. **PROCEDURES**

I. Under the direction of the Chief Medical Officer (CMO), a Medical Director (MD) with a current unrestricted California license to practice medicine (MD or DO) oversees the UM review process in accordance with California Health & Safety Code (HSC) section 1367.01, and qualified staff responsible for the UM program. The MD is substantially involved in UM Program operations through active involvement in the Medical Services Committee (MSC).

II. Licensed health care professionals, performing within the scope of their license, may review and approve services for which there are explicit criteria.

III. Persons who are not qualified health professionals may, under the supervision of appropriately licensed health professionals, collect and transfer nonclinical data for preauthorization and concurrent review, review requests for completeness of information, and approve (but not deny) services using explicit criteria through established Extension of Authority (EOA) workflows. Non-clinical staff are limited

to activities that do not require evaluation or interpretation of clinical data.

IV. Denials based on medical necessity are only issued by the following professionals with a current, unrestricted license to practice in the state of California:
    a. Physicians, all types: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic, and vision denials.
    b. Doctoral-level clinical psychologists or certified addiction medicine specialists: Behavioral healthcare denials.
    c. Pharmacists: Pharmaceutical denials.
    d. Dentists: Dental denials.
    e. Chiropractors: Chiropractic denials.
    f. Physical therapists: Physical therapy denials.
    g. Doctoral-level board-certified behavioral analysts: Applied behavioral analysis denials.

V. Directors and Managers of UM:
    a. Provide day-to-day supervision of assigned UM staff
    b. Participate in staff training
    c. Monitor for consistent application of UM criteria by UM staff for each level and type of UM decision
    d. Monitor documentation for adequacy and available to UM staff onsite or by telephone

VI. Denial categories requiring appropriate professional review as defined in section D(IV) of this policy include:
    a. Medical necessity denials of covered medical benefits as defined in the Blue Shield Promise Medi-Cal Member Handbook.
    b. Denials of non-covered benefits requested by the member or practitioner that could be considered covered or non-covered (e.g., cosmetic or medical) depending on the circumstances.
    c. Denials of investigational/experimental treatments for specific services that are not explicitly excluded from the member's Evidence of Coverage. (Note: Specific services not covered by BSC under any circumstances and listed in the Blue Shield Promise Medi-Cal Member Handbook as an explicit exclusion are not subject to physician review.)
    d. Upholding denial on appeal reviews by appropriate licensed professionals.
        i. Appeals will be reviewed by a non-subordinate reviewer who was not involved in the previous determination.
        ii. The reviewer will have training and experience that aligns with the condition or health problem in question in the appeal (i.e., same-or-similar

specialist). A same-or-similar specialist must have training and experience meeting the following criteria:

1. Includes treating the condition.
2. Includes treating complications that may result from the service or procedure.
3. Is sufficient for the specialist to determine if the service or procedure is medically necessary or clinically appropriate.

VII. Denial files will reflect documentation of review by an appropriate professional (i.e., reviewer) as defined in section D(IV) of this document, of every denial based on medical necessity. This documentation of appropriate professional review may consist of:

a. The reviewer's handwritten signature or initials.
b. The reviewer's unique electronic signature or identifier on the letter of denial or on the notation of denial in the file.
c. A signed or initialed note from a UM staff person attributing the denial decision to the appropriate professional who reviewed the case.

VIII. Use of Board-Certified Consultants:

a. When an expert in their specialty area is required to review a service request, Blue Shield Promise uses board-certified consultants, including behavioral health practitioners. Consultants may be internal to Blue Shield Promise or from an external independent medical review organization. Blue Shield Promise maintains a list of board-certified consultants that includes contact information (e.g., phone numbers, names, specialties) and makes the list available to the professional reviewers defined in section D(IV) of this document.
b. When called upon to review a service request in his/her specialty area, the qualified licensed specialist consultant may recommend approval or denial of the service request. The consultant's recommendation is documented in the system of record (MedHok Auth Accel). The Blue Shield Promise Medical Directors assume ultimate authority and responsibility for review determinations.

E. MONITORING

N/A

F. REPORTING

N/A

G. ATTACHMENTS

N/A

H. REFERENCES

1. Blue Shield Promise Medi-Cal Member Handbook
2. HSC § 1383.15(a), (b), (c), (f), and (i)
3. HSC § 1367.01
4. Medi-Cal Provider Manual
5. NCQA UM1A
6. NCQA UM4A-F
7. NCQA UM 9C

I. REVISION HISTORY

Date	Modification (Reviewed and/or revised)	E-Filing Number
9/2024	Ad hoc update: • Added content related to appeals/same or similar specialty	
3/2024	2024 Annual Review • Formatting updates • Consolidated information in Policy and Procedure sections • Added references	
2/2023	AdHoc Update • Provide clarification on IMRs	
2/2023	New Policy • To reflect Regulatory requirements DHCS, DMHC	