blue california
Promise Health Plan

Policy Title: Authorization Denial, Pending /Deferral, and /or Modification Notification for Behavioral Health Treatment		POLICY #: 10.26.02 Line of business: Medi-Cal	
Department Name: Behavioral Health	Original Date 6/2016	Effective Date: 7/2018	Revision Date: 6/2019, 4/2023, 11/2023
VP Approval: Tracy Alvarez, VP Medical Care Solutions			Date of approval: 12/11/2023
Medical Services/P&T Committee: (If Applicable) Tosha Lara Larios, D.O. Vice President, Medical Director			Date of Committee Review: 12/11/2023

A. PURPOSE

To establish a standardized internal process for the Blue Shield of California Promise Health Plan's (Blue Shield Promise) Behavioral Health (BH) Utilization Management Department that outlines the appropriate procedure for denying, pending, and/or modifying Behavioral Health Treatment (BHT) authorization requests and subsequent notification to contracted providers and member in accordance with NCQA UM standards 7 and 8 and within timeframes as set per Title 22, CCR, Sections 51014.1 and 53894, and Health & Safety Code Section 1367.01.

B. DEFINITIONS

Behavioral Health Treatment (BHT) services are services based on reliable evidence and are not experimental. This includes professional services and treatment programs, including but not limited to: Applied Behavioral Analysis ("ABA"), and other evidence-based behavior intervention programs that develop or restore to the maximum extent practicable, the functioning of a beneficiary, including those with or without autism spectrum disorder (ASD).

C. POLICY

Blue Shield Promise decisions to deny, pend, defer, or modify a Treatment Authorization Request based upon medical necessity or benefit determination will only be made by a licensed psychologist or in their absence, a Medical Director. The signature of the licensed psychologist or Medical Director 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 Health & Safety Code Section 1367.01. Written notification to members and/or their authorized representative is provided as specified in accordance with timeframes set forth in Title 22, CCR, Sections 51014.1, 5104.2, 53894 and Health & Safety Code 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.

D. PROCEDURE

I. Routine/Standard Request

a. A decision will be made within 5 business days if all the necessary information is received at the time of the request. When making a determination of coverage based on medical necessity, relevant clinical information will be obtained along with a consultation with the requesting practitioner when necessary. Clinical information will be requested by the BH coordinator or Board Certified Behavior Analyst to apply the appropriate BHT Criteria, including but not limited to:
    i. Presenting problem and history, including patient, family and psychosocial history;
    ii. Functional Behavior Assessment (FBA)
    iii. Progress Reports (PR) from Applied Behavior Analysis (ABA) provider ;
    iv. Information from consulting providers and practitioners including rehabilitation evaluations

b. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below.

c. If additional clinical information is required, or a consultation by an expert reviewer is necessary, or an additional examination or test(s) is(are) to be performed, a written deferral notice will be issued to the provider and the member. The provider will be notified in writing of the additional information requested, additional examination or test(s) to be performed or the need for a consultation by an expert reviewer. If within 14 calendar days, the additional information has not been submitted by the provider, Blue Shield Promise will issue a written denial notification to the member and the provider within 2 working days of the determination (but within the 14-day timeframe). Providers will be notified verbally or electronically within 24 hours of the determination.

d. If the requested information is received, a decision will be made within 24 hours of receipt of the information. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member and provider will be notified, in writing, within 2 working days of the decision following the guidelines below.

II. Expedited Request

a. Where a provider requests or Blue Shield Promise determines that standard timeframes could seriously jeopardize a member's life, health, or ability to attain, maintain, or regain maximum functioning, and all necessary information is received at the time of the request, a decision will be made within 72 hours of the request. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member and provider will be notified, in writing, within 2 working days of the decision following the guidelines below.

b. If additional clinical information is required, a consultation by an expert reviewer is necessary, or an additional examination or test(s) is(are) to be performed, a written deferral notice will be issued to the provider and the member. The provider will be notified in writing of the additional information requested, additional examination or test(s) to be performed, or the need for a consultation by an expert reviewer. If within 14 calendar days, the additional information has not been submitted by the provider, Blue Shield Promise will issue a written denial notification to the member and the provider within two (2) working days of the determination, but within the 14-day timeframe. Providers will be notified verbally or electronically within 24 hours of the determination.

c. If the requested information is received, a decision will be made within 24 hours of receipt of the information. The practitioner will be notified within 24 hours of the decision either orally or electronically. The member will be notified, in writing, within 2 working days of the decision following the guidelines below.

III. Retrospective Request

a. A decision will be made within 30 calendar days from the receipt of the request. The Practitioner will be notified of the decision in writing within 2 working days of the determination not to exceed 30 calendar days from the receipt of the request.

b. If additional clinical information is required or a consultation by an expert reviewer is necessary, the request will be deferred, and the practitioner notified. The determination will be made as soon as the reviewer is aware that additional information is needed but not more than 30 days from the receipt of the request.

c. If the requested information is received a decision will be made within 5 working days not to exceed 30 calendar days from the receipt of the request. The Provider will be notified in writing within 2 working days of the determination not to exceed 30 calendar days from receipt of request.

d. If the requested information is incomplete or not received, a decision will be made based upon the information that is available by the end of the 30th calendar day from receipt of the request. The practitioner will be notified in writing within 30 calendar days from receipt of the request.

IV. Notification Requirements

a. Provider Notification

i. Blue Shield Promise will provide a written notification decision to deny, defer, or modify requests on a standardized form informing the provider of the following:

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

   24 hours of the decision. The notice to the provider may be orally or in writing.

2. The communication to the provider will include the name and 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.
3. A disclosure of the specific utilization review criteria/guideline or benefit provision used as a basis for the denial will be included.
4. Criteria/guidelines will be disclosed upon request to the public, provider, or member. The disclosure will be accompanied by the following notice: "The materials provided to you are guidelines used by Blue Shield Promise to authorize, modify or deny care for person within similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

ii. Practitioners will receive 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.

b. Written Member Notification

i. Blue Shield Promise will provide a written notification decision to deny, defer, or modify requests to the member or member's representative on a standardized form informing the member of the following:

1. The written response to the member will include a clear and concise explanation of the reason for the denial or modification of the requested services(s) and the specific clinical criteria used for the determinations in the denial or modification letters. (Member has a right to request a written copy of the criteria or the benefit provision used in making the decision).
2. Blue Shield Promise will notify members of a decision to deny, delay, modify or terminate requests of Prior Authorization, in accordance with Title 22, CCR, Sections 51014.1 and 53894 by providing written notification to members, and/or their authorized representative, regarding any denial, deferral, or modification of a request for an approval to provide a health care service.
3. Criteria/guidelines will be disclosed upon request to the public,

provider, or member. The disclosure will be accompanied by the following notice: "The material provided to you are guidelines used by Blue Shield Promise to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

c. Practitioners will receive 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.

d. Members and practitioners will be advised of the right to appeal to the Department of Managed Health Care (DMHC) if not satisfied with the appeal decision at the Health Plan level.

e. The notice to the member will inform the member that he/she may file an appeal concerning the determination through the health plan's grievance/appeal process within 60 days of the decision (as prescribed by the statute) prior to or concurrent with the initiation of a State Fair Hearing process, and the right to submit written comments, documents, or other information relevant to the appeal.

f. Members and practitioners will be advised about how to initiate an expedited appeal at the time they are notified of the denial, including the member's right to call the State Medi-Cal Managed Care "Ombudsman Office" for answering questions or help in appealing the decision.

g. The member will be advised of his/her right to and method for obtaining a State Fair Hearing, and the member's right to represent himself/herself at the State Fair Hearing or to be represented by Legal counsel or another spokesperson.

h. The member will be advised of his/her right to request an Independent Medical Review (IMR).

i. The notice will include the name and address of the entity making the determination.

j. The notice will include the name and address of Blue Shield Promise and the State's toll-free telephone number for obtaining information on legal service organizations for representation.

k. The notice will include the Department of Managed Health Care's toll-free telephone number to receive complaints regarding a grievance against the Plan that has not been satisfactorily resolved by the Plan to the member's satisfaction.

l. The notice will include possible alternative treatments or care.

V. <u>Pending Treatment Authorization Requests:</u>

a. Upon receipt of a treatment request, it will be triaged and processed as follows:

i. Routine/Standard

ii. Expedited

iii. Retrospective

b. When a determination has been made to pend the authorization request,

the following information will be entered into the Utilization Management system:

i. The reason for pending
ii. Any attempts to request information
iii. Any communication that has transpired with the provider to date.

c. Pended authorizations are flagged in the authorization system.
d. An aging report of the pended authorizations will be generated from the utilization management system each business day for turnaround timeframe compliance.
e. If the reviewer makes the determination to approve or deny the request, it will be processed per the standard BH procedures for processing an authorization.

E. MONITORING

At minimum, The Plan monitors determinations for compliance on timeliness of determination and notifications monthly. The outcomes of these are then submitted quarterly to the Promise Behavioral Health Committee for additional monitoring.

F. REPORTING

a. The direct manager of utilization management staff will pull daily report logs of timeliness and notifications.
b. Monthly and quarterly reports are generated to monitor compliance and to track and trend any identified issues.

G. REFERENCES & ATTACHMENTS

1. NCQA UM 7 & 8
2. Title 22, CCR, Sections 51014.1, 51014.2, 53894
3. Health & Safety Code Section 1367.01
4. All Plan Letter (APL) 21-011

H. REVISION HISTORY

Date	Modification (Reviewed and/or revised)	E-Filing Number
11/2023	Annual Review • Annual review of regulatory requirements DHCS, DMHC, NCQA • Updated formatting	
04/2023	Moved policy to new template	
06/2019	Moved Policy on to BSC Promise Template	
06/2016	Created Policy & Procedure	