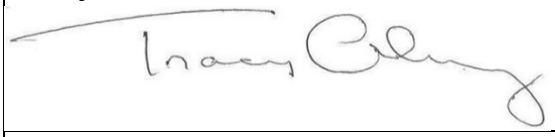
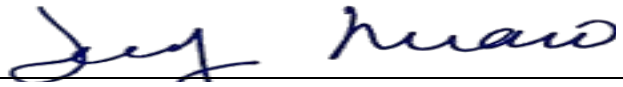
blue california
Promise Health Plan

Policy Title: Elective Admission Review		POLICY #: 10.02.65 Line of business: Medi-Cal	
Department Name: Utilization Management	Original Date 11/97	Effective Date 5/19	Revision Date 12/18, 11/22, 11/23
VP Approval: Tracy Alvarez, VP, Medical Care Solutions 		Date of Approval: 06/11/2024	
Medical Services/P&T Committee: (If Applicable): Jennifer Nuovo, MD Chief Medical Officer 		Date of Committee Review: 06/11/2024	

A. PURPOSE

To establish and define mechanisms for the Blue Shield of California Promise Health Plan (Blue Shield Promise) Utilization Management (UM) Department to approve, modify, or deny elective inpatient services.

B. DEFINITIONS

"Medical necessity review" is a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member's circumstances, relative to appropriate clinical criteria and the organization's policies.

C. POLICY

All elective inpatient admissions require an authorization by the Blue Shield Promise UM Department. The services must be provided by Blue Shield Promise network providers or other providers authorized as part of this review procedure.

D. PROCEDURE

I. REQUEST FOR ADMISSION: Requests for elective inpatient admissions must be obtained by either the member's primary care physician (PCP) or by the admitting physician provider. The request for an elective admission must be communicated to Blue Shield Promise UM Department by fax or phone with the priority level standard/urgency. Whenever possible, these requests should be submitted no less than five business days prior to projected elective inpatient admission.

II. UTILIZATION REVIEW: The UM clinical staff will review the request for elective admission and evaluate it for satisfaction of criteria, i.e., Milliman Care Guidelines [MCG], Clinical Rationale. Criteria to be evaluated include both clinical indicators for inpatient level of care, as well as choice of physician and facility providers.

a. The UM clinical staff will obtain the demographic and clinical information available in the authorization system.
    i. If there is sufficient clinical information to determine that admission criteria are satisfied, the clinician will authorize the admission and will code the case for follow-up review. Pre-determined length of stay (LOS) is not assigned.
    ii. If there is not sufficient information to determine satisfaction of admission criteria, the clinician will contact the admitting physician to obtain more information.
        1. If the additional information satisfies admission criteria, the clinician will authorize it.
        2. If the additional information does not satisfy admission criteria, the case will be pended to the Blue Shield Promise Chief Medical Officer or physician reviewer for review and determination.

b. If an Assistant Surgeon is requested, the UM clinical staff will access the MCG criteria to determine that the surgery itself satisfies the criteria.

c. If the surgery does not require an assistant surgeon per the criteria list, the clinician will request additional information from the attending surgeon. If the attending surgeon is able to substantiate the need for an assistant surgeon, the clinician will approve the request.

d. If the request for an assistant surgeon is not substantiated, the clinician will advise the attending surgeon that the case will be referred to the Blue Shield Promise Chief Medical Officer or physician reviewer for evaluation.

III. MEDICAL REVIEW: if the request for elective inpatient admission does not satisfy criteria or if the services do not require an assistant surgeon, then the Blue Shield Promise Chief Medical Officer or physician reviewer will contact the requesting physician to discuss the case. Depending on the information provided by the requestor, the Blue Shield Promise physician reviewer may approve the admission, modify the admission, or deny the admission. In some cases, the physician reviewer may decide to consult with an alternate specialty physician before rendering a final decision.

If the admission is approved, the case will be returned to the clinician for processing as above.

IV. DECISIONS & NOTIFICATION: Pursuant to California Health and Safety Code (HSC) § 1367.01, Blue Shield Promise will render a decision to approve, modify, or deny elective admission requests within five (5) business days from the receipt of information reasonably necessary to make the determination. Notification to the

requesting/ordering provider will be made within 24 hours of the decision. If the requested admission is denied, deferred, or modified, the notification will be issued to the provider within 24 hours and to the member no later than two working days after the decision is made, not to exceed 14 calendar days from receipt of the original request. See UM Policy 10.02.22 UM Decision Making & Timeframes for further information.

E. MONITORING

N/A

F. REPORTING
N/A

G. REFERENCES & ATTACHMENTS

1. UM Policy 10.02.22 UM Decision Making & Timeframes
2. HSC § 1367.01

H. REVISION HISTORY:

Date	Modification (Reviewed and/or revised)	E-Filing Number
11/2023	Annual Review • Formatting updates • Clarified decision/notification timeframes & regulatory requirements • Annual Review of Regulatory Requirements DHCS, DMHC, NCQA	
11/2022	Annual Review: • Updated Policy Numbering to reflect Medi-Cal Only; • Annual Review of Regulatory Requirements DHCS, DMHC, NCQA	