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Appendix for Section 5

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Utilization Management Delegation Standards

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Utilization Management Delegation Standards

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Utilization Management Delegation Standards Overview

Blue Shield of California (Blue Shield), as the Managed Care Organization (MCO), is responsible for the management and provision of care to all contracted members. Much of this health care is provided through contractual arrangements with Independent Provider Association/Medical Groups (IPA/medical groups) throughout California. Additionally, contractual arrangements have been established with other entities such as Managed Behavioral Health Organization (MBHO) and other specialty health plans (e.g., for chiropractic services). These entities, based on our monitoring of their demonstrated performance to comply with the requirements of the Blue Shield of California UM Program, will be delegated for certain Utilization Management (UM) administrative functions.

When a group is delegated for UM, it is responsible for all UM functions delegated to them for all Blue Shield members assigned to them, unless the services are excluded from delegation by the Delegation Agreement or Contract.

IPA/medical groups are not delegated for appeals, experimental and investigational procedure determinations, cancer clinical trials, specific major organ transplants, and any prescriptions, which require prior authorization from the Blue Shield Pharmacy Department.

In order for the entities to qualify for initial delegation status, pre-delegation audits are performed. Blue Shield's standards for delegated UM will comply with NCQA Standards, CMS guidelines when applicable, and incorporate relevant state and federal regulatory standards and specific Blue Shield requirements. These standards are updated and approved on an annual basis by the Blue Shield Delegation Oversight Committee in order to meet new regulatory requirements and quality monitoring agencies.

Delegation status, whether in total or in part, is renewable annually but can be revoked upon Blue Shield's determination that the entities are no longer able to meet the delegation requirements. In addition, the group may qualify for delegation with corrective actions. These corrective actions can include changes by the IPA and may involve Blue Shield managing or co-managing various functions. Revocation of delegation may include deducting from group's capitation payment an amount commensurate (as spelled out in the services contract) with the reduced obligations required of the group.

Continued delegation or reestablishment of a delegated function is contingent on achieving compliance, as determined by a reevaluation similar to the initial delegation audit, of the entities' processes, UM Program, associated structure, and performance outcomes which demonstrate successful management of the delegated function. Underpinning these audit measures is the expectation that the IPA/medical group demonstrate a commitment to applying evidence-based medicine (EBM) to the delivery of care to Blue members. This commitment must be in evidence through educational outreach to their network physicians regarding the practice of EBM, application of EBM to the prior authorizations process for elective procedures, and the delivery of acute care in an inpatient setting. As a part of this annual evaluation, the entities must comply with all reporting requirements per the attached schedule and with any legislative mandates or regulatory requirements that are mandated and communicated to the group.

Utilization Management Delegation Standards Overview *(cont'd.)*

Additional auditing and review of compliance is conducted at least annually in conjunction with other oversight measures, and more often as appropriate, to evaluate the entity's ability to continue in the delegated status. In addition, Blue Shield shall use other measures as appropriate to oversee the entity's management of Blue Shield patients. This may include, but is not limited to surveys, reports, personal interviews with staff, system control review and chart reviews. The following outlines the Utilization Management Standards and Reporting Requirements Blue Shield expects of its delegated entities.

Evaluation for Delegation

An evaluation of the entities' abilities to perform delegated utilization management activities is conducted within twelve months prior to contracting, or prior to delegation for entities already contracted with Blue Shield, and at least once annually thereafter. The outcome of the evaluation determines the delegation status. This process ensures that the standards set by Blue Shield and all appropriate governing regulatory agencies are met.

As part of the ongoing oversight, the entities must comply with reporting requirements, submitting required documentation per the schedule outlined in these standards. Blue Shield's Delegation Oversight Nurses review the submitted documentation for compliance twice a year prior to the annual evaluation. Entities will be evaluated for their compliance with legislative, CMS and NCQA standards for delegation of utilization management functions using Blue Shield of California's Standardized Utilization Management Audit Tool and Scoring Guidelines. This tool includes Blue Shield and NCQA standards, CMS guidelines, as well as federal and state legislative requirements. The entities may wish to use this tool prior to their delegation evaluation to self-audit their preparedness. A copy of this tool will be sent to the IPA prior to their annual audit and can be obtained from the assigned Delegation Oversight Nurse. The tool may be modified or updated during the year if regulations are changed, or laws are enacted. Blue Shield may elect to conduct periodic surveys to assess the IPA/medical group's medical management infrastructure and capabilities. These must be completed by the IPA/medical group within two weeks of the request.

Evaluation for Delegation *(cont'd.)*

Entities' Timely Submission of Corrective Action Plans

Blue Shield's approach to delegated entities' correction of deficiencies is based on a commitment to continuous quality improvement (CQI) and is educational and consultative in nature in an effort to promote collaboration and mutual success.

Upon identification of deficiencies, Blue Shield will outline the deficiencies in writing and send a "Audit results letter follow up needed" letter to the IPA/medical group. The entities are required to submit a response to the written Corrective Action Plan (CAP) for approval within 30 calendar days. The submitted CAP will include supporting documentation to demonstrate that measurable actions are taken to remediate identified deficiencies and identify key staff responsible for the implementation and information will be tracked by Blue Shield. In the event a CAP is issued for a file review, the group will need submit evidence of training when applicable, to all UM staff within 30 days of the initial CAP notification.

Blue Shield will review the implementation of the CAP to ensure correction of the deficiencies within 10 calendar days or an agreed timeframe from the date of receipt of the CAP response. If the CAP is in compliance with the Blue Shield requirements, a letter will be sent to the group confirming receipt and approval. If the CAP is not in compliance with Blue Shield requirements, a follow-up letter will be sent outlining the areas of deficiency and further requirements for compliance. Failure to correct deficiencies within stated timeframes will lead to further action, including additional audits or monitoring and revocation of specific delegated functions. Revocation of specific delegated functions may be required until the entity can demonstrate the ability to perform the function in compliance with Blue Shield standards.

Standards for Program Structure and Processes

Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria

The delegated entity must have a well-structured UM program and make utilization decisions affecting the health care of members in a fair, impartial, and consistent manner. The UM Program Description may be contained in a separate document or included in the *UM/Case Management Policies and Procedures Manual*. Evidence that the UM Program, Policies & Procedures, and Review criteria are being followed may be requested.

The UM Program Description or the Policies and Procedures (P&P) should include the following elements for all activities performed:

- Approval date and signature by the appropriate senior management or the chairperson of the group's Utilization Review/Quality Management Committee.
- Program description must be organized and written so that staff members and others can understand the program's structure, scope, processes, and information sources used to make UM determinations.
- Confidentiality statement.
- Structure and accountability outlined.
- Defined scope of program, processes, and information sources to make appropriate benefit coverage and medical appropriateness determinations.
- Designated senior physician involvement. There must be evidence that this physician has a California license with no restrictions.
- Description of the specific behavioral health aspects of the UM program. This description should include the processes for centralized triage and referral, as applicable.
- Description of how a designated behavioral healthcare physician or a doctoral-level behavioral healthcare practitioner is involved in implementing and evaluating the behavioral health aspects of the UM program. The behavioral healthcare practitioner must be a physician or have a clinical PhD or PsyD, and may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable).
- Clearly defined staff responsibilities and qualifications.

Standards for Program Structure and Processes *(cont'd.)*

Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria *(cont'd.)*

- Appropriately licensed health professionals supervise all the review decisions, including a physician review of any medical necessity denial determination. Medical necessity denials must be reviewed by either a psychiatrist with an unrestricted California license or a doctoral-level clinical psychologist with an unrestricted California license for any denial of behavioral health care based on medical necessity. The group must be able to provide evidence of medical necessity review either with electronic or written documentation.
- Qualified licensed health professionals assess the clinical information used to support UM decisions.
- Description of authorization/review process.
- Written utilization management (UM) decision-making criteria that are objective and based on medical evidence. Involves appropriate practitioners in developing, adopting, and reviewing criteria. Criteria is reviewed annually by the UM Committee.
- Description of criteria for Length of Stay (LOS) and Medical Necessity, including:
    - The process by which the criteria are developed or chosen including the involvement of practitioners in the development or adoption of criteria and in the review of procedures for applying the criteria.
    - The procedures for applying criteria based on the needs of individual patients and assessment of the local delivery system.
    - The process by which criteria are reviewed, updated, and modified, at specified intervals and appropriate.
    - The evidence that the Health Plan's criteria, as defined in Blue Shield's Utilization Management Program Description, have been reviewed and adopted.
- A description of the process by which the medical necessity of inpatient admissions (including LOS) and outpatient services is determined, including those staff members who have the authority to deny coverage.
- Concurrent care shall not be discontinued until the treating provider has been notified of the health plan delegate's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient. The member and provider are informed in writing of the decision.
- Inpatient reviews should include pre-admission, concurrent, discharge planning, case management (if appropriate) and retrospective review.
- Outpatient reviews should include, but not be limited to ambulatory, diagnostic procedures, specialty referrals, referrals to non-contracted providers, retrospective review.

Standards for Program Structure and Processes *(cont'd.)*

Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria *(cont'd.)*

- Emergency services policy and procedures.
- A description of the data and information used in making determinations.
- Process for redirecting requests for non-delegated functions, including cancer clinical trials, specific major organ transplants, non-formulary drugs or any prescriptions which require prior authorization from the Blue Shield Pharmacy Department, appeals.
- A description of the procedures by which the entities facilitate the ability of a member and practitioner to appeal to the health plan and Department of Managed Health Care (DMHC) or Centers for Medicare & Medicaid Services (CMS) for a determination.
- A description of the process of how practitioners and members can obtain the UM criteria and how the criteria is made available upon request.
- Disclosure of the general processes and criteria used to approve or deny care to anyone, upon request.
- Guidelines, criteria, or substantiated documentation of rationale must be used for making utilization review (UR) decisions. That criteria and source of the criteria must be described in the denial letter sent to the member with documentation of what criteria was not met.
- Description of case management program.
- Documentation of referral process to notify the Health Plan about authorization requests for services which are investigational or experimental for Health Plan determination.
- Description of denial process, and the use of Blue Shield-approved denial letter language including DMHC or CMS appeal language informing the member of the right to appeal and referring the member to Blue Shield's Member Services department.
- Method for implementing corrective action.
- Process for communicating information back to the Health Plan.

Standards for Program Structure and Processes *(cont'd.)*

Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria *(cont'd.)*

- Process for determining inter-rater reliability IRR (consistency of review decision making) regarding the application of clinical review criteria, including (at a minimum):
    - Annual performance goals for inter-rater reliability (IRR) of at least 90% should be achieved. When the threshold is not met, a remediation plan will need to be provided by the delegate.
    - All new staff must meet 90% threshold prior to conducting independent utilization reviews without supervision.
    - Review of physician and non-physician staff involved in UM decision-making.
    - Documented evidence that the entities have evaluated conformity with Health Plan medical policy, including conformity with Health Plan clinical practice guidelines, preventive health guidelines and other published policy.

Review Committees are strongly encouraged to utilize nationally developed evidence-based, acceptable review criteria; e.g., Milliman Care Guidelines and InterQual®. Blue Shield Medicare Advantage HMO participants must utilize the Centers for Medicare & Medicaid Services (CMS) national and local coverage guidelines.

On an exception basis only, entities may also develop their own criteria with the involvement of participating practitioners. Such criteria must be based on documented scientific medical evidence that covers the broad scope of services provided and approved by the IPA/medical group UM Committee. In addition, there must be evidence that criteria were reviewed by physicians with sufficient expertise in the criteria being adopted and the criteria must encompass a full scope of services. The medical group's own criteria must be available to Blue Shield for review.

The entities' Review Committee must use Blue Shield's Medical Policy for decision-making when available. These Medical Policies includes the application of Clinical Practice and Preventive Health Guidelines, as well as findings by the Blue Shield Medical Policy Committee. For Blue Shield Medicare Advantage plan participants, Medicare national and local coverage guidelines must be the first guidelines used whenever available for Blue Shield Medicare Advantage plan patients.

Blue Shield may request that evidence of criteria, policies, procedures, and UM program descriptions are being followed.

Standards for Program Structure and Processes *(cont'd.)*

Use of Qualified Professionals in Decision Making

The entities must utilize qualified health professionals to assess the clinical information used to support UM decisions. The entities must have written procedures requiring:

- Appropriately licensed health professionals to supervise all medical necessity decisions.
- Description of the personnel responsible for each level of UM decision-making.
- Written job description, with qualifications, for physicians who review medical necessity denials that requires:
  - Education, training, or professional experience in medical practice.
- Behavioral healthcare medical necessity denials are reviewed by a physician or appropriate behavioral healthcare practitioner, with an unrestricted California license, UM Medical Directors must hold an active unrestricted California medical license.
- Written procedure for using board-certified internal and external consultants to assist in making medical necessity determinations.
  - Evidence of Board-Certified consultants in making decisions on adverse determinations.
- Evidence that compensation plans for individuals who provide utilization review services do not contain financial incentives, direct or indirect, for those individuals who are making review decisions.

Entities' Utilization Management Committee Meetings

Utilization Management Committee Charter/Mission Statement

UM Committee responsibilities, processes, and activities must be delineated through a written charter or committee mission statement. This document must include:

- Term of membership
- Committee composition (including specialties represented)
- Voting rights
- Definition of quorum of voting members
- Provision for Health Plan representatives to attend Committee meetings
- Frequency and schedule of meetings
- Committee / Subcommittee reporting relationship
- Outline of Committee responsibilities

Standards for Program Structure and Processes *(cont'd.)*

Entities' Utilization Management Committee Meetings *(cont'd.)*

Entities' Utilization Management Committee Meeting Minutes

The entities' UM Committee meeting minutes must reflect the following:

- Oversight of the UM process (as outlined in previous sections).
- Approval of UM policies/procedures and standards.
- Results/reports of clinical data and UM statistics.
- Evidence of feedback/ongoing education of physicians/practitioners by the committee.
- UM information relevant to quality improvement activities is identified and reported to the entities' Quality Improvement/Peer Review committee.
- The delegated entities' written Utilization Management (UM) Program Description, work plan, UM/Case Management policies and procedures and utilization review decision protocols (review criteria) must be reviewed and approved on an annual basis by the entities' UM Committee, which will recommend changes to the entities' Board of Directors, as necessary.

The Committee's minutes must be on file and available for Health Plan reviewers.

Health Plan Attendance at Review Committee Meetings

The review process conducted by each entities' UM Committee will be conducted by participating physicians who will be the only voting members on the Committee. However, a Health Plan representative may attend any meeting of the UM Committee that deals with utilization of services provided to Blue Shield members. The Blue Shield representative will generally be a member of the Blue Shield's Delegation Oversight Staff or Medical Director who will contact the entities to request attendance at the meeting. The representative will monitor the process used by the entities to conduct review, provide technical assistance, and provide data summaries or other information as needed to facilitate the operation of the UM Committee.

Member and Practitioner Communication Services Regarding Utilization Management Process and Authorization of Care Standards

The entities must have processes in place to provide access to staff for members and practitioners seeking information about the UM process and authorization of care. The process for areas outlined below must be evidenced by a written description that outlines the delegated entity's system of operation and may include policies and procedures, process flow charts, protocols, and other methods that describe the actual process used by the delegated entity.

Staff Availability During Normal Business Hours

- Staff must be available at least eight hours a day during normal business days and business hours to receive inbound collect or toll-free calls and outbound communications regarding UM issues.
- Staff must respond to general UM inquiries which may include speaking directly with practitioners and members by telephone, including voicemail, electronically, or fax.
- Staff must document inbound and outbound communications and their response.
- Staff must triage and refer specific UM communications to UM staff.
- Staff must identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- TTD/TTY are available for members who may need them.
- Language assistance for members to discuss UM issues.

Staff Availability After Normal Business Hours

Staff must be able to receive inbound communications after normal business hours either by directly speaking with practitioners and members by telephone, voicemail, electronically, or fax.

Initial Organization Determinations (Treatment Authorization Request Decisions) Standards

Evidence That Determinations of Coverage Are Based On Medical Necessity, Are Appropriate and Are Based on Sound Clinical Evidence

The entities must obtain relevant clinical information and consult with treating physicians, take into consideration the individual needs of patients and characteristics of the local delivery system, and consult with treating physicians before making a determination of coverage. This process must be evidenced as indicated below:

- A written description (policy) that identifies information collected to support UM decision making.
- Evidence that relevant clinical information is collected to support UM decisions and documented appropriately.

Overturned Initial Determinations by Health Plan

Blue Shield may overturn any entity's decision that does not meet Blue Shield approved medical policy or recommended medical necessity review criteria. A decision to overturn the determination of the entities will be made by the Blue Shield Medical Director or a designated physician advisor, involving discussion with and/or notification to the entity's Medical Director. Groups are required to submit any information that is related to a denial when it is requested by Blue Shield.

Second Opinions (California Health and Safety Code 1383.15)

- Second opinion authorizations for members will be approved, when requested, as appropriate. Second opinion requests regarding care from the assigned PCP shall be provided by an appropriately qualified health care professional of the member's choice *within the entity's network* and within the entity's scope and practice.
- A second opinion authorization process for care from specialists and other licensed health care providers inside the member's IPA/medical group is the responsibility of the IPA/medical group.
- Second opinions will be rendered within 72 hours when the member faces an imminent or serious threat to life or health.
- The authorization process takes into account the member's ability to travel to the practitioner rendering the second opinion.
- If the second opinion differs from the initial, coverage for third opinion is available if requested.
- The above types of second opinion authorization requests are a delegated function.
- Considerations of requests for second opinions by non-contracted providers are not delegated and are referred to Blue Shield for approval or denial.

Medicare is excluded from this legislation. For D-SNP Plans, Second Opinions are reviewed under the Medi-Cal Benefit. See the *Blue Shield Promise Medi-Cal Provider Manual* for process steps.

Initial Organization Determinations (Treatment Authorization Request Decisions) Standards *(cont'd.)*

Organ Transplants (Commercial HMO)

All transplant evaluations and transplant authorization decisions for kidney, cornea and skin are the responsibility of the IPA/medical groups that are delegated for UM. Members needing transplant evaluations should be directed to a Blue Shield transplant center.

Non-Delegated Initial Determinations

There are certain initial authorization determinations that Blue Shield does not delegate. Please refer to the Blue Shield *HMO IPA/Medical Group Procedures Manual* or contact Blue Shield Performance Improvement for questions regarding non-delegated utilization management activities or non-delegated initial determinations. Non-delegated initial determination activities include the following:

- **Major organ transplant for Commercial HMO** – Transplant authorizations for other than kidney, cornea, and skin are Blue Shield's responsibility and will be coordinated with the IPA/medical group. All evaluations for transplant and transplantation are performed by a designated facility identified as part of Blue Shield's Transplant Centers of Excellence as specified by product line. (Call your Blue Shield Medical Care Solutions Transplant Case Manager or your Delegation Oversight Nurse for information.)
- **Major organ transplant for Blue Shield Medicare Advantage plan –** All transplant evaluations and transplant authorizations are the responsibility of Blue Shield Medicare Advantage Plan Medical Care Solutions. Blue Shield Medicare Advantage plan members must receive organ transplants from Medicare-designated transplant facilities. (Information regarding the location of these facilities may be obtained by contacting Blue Shield Medical Care Solutions Transplant Case Manager.)
- **Hip or knee replacement surgery for CalPERS Commercial HMO** – Referrals for hip or knee replacement surgery for commercial HMO CalPERS members are the responsibility of Blue Shield. Commercial HMO CalPERS members must have these surgeries performed at a Blue Shield Preferred Center, unless otherwise authorized by Blue Shield.
- **Prescriptions which require prior-authorization through the Blue Shield Pharmacy Department** – (Examples include non-formulary, some self-injectable medications.)

Initial Organization Determinations (Treatment Authorization Request Decisions) Standards *(cont'd.)*

Non-Delegated Initial Determinations *(cont'd.)*

- **Experimental/Investigational care/services** – If an experimental/investigational treatment is not approved by Blue Shield Policy, or there is no Blue Shield policy regarding requested services, the entity is not delegated for determination and a request must be submitted to Blue Shield for determination. If groups are unable to determine whether the services are or are not experimental/investigational, they should forward their request to Blue Shield for determination.
- **Cancer Clinical Trials** – Blue Shield is responsible for making decisions of coverage for commercial cancer clinical trials.
- **Second Opinions Outside the Member's IPA/medical group** – Second opinion authorization process for care from specialists and other licensed health care providers for care outside the member's IPA/medical group is the responsibility of Blue Shield. Specialist second opinions can be with any specialist or other licensed health care providers within Blue Shield's HMO network. Medicare second opinions must be within the group network if available.

Triage and Referrals for Behavioral Health Care

If the delegated IPA/medical group has a centralized triage and referral process to address a member's needs, including crisis or clinically emergent situations, the entity must have the following program elements in place:

- Evidence of the entities' protocols for mental health and substance use triage and referral, and process to define the level of urgency and appropriate setting of care. Implementation of current, clinically based triage and referral guidelines/protocols represent currently acceptable practices for behavioral health care (including mental health and substance use).
- Protocols define a level of urgency and appropriate setting of care.
- Protocols used by staff have been reviewed or revised within the past two years.
- Decisions not requiring clinical judgment are made by appropriately trained triage and referral personnel (e.g., providing information on whether a specific provider is in the network) with evidence that they have received the necessary education and training regarding protocol use.
- Appropriately licensed behavioral health care practitioners must make triage and referral decisions that require clinical judgment. These licensed staff must be supervised by a licensed master's-level practitioner. In addition, evidence must show that a licensed psychiatrist or doctoral-level clinical psychologist with experience in clinical risk management oversees all triage and referral decisions (within the scope of his/her license to practice).

UM Decision Timeliness Standards – Commercial

The entities make timely UM decisions, as follows, based upon state and federal regulatory requirements, NCQA Standards and the clinical urgency of the situation. Decisions should be made as expeditiously as possible, in the least time needed based on a member's condition.

Web Portal Notification/Provider

If a practitioner web portal is used to provide electronic denial notifications, the entity must:

- Inform practitioners of the notification mechanism and their responsibility to check the portal regularly.
- Document the date and time when the information was posted in the portal.
- Provide alternative notification method for practitioners who do not have web portal access.
- Ensure a process is in place for notifying a practitioner of a denial notification via the web portal.

Web Portal Notification/Member

The organization must document the member's agreement to receive electronic notifications via the portal. The entity must:

- Document the date and time when the information was posted in the portal.
- Members receive notification that a new document or update is available in the portal when posted.
- Provide alternative notification method for members who do not have access to the web portal access or do not agree to receive notifications via the web portal.
- Ensure a process is in place for notifying a member of a denial notification via the web portal.

UM Decision Timeframes – Commercial Standards Table

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic/ Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 72 hours after receipt of the request.**	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. ***Note:*** If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed • Additional clinical information required	Additional clinical information require Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information. ***Note:*** Decision must be made in a timely fas appropriate for the member's conditi to exceed 48 hours after receipt of information.	*Additional information received or incomplete* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials). Member: Within 48 hours after receipt of information (for approval decisions). Document date and time of oral notifications.	*Additional information received or incomplete* Within 48 hours after receipt of information. ***Note:*** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
	Additional information not received: If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. ***Note:*** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after the deadline for extension has ended.	*Additional information not received* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials). Member: Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions). Document date and time of oral notifications.	*Additional information not received* Within 48 hours after the timeframe given to the practitioner & member to supply the information. ***Note:*** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic/ Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. **Exceptions:** • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to *Urgent Pre-service* category. If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to *Non –urgent Pre-service* category.	Within 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request. ***Note:*** If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.
Standing Referrals to Specialists / Specialty Care Centers **-** All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. ***Note:*** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent, or non-urgent) for specific notification timeframes.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent, or non-urgent) for specific notification timeframes.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic/ Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
Non-urgent Pre-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	*Additional clinical information required*: Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be ma in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	Require consultation by an Expert Reviewer: Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5-business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	*Require consultation by an Expert Reviewer.* Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	*Require consultation by an Expert R* Within 2 business days of making the decision.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic/ Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Post-Service - All necessary information received at time of request (decision and notification are required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request (for approvals). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
Post-Service - Extension Needed • Additional clinical information required Require consultation by an Expert Reviewer	Additional clinical information require Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	*Additional information received or incomplete* Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	*Additional information received or incomplete* Within 15 calendar days of receipt of information.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	*Additional information not received* Practitioner: Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). Member: Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	*Additional information not received* Within 15 calendar days after the timeframe given to the practitioner & member to supply the information.
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30-calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic/ Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
	Require consultation by an Expert Reviewer: Within 15 calendar days from the date the delay notice.	*Require consultation by an Expert Reviewer:* Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 15 calendar days from the date of the delay notice.
Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity). 2. Non-Urgent (e.g., post-service pend or denial notifications).	**LAP Services Not Delegated:** All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request. 2. Request forwarded within two (2) business days of member's request.		**LAP Services Delegated/Health Plan:** All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.
Prescription Drugs CA Health & Safety Code Section 1367.241 (CA SB 282; 2015-2016) *"**Exigent circumstances**" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function **OR** when an insured is undergoing a current course of treatment using a non-formulary drug.	▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	Practitioner: ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***Note:*** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.	Practitioner: ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***Note:*** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.

UM Decision Timeliness Standards – Centers for Medicare & Medicaid Services (CMS)

Decisions should be made in the least time needed based on the member's condition.

Web Portal Notification/Provider

If a practitioner web portal is used to provide electronic denial notifications, the entity must:

- Inform practitioners of the notification mechanism and their responsibility to check the portal regularly.
- Document the date and time when the information was posted in the portal.
- Provide alternative notification method for practitioners who do not have web portal access.
- Ensure a process is in place for notifying a practitioner of a denial notification via the web portal.

Web Portal Notification/Member

The organization must document the member's agreement to receive electronic notifications via the portal. The entity must:

- Document the date and time when the information was posted in the portal.
- Provide members notification that a new document or update is available in the portal and when it was posted.
- Provide alternative notification method for members who do not have access to the web portal access or do not agree to receive notifications via the web portal.
- Ensure a process is in place for notifying a member of a denial notification via the web portal.

UM Decision Timeframes – CMS Standards Table

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. • Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
For D-SNP Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	Decision must be made within 5 working days from receipt of the information reasonably necessary to render a decision, but no later than 14 calendar days from receipt of request (if it for a Medicare service). Extensions are not permitted for D-SNP Members in Los Angeles and San Diego	Practitioner: Within 24 hours of the decision (for approvals, denials, and modifications). Member: Within 2 business days of the decision (for denials/modifications decisions).

Type of Request	Decision	Notification Timeframes
	Counties.	
Standard Part B Drug Requests	Within 72 hours after receipt of request (includes weekends & holidays). No extension.	Within 72 hours after receipt of request (includes weekends & holidays). No extension.
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	May extend up to 14 calendar days. ***Note:*** Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers.	Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. **Extension Notice:** • Give notice in writing within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay. 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ***Note:*** The Health Plan must respond to an expedited grievance within 24 hours of receipt. Decision Notification After an Extension: Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.
Expedited Initial Organization Determination - If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: • Automatically transfer the request to the standard timeframe. The 14-day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. • Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination; 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and Provide instructions about the expedited grievance process and its timeframes.

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination **- If No Extension Requested or Needed** (See footnote)[1]	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. Approvals – Oral or written notice must be given to member and provider within 72 hours of receipt of request. – Document date and time oral notice is given. – If written notice only is given, it must be received by member and provider within 72 hours of receipt of request. Denials – When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be received by member and provider within 72 hours of receipt of request. Use NDMC template for written notification of a denial decision.
Expedited Part B Drug Requests	Within 24 hours after receipt of request. No extension.	Within 24 hours after receipt of request. No extension.

[1] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination **-** If Extension Requested or Needed	May extend up to 14 calendar days. ***Note:*** Extension allowed **only** if member requests or the provider/ organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions **must not** be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension. **Extension Notice:** Give notice **in writing**, within 72 hours of receipt of request. The extension notice must include: The reasons for the delay 1) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ***Note:*** The Health Plan must respond to an expedited grievance within 24 hours of receipt. **Decision Notification After an Extension:** **Approvals** – Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. **Denials** – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be received by member and provider no later than upon expiration of extension. Use NDMC template for written notification of a denial decision.

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) within 2 calendar days of admission to a hospital inpatient setting. 2) not more than 2 calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).	Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital. ***Note:*** Follow up copy of IM is not required: • If initial delivery and signing of the IM took place within 2 calendar days of discharge. • When member is being transferred from inpatient-to-inpatient hospital setting. • For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.	Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO. **The DND must include:** • A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. • A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization. • Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. • Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case. • Any other information required by CMS.

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Termination of Provider Services: ▪ Skilled Nursing Facility (SNF) ▪ Home Health Agency (HHA) ▪ Comprehensive Outpatient Rehabilitation Facility (CORF) ***Note:*** This process does not apply to SNF Exhaustion of Benefits (100-day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services OR ▪ A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative • The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. • The NOMNC may be delivered earlier if the date that coverage will end is known. • If expected length of stay or service is 2 days or less, give notice on admission. ***Note:*** Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: • The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.

Note: Health plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

UM Decision Timeliness Standards – Centers for Medicare & Medicaid Services (CMS) *(cont'd.)*

Review of Emergency Services

It is the expectation of Blue Shield that each entity provides emergency services to members in keeping with state and federal guidelines. These guidelines include:

- The entity approves emergency services necessary to screen and stabilize members without pre-authorization of emergency services in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition exists.
- The entity approves emergency services if a practitioner or other representative acting through the IPA/medical group has authorized the provision of emergency services.
- The entity may utilize Blue Shield's Automatic Payment Emergency Diagnosis List (Autopay List) for approval, which is available for both Medicare and Commercial products, as part of the ER claim review process.

Medicare Expedited Initial Determination Process and Tracking

The Centers for Medicare & Medicaid Services (CMS) mandated an expedited review requirement effective August 1997 for Medicare members. If a request for expedited initial determination meets criteria, the determination must be made within a required 72 continuous hour time frame (including nights, weekends, and holidays). If a request does not meet criterion for expedited review, the delegate will notify the member within 72 hours and send written follow up. The time frame begins when the request to expedite the determination is received by Blue Shield Medicare or the IPA/medical group (not after all medical information has been obtained).

The entity may contact the health plan to request extensions to the 72-hour timeframe up to 14 additional calendar days if the extension benefits the beneficiary, such as allowing time for additional diagnostic testing or consultation with medical specialists; or if the beneficiary requests an extension to provide additional information. Failure of the entities to make an expedited initial determination within the time frame will result in the health plan making the determination on the entity's behalf.

- When Blue Shield receives a member request for an expedited initial organization determination, the health plan will notify the entities of the request via telephone. The 72 continuous hour decision time frame begins from the time the call is received by Blue Shield.
- The health plan will work with the entity to ensure that a decision is made within the required timeframe. Blue Shield will notify the member of the group's determination by telephone and by letter if the request is approved. The entity is responsible for issuing any applicable denial notices.
- The health plan may obtain a written approval from the member to extend the decision time frame for up to 14 days in order to make a more informed decision if the delay will benefit the member.

Denial Standards

Each entity shall provide evidence of use of approved denial letter language to communicate service denials (adverse initial determinations) to members and practitioners. The required denial letter language differs between Medicare and Commercial HMO products. The delegated entities must be certain their process allows for the selection and issuance of the correct denial letter format, given the product and the circumstances surrounding the denial.

The written notification of a denial must be sent to members and practitioners within specified notification timeframes, as appropriate, explaining the reason for the denial and must inform the member of the right to appeal, including their right to external review, and refer the member to the Blue Shield appeal process.

Service Denial Letter Format Components

An approved service denial letter (written notification) format shall be created on the letterhead of the entity, and shall include the following elements:

- Member name and address.
- Subscriber ID number.
- Date.
- The service requested.
- Notification of the initial determination (review decision).
- The specific reasons for the denial, in easily understandable language.
- Reference to the member's evidence of coverage, if the service was not a covered benefit, or for additional language regarding coverage.
- A statement that members can obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based, upon request.
- Description of the benefit provisions, criteria, guidelines, protocol, or other similar criteria used (if any) and the clinical reasons for the medical necessity decision. In addition, reference to the particular criteria used. A copy of the scientific or clinical information must be provided upon request. Contact information and procedures to follow to obtain the information must be included in the denial letter.
- Suggestion for alternative treatment or services, if appropriate.
- Right to request an appeal (reconsideration) includes language with regard to members' right to submit written comments, documents, or other information relevant to the appeal.
- An explanation of the appeal process, including members' rights to representation and appeal time frames.

Denial Standards *(cont'd.)*

Service Denial Letter Format Components *(cont'd.)*

- Right to request a 72-hour expedited appeal process from Blue Shield's Appeals and Grievance Department.
- Right to request an external review from the DMHC. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.
- Blue Shield Medicare Advantage plan denial letters must conform to CMS regulatory requirements.
- If member's employer is governed by the Employee Retirement Income Security Act ("ERISA"), include mandated ERISA statement in denial letter regarding the member's the right to bring a civil action under Section 502(a) of ERISA if all required reviews of the service/claim have been completed and the service/claim has not been approved. (Commercial only).
- Inclusion of the DMHC appeal process, address, Internet address and phone numbers. (Commercial only).
- Inclusion of Blue Shield's Notice of the Availability of Language Assistance Services with all denial letters to the member.
- Inclusion of Blue Shield's Notice Informing Individuals about Nondiscrimination and Accessibility Requirements.
- Appropriate Medicare appeal language for denial letters issued to Blue Shield Medicare Advantage plan members.
- Reference to any other reconsideration entity that the member may wish to access (e.g., CMS denial letters provide for reference to the quality improvement organization (QIO) authorized by Medicare (CMS) to review inpatient hospital services.).
- Reference to attachments appropriate to the subject of the letter.
- Notification letter to the physician or other provider must include the name and direct phone number or extension of the professional who is responsible for the decision, i.e., the Medical Director or behavioral health care provider.
- For Blue Shield Medicare Advantage plans, denial notification letters must be in keeping with the approved CMS format and content.
- For Blue Shield Medicare Advantage plans, facility denials must contain an acknowledgement page, which is signed by the member and witnessed by the staff issuing the letter.

Note: Appeals are not a delegated UM activity but may be delegated separately under Member Rights and Responsibilities to fully Knox-Keene licensed entities in the Commercial HMO.

Denial Standards *(cont'd.)*

Medicare Service Denial Letters

Blue Shield denial letter templates may be obtained by contacting a Blue Shield Delegation Oversight Nurse or by accessing the Health Industry Collaboration Effort (HICE) website at iceforhealth.org.

> *Note:* All initial determination/service denial letters sent to Medicare beneficiaries must be issued in **12-point font**.

Should you have any questions regarding the use of CMS-approved service denial letter formats, please contact your Blue Shield Delegation Oversight Nurse.

D-SNP Coverage Decision Letters can be found on Provider Connection at blueshieldca.com/provider in the *Forms* section.

Evaluation of Entities' Handling of Denials

Blue Shield's reporting requirements and audit process ensure simultaneous review of denials, which includes evaluating the appropriateness of the determination. In order to understand and provide oversight for the contracted IPA/medical group, Blue Shield requires that all denials, for both Commercial and Medicare services, be submitted at least monthly via a log unless otherwise specified (for fully Knox-Keene licensed entities). The entities will be evaluated at least annually for handling of UM denials (both Medicare and Commercial) including whether:

1. Time frames are met.
2. Medical Director/physician reviewer's reason for decision is documented in the denial file.
3. Adequate and appropriate information is gathered to make an appropriate initial denial decision.
4. Reasons for denial are clearly and concisely documented in terms the member will understand. The benefit provisions, criteria, guidelines, protocol, or other similar criteria used (if any) and the clinical reasons for the medical necessity decision are documented. *Note:* A copy of the scientific or clinical judgment must be provided upon request and the contact information and procedures to follow to obtain the information must be included in the denial letter.
5. Alternate treatment plan is identified when medically indicated.
6. Appropriate denial letter language and protocol is used for members and practitioners.
7. Notification letter to the physician or other provider includes the name and direct phone number of the professional who is responsible for the decision, i.e., the Medical Director.
8. Upon member request, the identity of experts whose advice was obtained on behalf of Blue Shield in connection with an adverse determination must be provided without regard to whether the advice was relied upon to make the determination.

   Note: Entities must comply with the additional UM standards in #8 above to align with the Employer Retirement Income Security Act (ERISA) upon the member's employer group enrollment or renewal. The additional UM requirements will apply to IFP members and any remaining members after 1/1/2003.
9. The appeal process is clearly explained in each denial letter. Letters for denial, modification, or delay of treatment or service, based on a decision that the service is not medically necessary, must include the external review process. Requests for external review are handled by the DMHC with submission of the request to an independent agency.
10. Explanation of appeal process clearly explains the members' right to submit written comments, documents, or other information relevant to the appeal for all denials, whether they are based on a decision for benefits or medical necessity.

Evaluation of Entities' Handling of Denials *(cont'd.)*

11. The member's right to an expedited appeal in compliance with the Expedited Review regulations is clearly explained in each denial letter. (Procedures for referring expedited appeals must be in place which allow for initiation of the appeal process by member or physician/practitioner. The entities must demonstrate knowledge of the member's and practitioner's appeal rights as well as ability to provide necessary information to the Health Plan within required response time frames.)
12. Inclusion of the mandatory DMHC language (Commercial only).
13. Inclusion of Blue Shield's Notice of the Availability of Language Assistance Services.
14. Inclusion of Blue Shield's Notice Informing Individuals about Nondiscrimination and Accessibility Requirements.
15. Inclusion of the mandatory ERISA language, for members whose employers are governed by the Employee Retirement Income Security Act (ERISA), stating the right to bring a civil action under Section 502 (a) of ERISA if all required reviews of the service/claim have been completed and the service/claim has not been approved (Commercial only).
16. Entities must maintain a tracking system for all denials.

Standards for Personal and Health Information (Protected Health Information)

Entities are required to sign a Business Associate Agreement that includes, but is not limited to:

- A list of the permitted uses and disclosures of Protected Health Information (PHI).
- A description of information safeguards to preserve the confidentiality of and prevent inappropriate use or unauthorized disclosure.
- A stipulation that the delegate ensures that subdelegates have similar safeguards.
- A stipulation that the delegate will provide individuals (or individual's personal representative) with access to their protected health information.
- A stipulation that the delegate will inform Blue Shield of illegal, inadvertent, or wrongful disclosure or inappropriate uses of the information when it occurs.
- Upon termination of the delegation agreement, the delegate will return, destroy, or protect PHI within 30 days of the termination.

Standards for Personal and Health Information (Protected Health Information) *(cont'd.)*

Standards for Evidence of Oversight for Any Delegated (Sub-Delegated) Activity, When Applicable

Entities that have a sub-delegated arrangement must have a mutually agreed upon delegation document defining the following:

- Describes the delegated activities and the responsibilities of the organization and the sub-delegated entity.
- Requires at least semiannual reporting by the sub-delegated entity to the organization.
- Describes the process by which the organization evaluates the sub-delegated entity's performance.
- Describes the process for providing member experience and clinical performance data to its sub-delegates when requested.
- Describes the remedies available to the organization if the sub-delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Additionally, there must be evidence that the entities:

- Conduct an initial assessment prior to sub-delegation;
- Annually reviews the sub- delegates UM Program;
- Annually audits UM denials files against NCQA standards;
- Semi-annually evaluates required reports, and
- Annually evaluates sub-delegates' performance.

If the entity sub-delegates and the delegation arrangement include the use of protected health information, the delegation document must also include the following provisions:

- A list of the allowed uses of protected health information.
- A description of delegate safeguards to protect the information from inappropriate use or further disclosure.
- A stipulation that the delegate will ensure that sub-delegates have similar safeguards.
- A stipulation that the delegate will provide individuals with access to their protected health information.
- A stipulation that the delegate will inform the entity if inappropriate uses of the information occur.
- A stipulation that the delegate will ensure protected health information is returned, destroyed, or protected within 30 days if the delegation agreement ends.

The Blue Shield Delegation Oversight Nurse will review Policies and Procedures along with the annual site review, audit findings, Corrective Action Plan, and regular reports that the delegated entity receives from the sub-delegate.

Standards for Personal and Health Information (Protected Health Information) *(cont'd.)*

Member Experience and Clinical Performance Data

Blue Shield will proactively share member experience and clinical performance data with the delegate, and also if requested by the delegate. Blue Shield's policy is as follows:

- Blue Shield will provide member experience and clinical performance data to the delegate.
- Data will be provided at in-person meetings such as JOMs and/or by secure email.
- Data will be provided at least annually but may be provided as frequently as monthly if appropriate.
- Examples of data to be provided include utilization data from claims, Member Experience Survey Data, and selected quality measures.
- Examples of member experience data include CAHPS survey results, or other data collected on experience with delegate services.
- Examples of Clinical performance data include HEDIS outcomes and other clinical data collected by Blue Shield/delegate.
- Blue Shield shall allow the delegate to collect data necessary to assess member experience and clinical performance, if applicable.
- If, for any reason, Blue Shield does not allow the delegate to collect data from members or practitioners directly, Blue Shield shall provide data to the delegate, when requested.

Clinical Data Collection and Analysis Standards

The entities must collect data for tracking, trending, and education of the providers in the network and submit on their bi-annual report. Evidence to include health plan specific reports (12 months) containing supporting data which includes rate adherence to time frames for each category of request (i.e., urgent concurrent, urgent preservice, nonurgent preservice and post service.) If the organization is delegated for various lines of business, then reports should be generated to reflect those differences. Some areas of review include:

- Inpatient Metrics
- Referral Metrics
- ER Metrics
- UM TAT Metrics (Turn-around time decision, notification, and percent compliant for UM, BH and Pharmacy)
- Experience with the UM Process (Member and Provider)
- Over and Under Utilization Metrics

The entities must also document actions taken as a result of clinical data analysis, such as evidence of feedback to individual physicians/practitioners and use of data analysis in improvement of performance.

Standards for Personal and Health Information (Protected Health Information) *(cont'd.)*

Evaluation of Member and Practitioner Satisfaction with the UM Process Standards

The entities must evaluate member and practitioner satisfaction with the UM process as follows:

- Gather information from member and practitioners about their satisfaction with their UM process, at least annually.
- Address identified sources of dissatisfaction with corrective action within 30 days of receipt of information.
- Report satisfaction survey results and actions taken to address opportunities for improvement to Health Plan annually.

UM System Controls

IPA/medical groups are required to have policies and procedures describing system controls specific to UM denial notification, as listed below:

1. Defines the date of receipt consistent with NCQA requirements.
2. Defines the date of written notification consistent with NCQA requirements.
3. Describes the process for recording dates in systems.
4. Specifies titles or roles of staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.
5. Specifies how the system tracks modified dates.
6. Describes system security controls in place to protect data from unauthorized modification.
    - Limiting physical access to the operating environment that houses utilization management data, including, but not limited to, the organization's computer servers, hardware and physical records and files.
    - Preventing unauthorized access and changes to system data.
    - Password-protecting electronic systems.
    - Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.
7. Describes how the organization monitors its compliance with the policies and procedures in factors 1–6 (all content above) at least annually and takes appropriate action, when applicable.

Standards for Personal and Health Information (Protected Health Information) *(cont'd.)*

UM Systems Controls Compliance

At least annually, the organization demonstrates that it monitors compliance or audits reports with its UM denials controls by:

- Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modifications.
- Analyzing all instances of date modifications that did not meet the organization's policies and procedures for date modifications.
- Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.
- Documentation indicates the staff roles or department involved in the audit.
- The organization uses one of the following methods to audit files, if sampling it utilized:
    - 5 percent or 50 of its files, whichever is less, to ensure that information is verified appropriately.
    - The NCQA "8/30 methodology" available at www.ncqa.org/programs/health-plans/policy-accreditation-and-certification/

Commercial Required Reporting to Health Plan

Blue Shield requires regular activity reporting from its delegated groups. This reporting is used to facilitate Blue Shield's oversight and coordination of delegated activities. If Blue Shield identifies deficiencies, the delegate will develop a written action plan that includes specific time frames for resolution and demonstrates implementation of change and improvement in the delegated function.

For the purposes of reporting, the following table outlines reports to be submitted and frequency along with the activity or function the report is demonstrating.

Note: For Blue Shield Medicare Advantage plan reporting requirements, refer to Section 6.5.

Required Reporting to Health Plan – Commercial Standards Table

Activity / Function	Entity's Responsibilities	Reporting Frequency	Submit To
UM Program description and selected supporting policies and procedures as necessary to meet federal, state, NCQA and plan requirements.	Must be consistent with federal, state, NCQA and Blue Shield guidelines.	**Annually**	Delegation Oversight Nurse

UM Work Plan to include Commercial Reporting on:
• Acute & SNF
  - Bed Days/1000
  - Admits/1000
  - Average LOS
  - Readmits/1000
• Total number of processed Referrals
• Total number of Denials
• Denial Rate
• ER visit & Denial Rate
• Turn Around Time (TAT)
• Total # of decisions compliant with TAT & % compliant (UM, BH, Pharmacy)
• Total # of notifications compliant with TAT & % compliant (UM, BH, Pharmacy)
• % of Referrals that exceed TAT
• Member and Provider Satisfaction Results
• IRR results
• Updates to UM Program
	Must be consistent with federal, state, NCQA and Blue Shield guidelines.
	
	Maintain documentation of analysis and actions taken. Reports submitted must be Blue Shield specific.
		Semi-Annually	Delegation Oversight Nurse

UM Annual Evaluation	Must be consistent with federal, state, NCQA and Blue Shield guidelines.	**Annually**	Delegation Oversight Nurse

Activity / Function	Entity's Responsibilities	Reporting Frequency	Submit To
UM Criteria and Guidelines	Must be consistent with federal, state, NCQA and Blue Shield guidelines.	**Annually** (can be reviewed at time of annual delegation audit)	Delegation Oversight Nurse
Behavioral Health Reporting • Assessment of under-and over-utilization of UM data related to behavioral health	Maintain documentation of analysis and actions taken.	**Annually**	Delegation Oversight Nurse
Behavioral Health Reporting • Total number of processed Referrals • Total number of Denials • Denial Rate • Turn Around Time (TAT) • Total # of decisions compliant with TAT & % compliant • Total # of notifications compliant with TAT & % compliant • % of Referrals that exceed TAT • Total # OON requests • Total # of OON approvals • Member and Provider Satisfaction Results • IRR results • Updates to UM Program	Must be consistent with federal, state, NCQA and Blue Shield guidelines. Maintain documentation of analysis and actions taken. Reports submitted must be Blue Shield specific	**Semi-annually**	Delegation Oversight Nurse
Encounter Data	Submit ALL Encounter Data to Blue Shield.	**Monthly**	Electronic submission
End Stage Renal Disease	Report of any new members initiated on dialysis with a diagnosis of End Stage Renal Disease.	**Monthly**	ESRD@blueshieldca.com
Changes in Key Management and/or Professional Staff, including Sub-Delegated changes		**Monthly**	Network Management
Commercial Shared Risk Authorizations (For groups with shared risk contracts ONLY)	Includes all services that entities approve and deny that are paid out of shared risk pool. These include: • Acute and skilled admits: med/surg/rehab/ detox/ MHSA-mental health and substance use disorder • DME • Home Health • Hospice Check your individual group shared risk matrix for additional details.	**Weekly** Approval/denial data files ("Authorization Logs") must be delivered via secure email or Secure File Transfer Protocol (STFP) file to Blue Shield using either the IPA9 or IPA10 file layout. To initiate the delivery of authorization logs by means of a STFP or to obtain the IPA9 or IPA10 Blue Shield standard file layout and data dictionary, please email Medicare Care Solutions at IPAAuths@blueshieldca.com. Only shared risk services for which IPA/Medical Group is delegated to perform UM and Blue Shield is responsible for claim adjudication are required on the data file. Authorization logs must be sent, at a	IPAAuths@ blueshieldca.com

Activity / Function	Entity's Responsibilities	Reporting Frequency	Submit To
		minimum, on a weekly basis in order to ensure timely data processing. IPA approvals, denials, and partial denials should be delivered on one file. If sent via email, the data MUST be delivered in a file format that is suitable for data processing, such as excel spreadsheet or delimited fixed width file. **Please note:** Any data file which does not comply to the format, content requirements and/or delivery frequency will be considered out of compliance, rejected by Blue Shield, and returned to the IPA/medical group for correction and resubmission. The following information is required on the Authorization Log. Please do not modify (add or subtract) any of these data elements from the Authorization Log. • Subscriber ID # • Patient Last Name • Patient First Name • Patient Date of Birth (mm/dd/yyyy) • Health Plan/Line of Business (CMC, Medi-Cal, Medicare Advantage or Commercial) • Request Type (Inpatient, Service or Medication) • Place of Service (Using CMS Industry Standard Place of Service Code Set and/or Name/Description: POS 11/Office, POS 21/Inpatient Hospital, POS 31/Skilled Nursing Facility) • Admission Bed Type or Level of Care (Using industry standard descriptions: Acute Rehabilitation, Acute Behavioral Health, ICU, LTAC, Med Surg, NICU, NICU Level 1, Observation, SNF Level 1, Sub-Acute, etc.) • First date of service or Admit date (mm/dd/yyyy) • Last date of service or Discharge date (mm/dd/yyyy) • Diagnosis Code(s) (ICD-10-CM Codes) – Primary code and up to 3 additional codes, if applicable • Procedure Code(s) (CPT-4/HCPC Codes and for inpatient facility claims only ICD-10-PCS Codes) – Primary code and up to 13 additional codes, if applicable • Units: Number of procedures, treatments, days, sessions, or visits • Servicing Provider Name • Servicing Provider NPI # • Facility Name (if applicable) • Facility NPI # (if applicable)	

Activity / Function	Entity's Responsibilities	Reporting Frequency	Submit To
		• Requesting Provider Name • Requesting Provider NPI # • Authorization or Decision Reference # • Blue Shield IPA/Medical Group Provider Identification # (i.e., IPxxxxxxxxxx) – It is highly recommended to include your Blue Shield PIN # to expedite processing. If unknown, the PIN # can be obtained from your Blue Shield Provider Relations representative. • Receipt Request Date (Date provider requested authorization from IPA/medical group) • Decision (Approved, denied, partially denied or void) • Full/Partial Denial Reason (i.e., Not medically necessary, not a benefit, etc.) • Decision Date (mm/dd/yyyy) • Discharge Diagnosis (if applicable) • Discharge Status (i.e., To Home, SNF…., if applicable)	
Commercial Contracted entity, Denial Logs Pre-Service/Concurrent/ Retrospective (ER, Claims)	Required to use Plan denial letter templates and required data elements for Commercial denials.	**Weekly** submission of denial logs showing 100% of all denials must be sent to Blue Shield of California, at minimum, on a weekly basis in order to ensure timely data processing. Denial data files ("Authorization Logs") must be delivered via secure email or Secure File Transfer Protocol (STFP) file to Blue Shield using either the IPA9 or IPA10 file layout. To initiate the delivery of authorization logs by means of a STFP or to obtain the IPA9 or IPA10 Blue Shield standard file layout and data dictionary, please email Medicare Care Solutions at IPAAuths@blueshieldca.com. Only shared risk services for which IPA/Medical Group is delegated to perform UM and Blue Shield is responsible for claim adjudication are required on the data file. Authorization logs must be sent, at a minimum, on a weekly basis in order to ensure timely data processing. IPA approvals, denials, and partial denials should be delivered on one file. If sent via email, the data MUST be delivered in a file format that is suitable for data processing, such as excel spreadsheet or delimited fixed width file. **Please note:** Any data file which does not comply to the format, content requirements and/or delivery frequency will be considered out of compliance, rejected by Blue Shield, and returned to the IPA/medical group	IPAAuths@ blueshieldca.com

Activity / Function	Entity's Responsibilities	Reporting Frequency	Submit To
		for correction and resubmission. The following information is required on the Authorization Log. Please do not modify (add or subtract) any of these data elements from the Authorization Log: • Subscriber ID # • Patient Last Name • Patient First Name • Patient Date of Birth (mm/dd/yyyy) • Health Plan/Line of Business (CMC, Medi-Cal, Medicare Advantage or Commercial) • Request Type (Inpatient, Service or Medication) • Place of Service (Using CMS Industry Standard Place of Service Code Set and/or Name/Description: POS 11/Office, POS 21/Inpatient Hospital, POS 31/Skilled Nursing Facility) • Admission Bed Type or Level of Care (Using industry standard descriptions: Acute Rehabilitation, Acute Behavioral Health, ICU, LTAC, Med Surg, NICU, NICU Level 1, Observation, SNF Level 1, Sub-Acute, etc.) • First date of service or Admit date (mm/dd/yyyy) • Last date of service or Discharge date (mm/dd/yyyy) • Diagnosis Code(s) (ICD-10-CM Codes) – Primary code and up to 3 additional codes, if applicable • Procedure Code(s) (CPT-4/HCPC Codes and for inpatient facility claims only ICD-10-PCS Codes) – Primary code and up to 13 additional codes, if applicable • Units: Number of procedures, treatments, days, sessions, or visits • Servicing Provider Name • Servicing Provider NPI # • Facility Name (if applicable) • Facility NPI # (if applicable) • Requesting Provider Name • Requesting Provider NPI # • Authorization or Decision Reference # • Blue Shield IPA/Medical Group Provider Identification # (i.e., IPxxxxxxxxxx) – It is highly recommended to include your Blue Shield PIN # to expedite processing. If unknown, the PIN # can be obtained from your Blue Shield Provider Relations representative. • Receipt Request Date (Date provider requested authorization from	

Activity / Function	Entity's Responsibilities	Reporting Frequency	Submit To
		IPA/medical group) • Decision (Approved, denied, partially denied or void) • Full/Partial Denial Reason (i.e., Not medically necessary, not a benefit, etc.) • Decision Date (mm/dd/yyyy) • Discharge Diagnosis (if applicable) • Discharge Status (i.e., To Home, SNF…., if applicable)	
Information on any denial or authorization which has been made. Including but not limited to the regulatory or appeals process.	Make available to Blue Shield all information requested on the denial.	**As needed**	Fax (844) 295-4637
Requests for Investigational/Experimental Services	**NOT** DELEGATED	Forward to Plan **Immediately** for determination	Fax (844) 807-8997
Request for Cancer Clinical Trials (Commercial HMO only) (Medicare Clinical Trials are handled by the Intermediary and not Blue Shield).	**NOT** DELEGATED	Forward to Plan **Immediately** for determination	Fax (844) 807-8997

Definitions of Delegation and Subdelegation

Delegation is defined by NCQA as:

> "…when an MCO gives another entity the authority to carry out a function that would otherwise be performed by the MCO. This authority includes the right to decide what to do and how to do it, within the parameters agreed upon by the MCO and the other entity. When referring to delegation, NCQA assumes the presence of a mutual agreement between MCO and another entity in which the other entity performs specific functions that are related to the NCQA standards. Although the MCO does not directly perform the delegated functions, it is obligated to oversee these functions, i.e., to ensure that the functions are properly performed by the delegate. The MCO may reclaim the right to carry out the delegated functions at any time."

Sub-delegation is defined by NCQA as:

> "…when a delegate of an MCO gives a third entity the authority to carry out a function that has been delegated by the MCO. For example, an MCO may delegate UM activities to an IPA/medical group, which then delegates some credentialing functions to a hospital. The hospital, in this case, is the subdelegate."

Documented process refers to a written description that outlines your system of operation for implementing your organization's expectations. A "documented process" may include Policies and Procedures, process flow charts, protocols, and other methods that describe the actual process used by the organization. Policies and procedures are one type of documented process and typically indicate the plan for the course of action to be taken and the method in which the action will be carried out.

Credentialing/Recredentialing Standards

The following standards apply to delegation of the credentialing/recredentialing process for Blue Shield of California (Blue Shield). The IPA and/or medical group (IPA/medical group) or other entities such as a Managed Behavioral Health Organization (MBHO) or Specialty Health Plan shall be able to show documented evidence of the following standards in order to be delegated or maintain delegation status. Credentialing/recredentialing functions cannot be delegated separately. The delegate's failure to meet Blue Shield delegation requirements can result in the need to implement a corrective action plan, additional audits of compliance, and up to revocation of delegation status upon Blue Shield's determination of the entity not meeting the delegation requirements. Groups will be subject to all Blue Shield, NCQA, CDI, DMHC, CMS, state and federal standards and regulations.

A copy of the Credentialing/Recredentialing Tool used by Blue Shield during audits can be obtained by contacting your Blue Shield Credentialing Delegation Oversight Auditor or on the Health Industry Collaboration Effort (HICE) website at iceforhealth.org.

Blue Shield retains oversight and responsibility for the final decision regarding credentialing and recredentialing recommendations.

I. Credentialing and Recredentialing Policies and Procedures

A. The entities must have written policies and procedures for credentialing and recredentialing of licensed independent health care professionals whom they employ and with whom they contract. These policies and procedures must include the following elements and be reviewed and approved annually:

1. Scope of practitioners covered, which at a minimum include Medical Doctors, Osteopaths, oral surgeons, dentists (who provide care under the medical benefit plan e.g., outside dental benefits such as trauma surgery), podiatrists, chiropractors, telemedicine practitioner and allied behavioral health practitioners. Blue Shield will be assessing the following allied health professionals: doctoral and/or master's level licensed psychologists, licensed clinical social workers, marriage family therapists, qualified autism service professional, addiction medicine specialists, physician assistants, nurse practitioners, nurse midwives, licensed clinical nurse specialists, psychiatric nurse practitioners, speech pathologists, physical therapist, occupational therapist, acupuncturist, as well as covering physicians who have an independent relationship with the organization if they serve in the capacity for more than 90 days. Defined criteria to assess practitioner ability, and how each criterion is verified, including current unrestricted license to practice in the State of California, and a participant with Medicare, when providing care to Blue Shield Medicare Advantage plan members.
2. Description of verification sources it uses.
3. Criteria for credentialing and recredentialing.
4. Process for making credentialing and recredentialing decisions.

5. Process for managing files that meet the IPA/medical group's established criteria.
6. Process used to make decisions in a non-discriminatory manner (i.e., not based solely on an applicant's race, ethnicity/nationality, gender, age, sexual orientation, types of procedures or types of patients the practitioner specializes in), including receiving advice from participating practitioners and how decisions are made by a designated credentialing committee. Process to include processes for preventing and monitoring discriminatory practices. Monitoring must be conducted at least annually.
7. Process for notifying practitioners if information obtained during the credentialing process varies substantially from the information provided to the IPA/medical group.
8. Process for ensuring that practitioners are notified of the credentialing and recredentialing decision within sixty (60) calendar days of the committee's decision.
9. Sub-delegation of any credentialing/recredentialing activities defined and the related oversight process described; sub-delegation is not permitted should the entity lose their delegation status.
10. Protection of practitioner rights, includes the right to review information obtained from outside sources used to evaluate their credentialing application, notification, of the status of the practitioner's credentialing or credentialing application, upon request and practitioners' right to correct erroneous information. Policy to include how practitioners are notified of these rights.
11. Description of Medical Director or designated physician direct responsibility, accountability, and participation in the credentialing process.
12. Clear statement of the confidential nature of the information obtained in the credentialing process, except as otherwise provided by law, and the mechanisms in place to protect this confidentiality.
13. Description of the process for facilitating that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty.
14. Credentialing System Controls policy to include (NCQA CR1, Element C, Factors 1-4):
    a. How primary source information is received, dated, and stored.
    b. How modified information is tracked and dated from its initial verification to include:
        - When the information was modified.
        - How the information was modified.
        - Staff who made the modifications.
        - Why the information was modified.

c. Titles or role of staff who are authorized to access, review, modify, and delete information to include circumstances when modifications or deletions are appropriate.

d. Documentation that security controls are in place to protect information from unauthorized modifications.

   Policies must describe:

   - Limiting physical access to the operating environment that houses credentialing information, to protect the accuracy of information gathered from primary sources and NCQA-approved sources.
     - Physical access may include, but is not limited to, the organization's computer servers, hardware and physical records and files.
     - "Physical access" does not refer to the organization's building or office location.
   - Preventing unauthorized access, changes to, and release of credentialing information.
   - Password-protecting electronic systems, including user requirements to:
     - Use strong passwords.
     - Discourage staff from writing down passwords.
     - Use IDs and passwords unique to each user.
     - Change passwords when requested by staff or if passwords are compromised.

       Note: If the organization's policies and procedures state that it follows the National Institute of Standards and Technology guidelines, this is acceptable to describe the process for password-protecting electronic systems.

     - Disabling or removing passwords of employees who leave the organization and alerting appropriate staff who oversee computer security.

e. Describe how the organization monitors compliance with policy and procedures in items a-d, at least annually, and takes appropriate action when applicable. Policies and procedures describe the process for at least annual monitoring that includes:

   - Demonstrating that specified policies and procedures for items a-d are followed.
   - Analyzing modifications that do not meet the organization's established policy.

At a minimum, the description includes:

- The method used to monitor compliance with the organization's policies and procedures described in items a-d/NCQA CR1, Element C, Factors 1–4.
    - If the IPA/Medical Group conduct auditing as the method for monitoring:
        - All noncompliant modifications must be reviewed if the IPA/Medical Group's system can identify noncompliant modifications.
        - Sampling is allowed only if the IPA/Medical Group does not use a credentialing system that can identify all noncompliant modification.
- The description specifies the staff roles or department involved in the audit and the audit frequency.
- The staff titles or roles responsible for oversight of the monitoring process.
- The IPA/medical group's process for taking actions if it identifies modifications that do not meet its established policy, including:
    - A quarterly monitoring process to assess the effectiveness of its actions on all findings until it demonstrates improvement for one finding over at least three consecutive quarters.
    - The staff roles or department responsible for the actions.
    - The process for documenting and reporting modifications that do not meet established policy.
- The IPA/Medical Group's policy and procedures must include a description of the monitoring process outlined above, regardless of the system functionality (e.g., the system prevents changes to the original record under any circumstances but allows creation of a new record to modify dates; allows date modifications only under specific circumstances; uses alerts or flags to identify noncompliance), with the exception of advances system controls capabilities.
- An advance system must have both capabilities:
    - Automatically record dates, and
    - Prevent changes that do not meet the IPA/Medical Group' policies and procedures
- If the IPA/Medical Group has advanced system controls capabilities, it is only required to describe how the functionality of the systems ensures compliance with the established policies for items a-d/NCQA CR1, Element C, Factors 1-4. Monitoring is not required.

- Sampling is allowed for IPA/Medical Groups that use auditing as the monitoring method and must use the following audit method:
    - The IPA/medical group must use the "5% or 50 files" audit method: Randomly select 5% of files or 50 files (whichever is less) from each applicable file type, to review against requirements.
    - At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the IPA/medical group audits the universe of files rather than a sample.
    - The file universe includes all files, with or without modifications. The sample that will be audited must include only files with modifications (whether modifications are compliant or noncompliant with the IPA/medical group's policies and procedures).
    - Once the sample size is calculated from the entire file universe, the IPA/medical group determines how it selects the sample. NCQA does not specify how the IPA/medical group selects the sample once the sample size is determined using the entire file universe.

If the IPA/medical group:

- *Can identify files with modifications*, it may randomly select a sample from a universe that contains modified files.
- *Cannot identify files with modifications*, it may randomly select a sample from the entire file universe; the IPA/medical group continues to pull files from the entire universe until 5% or 50 files in the sample have modifications.

Annually Monitoring the Credentialing Process

The IPA/medical group's policies and procedures describe its process for monitoring compliance with policies and procedures for Items a-d/NCQA CR1, Element C, Factors 1–4.

Methods of monitoring activities may include:

- An annual process for identifying modifications that did not meet policies and procedures in the past 12 months and taking actions to update credentialing system controls accordingly.
- A review of automatic system alerts or flags for modifications or events in real time, and a separate process for annually testing performance of the system's automatic alerts or flags and taking actions to update credentialing system controls accordingly.

- A monthly, quarterly, or semiannual process to audit files from a system-generated report of all date modifications to identify modifications that did not meet policies and procedures and take actions to update credentialing system controls accordingly.

Audit Sampling

- An IPA/medical group's credentialing and recredentialing file universe contains 800 files (with and without modifications). The minimum required sample for review is 40 files (5% of 800) which is less than 50files. The IPA/medical group's randomly selects the 40 files for review from the total universe of 800 files, or from only files with modifications (if the IPA/medical group's system can identify files with modifications). All 40 files must have a modification and the IPA/medical group reviews the files against its policies and procedures to identify noncompliant modifications.

15. Credentialing System Controls Oversight policy that, at least annually, demonstrates it monitors compliance with its CR controls, as described in item 14.e above, by:
    a. Identifying all modifications to credentialing and recredentialing information that did not meet the IPA/medical group's policies and procedures for modifications.
    b. Analyzing all instances of modifications that did not meet the IPA/medical group's policies and procedures for modifications.
    c. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.
16. Performance monitoring of recredentialing policy and procedure that require information from quality improvement activities and member complaints in the recredentialing decision making process.
17. Medicare sanctions and exclusions policy and procedure that prohibit employment or contracting with practitioners or entities that employ or contract with such practitioners or organizational providers that are excluded/sanctioned from participation in Medicare.
18. Notification to Authorities and Practitioner Appeal Rights policies and procedure to address the following:

    - Specifies that the organization reviews participation of practitioners whose conduct could adversely affect members' health or welfare.
    - Specifies the range of actions that may be taken to improve practitioner performance before termination.
    - Reports its actions to the appropriate authorities (i.e., licensing boards, the National Practitioner Data Bank (NPDB)).

- Establishes a well-defined appeal process and make the appeal process known to practitioners.

II. Credentialing Committee

1. Description of a Credentialing Committee designated to make recommendations regarding credentialing/recredentialing decisions.
   a. The Committee membership includes a range of participating network practitioners (primary care physicians and different types of specialists).
   b. A quorum is described and must be present to conduct a committee meeting.
   c. Identifies who has voting rights and voting members must be practitioners.
2. Conduct meetings and decisions in person or virtually (i.e., through video conference or web conference with audio). Meetings may not be conducted through email.
3. May take all files to committee for review or establish and utilize a clean file process for practitioners that meet established criteria, however, committee must review credentials of practitioners who do not meet the established criteria thresholds for participation.
4. Ensure that practitioner files that meet established criteria are reviewed and approved by a medical director or designated physician. Evidence of review and approval is documented in the file via handwritten signature or initials, electronic identifier unique to the approver.
5. Develop mechanisms to report serious quality deficiencies that could result in a practitioner's suspension or termination to appropriate authorities e.g., report to the Medical Board of California (MBC)/805/805.01 or the National Practitioner Data Bank (NPDB); includes review of who would be reported and under what circumstances.

III. Ongoing Monitoring and Interventions

1. Develop and implement policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and take appropriate action against practitioners when it identifies occurrences of poor quality. At a minimum, the IPA/medical group must collect and review the following:
   a. Medicare and Medicaid sanctions. (Must review within the thirty (30) calendar days of the report release date.)
   b. Sanctions or limitations on licensure. (Must review within the thirty (30) calendar days of the report release date.)
   c. Member complaints (Investigates practitioner-specific member complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable. Evaluates the history of complaints for all practitioners at least every six months.

d. Information from identified adverse events (monitors for adverse events at least every six months).

e. Implement appropriate interventions when IPA/medical group identifies poor quality related to items a-d.

2. Report actions taken by the IPA/medical group to Blue Shield, as appropriate.

a. Practitioner/Providers with encumbered licenses or exclusions from Medicare or Medicaid (Medi-Cal) must be reported to Blue Shield, immediately for appropriate action or termination.

b. Report actions to the designated auditor.

IV. Credentialing/Certification/Appointment Process

A. The entities must require a completed application for membership that is signed and dated. The application must include, at a minimum, statements regarding:

1. Reasons for any inability to perform the essential functions of the positions, with or without accommodation;
2. Lack of present illegal drug use;
3. History of loss of license and or felony convictions;
4. History of voluntary or involuntary loss or limitation of privileges or disciplinary action;
5. Current malpractice insurance coverage; and
6. An attestation to correctness/completeness of the application.

B. At a minimum, the entities must obtain and review verification of the following through appropriate means of primary sources during the 180-day period prior to a final determination:

1. Current, active, and unrestricted California medical license or applicable health profession license;
2. Clinical privileges in good standing at a contracted hospital affiliated with the practitioners IPA/medical group, as appropriate, or a mechanism for another credentialed physician to cover the practitioner's patients when hospitalized; (through appropriate means of primary sources or by attestation from provider);
3. Valid DEA certificate to practice in California, as applicable;
4. Work History (minimum of most recent five (5) years as a health professional);
5. Current and adequate malpractice coverage; and
6. Professional liability claims history.

C. In addition to the above six requirements, the entities must obtain and review verification through appropriate means of primary sources for:

1. Graduation from medical school, completion of residency and completion of training, and board certification, as applicable. For dentists and non-physician behavioral health providers, there must be verification of education and training from a professional school. Board certification cannot be substituted for verification of education and training; however, board certification must be confirmed, as applicable. This requirement is exempt from the 180-day rule.
2. Required data elements as outlined below. These data elements will be sent monthly for all new practitioners added to the network and on all quarterly rosters via electronic submission (Excel format).
    a. Medical School Name
    b. Medical School Graduation Year
    c. Residency Name
    d. Primary Specialty
    e. Secondary Specialty
    f. Board Name
    g. Board Status (certified, not certified, etc.)
    h. Board Award Date
    i. Board Expiration Date

    Email submission to BSC_IPA_Rosters@blueshieldca.com.

D. Prior to making a determination, the entities receive information on practitioners from the following designated agencies and the information is included in the practitioner credentialing file:

1. The National Practitioners Data Bank (NPDB).
2. Sanctions and restrictions on licensure, and/or limitations on scope of practice from the following agencies as applicable: Medical Board of California, Federation of State Medical Boards, Department of Professional Regulations, Osteopathic Medical Board of California or California Board of Chiropractic Examiners/Dental Board of California (as applicable); and for non-physician behavioral health providers, California Board of Registered Nursing, State Board of Psychology, or State Board of Behavioral Health Sciences (licensed clinical social workers and marriage/family therapists), and other licensing boards as appropriate.
3. The Medicare Opt-out List to assess participation in the Medicare Program when seeing Blue Shield Medicare Advantage plan members.

E. The entities implement appropriate interventions when occurrences of poor quality are identified and act on important quality and safety issues in a timely manner during the three-year interval between formal re-verification of credentials.

F. The entities shall submit, on a semi-annual basis, the list of providers who were reviewed for credentialing activity.

V. Office Site Visit and Medical Record Keeping Review

A. NOT DELEGATED.

1. When complaints are logged regarding a physician's office, Blue Shield will follow company procedure for follow-up and will not delegate this task to the IPA/medical group.
2. IPA/medical groups must have a process for notifying Blue Shield of site visit complaints upon receipt.

VI. Recredentialing

A. The entities must formally recredential practitioners at least every three years. There is no grace period beyond the 36-month allotted time.

B. The entities must conduct the same verification process, application/attestation requirements and NPDB query and Medicare and Medicaid Sanction, Medicare Opt-Out List review as described above in the Credentialing Sections I through II. The exception would be education and work history (5 years) do not need to be verified during recredentialing.

C. Performance monitoring data will be assessed by the entities for recredentialing on all practitioners. The review will include the following information, which must also be incorporated and documented in the recredentialing file:

1. Information regarding relevant member complaints and grievances:
    - Potential or actual trends
    - Complaints and grievances resulting in peer review
2. Identified adverse events.
3. Implementation of appropriate interventions when it identifies instances of poor quality.

    Examples include, but are not limited to, information from quality improvement activities, which may include:

    - Quality reviews; must include results from review of member complaints
    - Under- and over-utilization issues
    - Peer review
    - Potential or actual trends
    - Significant adverse sentinel events

VII. Organizational Provider Credentialing

A. Must develop and implement policies and procedures for evaluating/assessing an Organizational Provider/ Health Delivery Organization and specifies that prior to contracting with, and at least every three (3) years thereafter, it will confirm the following:

1. In good standing with the state and federal regulatory bodies.
2. That the provider has been reviewed and approved by an accrediting body.
3. Conducts an onsite quality assessment, if the provider is not accredited (CMS or DHCS survey, may be utilized in lieu of a site visit and may not be more than three (3) years only at the time of approval.

B. Medical Providers include Health delivery organizations (HDO) such as hospitals, home health agencies, skilled nursing facilities, and free-standing surgical centers.

C. Behavioral Health Providers include Inpatient, Residential and Ambulatory.

D. Assess Medical Providers against requirements prior to contracting and at least every three (3) years.

E. Assess Behavioral Providers requirements prior to contracting and at least every three (3) years.

VIII. Sub-Delegated Credentialing/Recredentialing Activities

Note: Blue Shield considers the use of a CVO to verify credentialing information, as sub-delegation, which aligns with NCQA. Policy and procedures must be reviewed annually for NCQA Certified CVOs.

A. If the delegated entity sub-delegates any portion of the credentialing process, it must ensure that the following occur:

1. Documentation of an agreement between the entity and sub-delegated organization is fully executed.
2. The delegation document describes the delegated activities and the responsibilities of the IPA/medical group and the delegated entity that includes detailed language of specific credentialing activities.
3. The delegation document requires at least semiannual reporting by the delegated entity to the IPA/medical group that specifies what information is reported regarding activities delegated, how and to whom information is reported.
4. The delegation document describes the process by which the IPA/medical group evaluates the delegated entity's performance.

5. The delegation document requires at least semiannual reporting by the delegated entity to the IPA/medical group that specifies what information is reported regarding activities delegated, how and to whom information is reported.
6. The delegation document specifies that the IPA/medical group retains the right to approve, suspend and terminate individual practitioners, providers, and sites, even if the IPA/medical group delegates decision making.
7. The delegation document describes the remedies available to the IPA/medical group if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.
8. An initial evaluation of the sub-delegated organization is conducted prior to delegation.
9. Sub-delegate submission of the list of providers who were reviewed for credentialing. (This list shall also be submitted quarterly or semi-annually to Blue Shield.)
10. An annual evaluation of the sub-delegated organization to include policy and procedures, file review and evaluates performance against NCQA, state and federal Standards for delegated activities.
11. Documentation that the IPA/medical group retains the right of final determination over the sub-delegated organization in credentialing decisions.
12. IPA/medical group annually monitors the delegate's credentialing system security controls to ensure that the delegate monitors its compliance with the delegation agreement or with the delegate's policy and procedures at least annually. (Delegates must meet this requirement.) IPA/medical groups must review all modifications made in all delegates' credentialing systems during the look-back period that did not meet the modification criteria allowed by the delegation agreement or by the delegates' policies and procedures. The organization provides documentation (which may be a report or other type of evidence) that it completed the monitoring process at least annually during the look-back period. If the delegate's credentialing system does not allow modifications, the delegate:

    - Describes the functionality of the system that ensures compliance with established policy.
    - Provides documentation or evidence of advanced system control capabilities that automatically record dates and prevent modifications that do not meet modification criteria.

    Audit. Auditing is allowed only if the organization or delegate does not use a CR system that can identify all noncompliant modifications.

    - Documentation indicates the staff roles or department involved in the audit.

- The organization or delegate identifies all CR system modifications but may use sampling to identify potential noncompliant changes for the audit.
- The organization uses one of the following methods to audit files:
    - 5 percent or 50 of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.
    - The NCQA "8/30 methodology" available at ncqa.org/programs/health-plans/policy-accreditation-and-certification.

13. Annually acts on all findings from item 12 above for each delegate and implements a quarterly monitoring process until each delegate demonstrates improvement for one finding over three consecutive quarters.
14. If the IPA/medical group contracts with delegates that store, create, modify, or use credentialing data on the IPA/medical group's behalf, the agreement describes (Delegates must meet this requirement):
    - The delegate's credentialing system security controls in place to protect data from unauthorized modification as outlined in the Credentialing System Controls item 14-e/ (NCQA CR1, Element C, factor 4).
    - How the delegate monitors its credentialing system security controls at least annually as required in item 12 above (NCQA, CR8, Element C, factor 5).
    - How the IPA/medical group monitors the delegate's credentialing system security controls at least annually, as required in item 12 above (NCQA, CR8, Element C, factor 5).

B. Blue Shield will review oversight of an initial evaluation or annual review, credentialing system control process and monitoring, audit findings, corrective action plan, and regular reports as well as the entities' evaluation of these reports. At a minimum, delegates must report on progress in conducting credentialing and recredentialing activities and on activities carried out to improve performance.

IX. Identification of Qualified HIV/AIDS Specialist (CA H&SC §1374.16; DMHC TAG (QM-004), DHCS MMCD All-Plan Letter 01001)

A. Develop policy and procedure describing the process that the organization uses to identify and reconfirm the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist, according to California State regulations, on an annual basis. The Department of Managed Health Care (DMHC) issued a definition of an HIV/AIDS specialist and criteria which can be accessed at dmhc.ca.gov.

C. Annually conducts screening of HIV/Aids Specialists to ensure qualifications and criteria of the DMHC are met.

D. Notify department responsible for authorizing standing referrals of its physician's that qualify as HIV/AIDS specialists according to DMHC regulations.

X. **IPA/medical groups delegated for credentialing all Mental Health/Substance Use Disorder providers must adhere to the requirements of Assembly Bill 2581 effective 1/1/2023.**

A. Develop and implement policy and procedures that includes notifying a behavioral health applicant within seven (7) business days upon receipt of an application to verify receipt and inform the applicant whether the application is complete.

B. Within sixty (60) days after receiving a completed application, providers must complete the credentialing process. (Note: This requirement only applies to the credentialing process and does not include contract completion). Monitoring will be reviewed during the annual file review.

Credentialing and Recredentialing

The Plan evaluates several factors in credentialing and recredentialing for practitioners in the organization's network, such as:

- How fully the organization investigates each practitioner's qualifications and practice history before letting the practitioner into the network.
- How the organization assesses practitioners in its network on an ongoing basis.

Guidelines for Use

- When conducting file review for multiple Provider Organizations who are serviced by the same MSO, the Auditing Plan must determine whether all Provider Organizations use the same Credentials Committee:
  - If so, then the plan may pull one file sample across all contracted organizations and apply the same score for CR 3-4 for each organization.
  - If not, the plan should pull one file sample for each organization.
- Surveyors are to provide support for any deficiency, even if the score is 100 percent.
- Clarify any issues related to each element.
- For questions regarding evaluation of compliance with NCQA standards, go to ncqa.org
- For questions regarding posted results, send an email to the Health Plan auditor.