blue california
Promise Health Plan

Policy Title: Minimum Necessary Information		POLICY #: 70.2.61 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 6/05	**Effective Date** 5/19	**Revision Date** 12/18, 3/22
Department Head: Sr. Director, UM		**Date: 4/25/22**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 4/25/22**	

PURPOSE

To establish departmental policy and procedures for Blue Shield of California Promise Health Plan (Blue Shield Promise) relating to provisions of Sections 164.502 and 164.514 of HIPAA Privacy Regulations requiring the request, use and disclosure of minimum necessary information in handling protected health information of individuals.

POLICY

It is Blue Shield Promise policy to comply with the request, use and disclosure of minimum necessary information in handling individually protected health information (PHI), as defined in HIPAA. This policy is applicable to various types of functions in the Utilization Management (UM) Department, such as prior authorization, inpatient concurrent reviews, discharge planning, , retrospective reviews, clinical appeals and Independent Medical Review (IMR). The UM staff will make all reasonable efforts not to use or disclose more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure (164.506b).

PROCEDURE

Following are the routine minimum necessary protected health information (PHI) requirements for various UM functions:

Prior Authorization – routinely providers submit Treatment Authorization Requests (TAR) to Blue Shield Promise UM Department for approvals. The disclosure of minimum necessary PHI on the TAR includes member's name, ID number, DOB, address, phone number, Diagnosis, requested medical service(s), and the medical reasons(s) for the request. When there is a lack of medical justification for the requested service, the prior authorization nurse will request additional PHI from the Primary Care Physician. The additional PHI includes history and Physical, progress notes, lab results, diagnostic results, and specialty consultation notes.

Inpatient Concurrent Reviews – routinely the inpatient nurse case managers conduct daily utilization review of acute hospital, skilled nursing, psychiatric (Health Families), and rehabilitation inpatient stays. They interface with the in-house case managers, discharge planners, attending physicians, IPA case managers.

Immediately upon notification of admission by the hospital, the Blue Shield Promise Case Manager will contact the hospital Case Management Department requesting the initial concurrent review via telephone. The minimum necessary disclosure of PHI to the hospital includes member's name, ID number, DOB, and the date of admission.

The minimum necessary PHI requested from the hospital includes, admitting diagnosis, source of admission, history and physical, current medical condition, labs, diagnostic work-ups, current medical treatment, and discharge plan.

Blue Shield Promise provide minimum necessary disclosure of PHI to IPA case managers include, daily inpatient census, and daily inpatient case reviews via FTP site.

Discharge Planning – Blue Shield Promise inpatient case managers interface daily with hospital case managers, discharge planners, social workers, attending physicians, and IPA case managers to identify, evaluate, and coordinate the discharge planning needs of the member. In order to pre-arrange medically necessary services, such as home health DME, SNF, or rehabilitation for the member's post hospitalization, Blue Shield Promise inpatient case managers disclose PHI to the ancillary providers. The minimum necessary disclosure of PHI to the ancillary providers includes name, ID number, DOB, address, phone number, Diagnosis, current medical condition, and discharge order.

Retrospective reviews – Blue Shield Promise UM Department also performs retrospective review of care provided to its member without prior authorization or inpatient hospitalization has been deferred due to lack of inpatient concurrent reviews. When this situation occurs, the case will be required to obtain a full medical record review for medical necessity.

Clinical Appeals – clinical appeals will be handled by the Blue Shield Promise UM Department. Appeals for denial, deferral, and/or modification determinations may be filed by the Primary Care Physician, provider requesting service, or by the member or member's representative. The minimum necessary PHI required for the clinical appeals include, name, DOB, address, telephone number, Diagnosis, service requested, DOS (if applicable), and additional clinical information to justify the requested service, i.e., medical record, progress notes, labs, diagnostic results, consultation notes, and medication list.

Independent Medical Review (IMR) – The IMR process is an expansion of the appeal process for health plan enrollees. Independent Medical Reviews are conducted through the Department of Managed Health Care. Blue Shield Promise is required to disclose all medical records that are relevant to the member's medical condition and the disputed health care services requested to the Department of Managed Health Care.

All request, uses and disclosures of a non-routine nature, including requests from public officials, another covered entity, persons providing professional services to the company, or persons conducting research, must be submitted to the Privacy Officer for the case by case determination of compliance with the minimum necessary rule by the Utilization Management Director. The Privacy Officer may consult, CFO, CMO, or legal counsel in making this determination.

REFERENCES