Policy Title: Authorization Denial, Pending/Deferral, and/or Modification Notification		POLICY #: 10.2.08 Line of business: Medi-Cal	
Department Name: Utilization Management	**Original Date** 11/97	**Effective Date** 11/22	**Revision Date** 12/18, 2/22, 10/22, 02/23, 03/24
VP Approval Tracy Alvarez, VP, Medical Care Solutions		**Date of Approval:** 3/12/2024	
Medical Services/P&T Committee: (If Applicable) PHP CMO Jennifer Nuovo, MD		**Date of Committee Review:** 3/12/2024	

A. PURPOSE:

To provide guidance on how Blue Shield Promise Health Plan (Blue Shield Promise) denies, pends, and/or modifies authorization requests and provides subsequent notification to contracted providers and members in accordance with NCQA UM standards and within timeframes as set per Title 22, California Code of Regulations (CCR), §51014.1 and §53894.

B. DEFINITIONS:

1. **Adverse benefit determination** means any of the following: 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; or 5) The failure to act within the required timeframes for standard resolution of grievances and appeals.

2. **Notice of action** is a formal letter from Blue Shield Promise informing a

member of an adverse benefit determination.

C. POLICY:

I. Decisions to deny, pend, defer, or modify a Treatment Authorization Request (TAR) based upon medical necessity or benefit determination will only be made by qualified health care professional with appropriate clinical expertise in treating the medical or behavioral health condition.

II. 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.

III. The signature of the Chief Medical Officer (CMO) or the reviewing physician is required on the denied authorization request form and the denial/modification/deferral notification. Practitioners and members, and/or their authorized representative, will be notified in writing of a denial, deferral, or modification of a request for approval to provide health care service determinations and members informed of their rights as per Title 22, CCR, Sections 51014.1, 51014.2, 53894, and California Health & Safety Code (HSC) Section 1367.01. The member has the right to be represented by anyone the member chooses, including legal counsel, friend, or other spokesperson and have that representative act on their behalf at all levels of an appeal.

IV. The Medical Services Committee (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, continuum of care, and 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.

D. PROCEDURE:

I. All UM activities are performed in accordance with HSC §1363.5 and §1367.01 and 28 CCR §1300.70(b)(2)(h) and (c).

II. Decisions to deny or authorize services in an amount, duration, or scope that is less than requested will 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. Appropriate clinical expertise may be demonstrated by relevant specialty training, experience, or certification. Qualified health care professionals do not have to be experts in all conditions and may use other resources to make appropriate decisions.

III. Blue Shield Promise 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 will include the name and telephone number of Blue Shield Promise's health care professional responsible for the denial, delay, or modification.

IV. Decisions will be made based on appropriate timelines; see UM P&P 10.02.22 UM Decision Making and Timeframes.

V. Notification Requirements – Notice of Action (NOA)
   a. Provider Notification: In accordance with 42 Code of Federal Regulations (CFR) sections 438.210(d) and 438.404, Blue Shield Promise will provide to the provider written notification of decisions to deny, defer, or modify requests on a standardized form informing the provider of the following:
      i. The name and direct telephone number of the health care professional responsible for the determination. The rationale is to afford the provider the opportunity to discuss the denial determination with him/her if the denial was based on medical necessity.
      ii. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline.
      iii. A clear and concise explanation of the reasons for the decision.
      iv. The clinical reasons for the decision. Blue Shield Promise will explicitly state how the member's condition does not meet the criteria or guidelines.
      v. Sufficient information in the Notice of Action letter to understand and decide whether to appeal a decision to deny, modify, or delay care or coverage.
         1. The requesting provider will be notified of any decision to deny, approve, modify, or delay a request, or to authorize a service in an amount, duration, or scope that is less than requested within twenty-four (24) hours

of the decision. The notice to the provider may be communicated initially by telephone or facsimile and also in writing.

b. Member Notification: In accordance with 42 CFR sections 438.210(d) and 438.404, Blue Shield Promise will provide to the member written notification of decisions to deny, defer, or modify requests on a standardized form informing the member of the following:
    i. The adverse benefit determination Blue Shield Promise has made or intends to make.
    ii. The reason for the action, including notification to the Member of the right to be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and any other information Blue Shield Promise relied on for the decision, including clinical criteria, Medical Necessity criteria, and any processes, strategies, or evidentiary standards relied on for the decision.
    iii. A description of the criteria or guidelines used. The Member has a right to a request a written copy of the criteria or benefit provision used in the decision.
    iv. A clear and concise explanation of the reason for the denial or modification of requested services(s).
    v. The member's right to request an appeal of the adverse benefit determination and the right to request a state fair hearing consistent with 42 CFR §438.402(c).
    vi. The right to call the State Medi-Cal Managed Care 'Ombudsman Office' to answer questions or help in appealing the decision.
    vii. The right to obtain the Blue Shield Promise's address and the State toll-free telephone number for obtaining information on legal service organization for representation.
        1. The written Notice of Action will be mailed to the member no later than 2 business days after the decision.
        2. Blue Shield Promise will send notifications in the member's required language or alternative format pursuant to APL 21-004 and APL 22-002.
        3. Blue Shield Promise will ensure all NOAs informing a Member of Adverse Benefits Determination (ABD) are in writing, in a format and language that, at a minimum, meet the standards set forth 42 CFR §438.10, §438.404, and §438.408; Welfare & Institutions Code (WIC) §14029.91; 22 CCR §53876; and DHCS Contract Exhibit A, Attachment III, Section 5.1.3 (Member Information).

c. A notification informing a member of an adverse benefit determination (ABD) is in writing, in a format and language that, at a minimum, meets the standards set forth 42 CFR §438.10, §438.404, and §438.408; WIC §14029.91; 22 CCR §53876; and Exhibit A, Attachment III, §5.1.3 (Member Information). Blue Shield Promise's NOA informing of an ABD includes all of the following:
    i. A clear and concise explanation of the action that Blue Shield Promise or its Network Provider has taken or intends to take, including a fully translated written notice with a fully translated clinical rationale for the decision at the point of each determination.
    ii. The Member's right to continue receiving Covered Services pending the resolution of the Appeal, and Blue Shield Promise's obligation to continue benefits as required by 42 CFR §438.420 and subsection 4.6.7 (Continuation of Services Until Appeal and State Fair Hearing Rights Are Exhausted).
    iii. The Member's right to request a clinical review of Blue Shield Promise's action, called an Independent Medical Review (IMR), from DMHC and that the Member must request an IMR before there is a final decision on their State Fair Hearing.

d. Failure to supply written NOA: Failure to render a decision and send a written NOA to the Member within the required timeframes is considered a denial of the requested service and therefore constitutes an ABD on the date that Blue Shield Promise's timeframe for approval expires in accordance with 42 CFR section 438.404(c)(5). In cases where Blue Shield Promise fails to meet the required notice timeframes, the Member may immediately request an Appeal; and Blue Shield Promise will send the Member written notice of all Appeal rights.

e. The NOA "Your Rights" Attachment includes all of the following required elements per APL 21-011:
    i. The member's or provider's right to file an appeal with Blue Shield Promise within 60 calendar days from the date on the NOA.
    ii. The member's right to request a state hearing after first filing an internal appeal with Blue Shield Promise and receiving notice that the adverse benefit determination has been upheld.
    iii. The member's right to request a state hearing without having to exhaust Blue Shield Promise's internal appeal process, in instances of deemed exhaustion.
    iv. Circumstances under which an expedited review is available and

how to request one.

v. The member's right to Aid Paid Pending and instructions on how to timely file for an appeal (i.e., within 10 days of the NOA or before the effective date of the intended action) of a decision to terminate, suspend, or reduce services. Blue Shield Promise will provide Aid Paid Pending regardless of whether the member makes a separate request to Blue Shield Promise when the member timely files an appeal of a decision to terminate, suspend or reduce services.

E. MONITORING:

N/A

F. REPORTING:

N/A

G. REFERENCES & ATTACHMENTS:

1. 22 CCR, §51014.1, §51014.2, §53876, §53894
2. 28 CCR §1300.70(b)(2)(h) and (c)
3. 42 CFR §438.10, §438.402(c), §438.404, and §438.408,
4. APL 21-004
5. APL 21-011
6. APL 22-002
7. DHCS Contract Exhibit A, Attachment III, §5.1.3
8. NCQA UM 2 & 8
9. HSC §1363.5, §1367.01
10. WIC §14029.91
11. 10.02.22 UM Decision Making and Timeframes

H. REVISION HISTORY:

Date	Modification (Reviewed and/or revised)	E-Filing Number
3/2024	2024 Annual Review • Updated regulatory requirements per DHCS • Added APL language/references • Formatting/grammatical updates	
3/2023	Updated language	

2/2023	Updated Regulatory Requirements DHCS	