Document ID:	**Title:** Aetna Medicaid Administrators LLC (AMA) 7200.03 Utilization Management (UM) Timeliness Standards and Decision Notification - Louisiana	
Parent Documents: AETAMA-075564 ~~Document ID of 7200.03 Utilization Management Timeliness Standards and Decision Notification policy~~		
Effective Date: See Document Information Page	**Last Review Date:** See Review and Revision History Section	**Business Process Owner (BPO):** Medical Management - Utilization Management, Regulatory Compliance
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Effective Date: 09/12/2023~~01/01/2023~~
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PURPOSE

This Amendment is written to meet regulatory and legislative requirements under Louisiana law/regulation that impact AMA 7200.03 UM Timeliness Standards and Decision Notification policy. This amendment will be used in conjunction with AMA 7200.03 to comply with Louisiana requirements.

SCOPE

Applies to Department:	☐ Care Management	☐ Precertification (including NME, SCPU, Specialty Medical Precert)	☐ NME Case Management	☐ Aetna Maternity Program
	☐ SCPU Case Management	☐ 24-Hour Nurse Line	☐ DM	☐ BH
	☐ Medical Management – Concurrent Review	☐ Medical Management – Prior Authorization	☐ Medical Management – Utilization Management	■ Medical Management

Product:	☐ HMO	☐ EPO	☐ PPO	☐ MC/POS	☐ TC	☐ JV
	■ Medicaid					

These requirements apply when the Controlling State is Louisiana.

POLICY

Glossary and Acronyms:

2023~~2~~2 Louisiana Medicaid Managed Care Organization Statement of Work, Section	

Medically Necessary Services* – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary.	**Medically Necessary Services*** – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the Beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the Beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Louisiana Medicaid Program. Services that are experimental, non-Food and Drug Administration (FDA) approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary.

Attachment A: Timeliness Standards for Decision and Notification –Medicaid

Legislation	Policy/Procedure Language Change:
2023 Louisiana Medicaid Managed Care Organization ~~-~~Statement of Work~~Attachment A: Model Contract~~, Section **2.7.14.2.2**	

Within one (1) Business Day of receipt of a request from designated LDH PSH Program staff, provide accurate information about current and past Service Authorizations and encounters for an Enrollee, particularly for behavioral health services such as Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), and Assertive Community Treatment (ACT);	Within one (1) Business Day of receipt of a request from designated State PSH Program staff provide accurate information about current and past Service Authorizations and encounters for a member, particularly for behavioral health services such as Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), and Assertive Community Treatment (ACT);
2.7.14.2.3 Ensure Timely Prior Authorization for PSH tenancy and pre-tenancy supports as applicable.	Ensure Timely Prior Authorization for Permanent Supportive Housing (PSH) tenancy and pre-tenancy supports as applicable.
2.12.6 Service Authorization Determination Timing and Notices	For standard service authorization Determination Timing and Notices
2.12.6.1 Standard Service Authorization	Standard Service Authorization
2.12.6.1.1 The Contractor shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate documentation that may be required regarding a proposed procedure, or service requiring a review determination, with the following exceptions:	The health plan will make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate documentation that may be required regarding a proposed procedure, or service requiring a review determination, with the following exceptions:
2.12.6.1.1.1 The MCO shall make all inpatient hospital service authorizations within two (2) calendar days of obtaining appropriate documentation; and	The health plan will make all inpatient hospital service authorizations within two (2) calendar days of obtaining appropriate medical information documentation; and
2.12.6.1.1.2 The Contractor shall make all CPST and PSR Service Authorizations within five (5) Calendar Days of obtaining appropriate documentation.	The health plan will make all Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehab (PSR) service authorizations within five (5) calendar days of

	obtaining appropriate medical information documentation; and
2.12.6.1.1.3 The MCO shall make all determinations for behavioral health crisis response services that require prior authorization as expeditiously as the enrollee's condition requires, but no later than one (1) calendar day after obtaining appropriate clinical documentation.	The health plan will make all determinations for behavioral health crisis response services that require prior authorization as expeditiously as the member / enrollee's condition requires, but no later than one (1) calendar day after obtaining appropriate clinical documentation.
2.12.6.1.2 All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.	All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.
2.12.6.1.3 The service authorization decision may be extended up to fourteen (14) additional calendar days if:	The service authorization decision may be extended up to fourteen (14) additional calendar days if:
2.12.6.1.3.1 The Enrollee, or the provider, requests the extension; or	The member, or the provider requests the extension; or
2.12.6.1.3.2 The Contractor justifies (to LDH upon request) a need for additional information and how the extension is in the Enrollee's interest.	The health plan justifies **(**to Louisiana Department of Health (LDH) upon request**)** a need for additional information and how the extension is in the member's interest.
2.12.6.1.4 The Contractor shall make all concurrent review determinations within one (1) Calendar Day of obtaining the appropriate medical information that may be required.	The health plan will make all concurrent review determinations within one (1) calendar day of obtaining the appropriate medical information that may be required.
2.12.6.2.1 In the event a provider indicates, or the Contractor determines, that following the standard Service Authorization timeframe could seriously jeopardize the Enrollee's life	In the event a provider indicates, or the health plan determines, that following the standard Service Authorization timeframe could seriously jeopardize the Enrollee's life or

or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization determination and provide notice as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service. **2.12.6.2.2** The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) Calendar Days if the Enrollee requests the extension or if the Contractor justifies to LDH a need for additional information and how the extension is in the Enrollee's best interest. **2.12.6.3.1** The Contractor shall make retrospective review determinations within thirty (30) Calendar Days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) Calendar Days from the date of receipt of request for Service Authorization.	health or ability to attain, maintain, or regain maximum function, the health plan will make an expedited authorization determination and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service. **2.12.6.2.2** The health plan may extend the seventy-two (72) hour time period by up to fourteen (14) Calendar Days if the member requests the extension or if the health plan justifies to the State a need for additional information and how the extension is in the member's best interest. The health plan will make retrospective review determinations within thirty (30) Calendar Days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) Calendar Days from the date of receipt of request for Service Authorization.

Notice of Action Requirements

Legislation	Policy/Procedure Language Change:

2023 Louisiana Medicaid Managed Care Organization -Statement of ~~WorkAttachment A: Model Contract~~, Section **2.2.7.2.3** The Contractor shall ensure Enrollees receive a notice of Adverse Benefit Determination per 42 CFR §438.915(b) and other sections of this Contract which extend notice requirements beyond denials. The Contractor shall make available in hard copy upon request at no cost to the requestor and available on the Contractor's website, the criteria for medical necessity determinations for mental health and substance use disorder benefits to any Enrollee, Potential Enrollee, or provider per 42 CFR §438.236(c) and §438.915(a). **2.12.6.4.1.1** For Service Authorization approval for a non-emergency admission, procedure or service, the Contractor shall notify the provider verbally or as expeditiously as the Enrollee's health condition requires but not more than one (1) Business Day of making the initial determination and provide written notification to the provider within two (2) Business Days of making the determination. **2.12.6.4.2.2** The Contractor shall notify the requesting provider of a determination to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The Contractor shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.	The health plan will ensure the member receive a notice of Adverse Benefit Determination and other sections of this Contract which extend notice requirements beyond denials. The health plan shall make available in hard copy upon request at no cost to the requestor and available on the health plan's website, the criteria for medical necessity determinations for mental health and substance use disorder benefits to any member / enrollee, Potential member / enrollee For Service Authorization approval for a non-emergency admission, procedure or service, the health plan will notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) Business Day of making the initial determination and provide written notification to the provider within two (2) Business Days of making the determination. The health plan will notify the requesting provider of a determination to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The health plan will provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.

PROCEDURE
N/A

REVIEW AND APPROVALS

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Date

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EXHIBIT(S): N/A