Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management – Utilization Management**		**SUBJECT (Document Title)** **Precertification of Requested Services – LA**	
Effective Date ~~January 20, 1996~~[WJL1]June 2, 2015	**Date of Last Review** ~~July 14, 2020~~ June 25, 2021	**Date of Last Revision** ~~December 28, 2020~~ June 25, 2021	**Dept. Approval Date** ~~December 28, 2020~~
Department Approval/Signature : **Policy applies to health plans operating in the following State(s). Applicable products noted below.**			

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☒ Louisiana	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Missouri	☐ South Carolina	☐ West Virginia
	☐ Indiana	☐ Nebraska		

POLICY:

To ensure that members are treated in the most appropriate, least restrictive, and most cost-effective setting that is compatible with medical necessity as determined by the severity of illness and/or the intensity of services needed to contribute to an improved health status relative to the specific condition.

The following services are subject to precertification (reference the precertification lookup tool (PLUTO) and appropriate resource ~~help~~ files for specific authorization rules):

1) Elective inpatient admissions;
2) Specialty procedures (precertification is not required for specialty emergency services or treatment of any immediately life-threatening medical condition); and
3) Non-emergent services rendered by an out-of-network practitioner or provider (with the exception of covered Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, family planning services, and women's preventive health services, unless excluded by State or Federal requirements).

Members may submit an authorization request for the provision of services verbally or in writing~~ as directed in the member handbook~~. Precertification and service authorization procedures are outlined in the member and provider handbooks ~~and~~ published online. Procedures and information required from a member or healthcare provider in order to make medical necessity determinations are given verbally when requested.

Healthy Blue is responsible for eliciting pertinent medical record information from the treating healthcare provider(s) as needed and/or requested by the Louisiana Department of Health (LDH) for purposes of making medical necessity determinations. Healthy Blue shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe. In cases where the member or provider will not release necessary information, a request may be denied within two (2) business days. Providers who do not provide requested medical information for the

purposes of making medical necessity determinations for a particular item or service, are not entitled to payment for the provision of such item or service, and financial penalties may be imposed against the provider at the plan's discretion or directive by LDH.

Healthy Blue provides covered services in accordance with LDH's definition of medically necessary services, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and the Contract [42 C.F.R. §438.210(a)(5)(i)]. Healthy Blue covers medically necessary services that address:

1) The prevention, diagnosis and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability;
2) The ability for a member to achieve age-appropriate growth and development; and
3) The ability for a member to attain, maintain, or regain functional capacity.

Covered services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for enrollees under the age of twenty-one (21), as set forth in 42 CFR Part 441, Subpart B [42 CFR §438.210(a)(2)]. Healthy Blue ensures that covered services are sufficient in an amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. Healthy Blue may not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of diagnosis, type of illness, or condition of the member [42 CFR §438.210(a)(3)].

In accordance with 42 CFR §438.210(a)(4), appropriate limits may be placed on a service that are on the basis of criteria applied under the State Plan, such as medical necessity; and for the purposes of utilization control, provided that:

1) The services furnished can reasonably be expected to achieve their purpose;
2) The services support members with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and
3) Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

Service authorization policies and procedures are consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, State laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of Chisholm v. Gee and Wells v. Gee for initial and continuing authorization of services (refer to *Prior Authorization Liaison (PAL) Policy – LA* for precertification guidance regarding Chisholm v. Gee; the Wells v. Gee Class Settlement terminated October 24, 2019).

DEFINITIONS:

** Denotes terms for which Healthy Blue must use the State-developed definition.*

Expedited/Urgent/STAT Request – Any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances:

1) Could seriously jeopardize the life, health, or safety of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment;
2) Could seriously jeopardize the life, health, or safety of others due to the member's psychological state;
3) In the case of a pregnant woman, could seriously jeopardize the life, health, or safety of the woman or fetus; or
4) In the opinion of a practitioner with knowledge of a member's medical or behavioral health condition, would subject the member to adverse health consequences or severe pain that cannot be adequately managed[WJL2] without the care or treatment that is the subject of the request. The practitioner must be allowed to act as the authorized representative of that member.

NOTE: Services designated as "Urgent" or "STAT" will be processed as non-urgent if the request does not meet Expedited/Urgent/STAT as defined above. If we receive requests marked urgent and determine in consultation with the provider that the request should be handled as non-urgent, it will be processed as non-urgent.

Licensed Utilization Reviewer (UR) – The licensed UR is responsible for day-to-day management of pre-certification activities. He or she manages member care ensuring essential, effective, and appropriate services, and coordinating behavioral health, physical health, and social services.

Medical Management Specialist (MMS)~~/Case Specialist/Customer Care Representative~~ – Non-clinician responsible for responding to inquiries from members and providers to clarify benefits, offer member education, and provide health referrals. MMS document precertification requests and arrange for services as identified by a licensed clinician. This role may also be fulfilled by Case Specialists or Customer Care Representatives.

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 Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."

Precertification – The process of determining medical necessity for specific services before they are rendered. Sometimes called prior authorization, prior approval, or preauthorization.

Qualified Practitioner* – An appropriately qualified practitioner who makes utilization management medical necessity denial decisions. Depending on the type of case, the qualified reviewer may be a physician, pharmacist, chiropractor, clinical psychologist, dentist, nurse practitioner, physical therapist, or other licensed and qualified practitioner type as appropriate. Licensed health care professionals will include appropriately qualified practitioners in accordance with state laws. Only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. The individuals who make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the Medical Director or other qualified and trained professionals.

Utilization Management (UM) – Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.

PROCEDURE:

1) The non-clinician MMS (may also be a non-clinician National Customer Care (NCC) associate, or other UM representative) receives a request for precertification via telephone, fax, or web portal.

2) The MMS performs the following actions:
   a) Checks for sanctions on every out-of-network (OON) provider requesting services (refer to *Exceptions* for Act 79 compliance). At a minimum the following shall be utilized to screen OON and/or non-participating providers:
      i) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
      ii) The System of Award Management (SAM);
      iii) Louisiana Adverse Actions List Search; and
      iv) Other applicable sites as may be determined by LDH.
   b) Validates the Medicaid ID number on every request indicated for OON providers;

c) Verifies member eligibility, other health insurance (OHI), and benefits coverage;
d) Creates the authorization shell with appropriate documentation in the UM system;
e) Ensures appropriate systems are completed and updated per documentation standards; and
f) Routes the request to the appropriate and qualified licensed UR for review and processing if needed.

3) The Licensed UR performs the following actions:
   a) Obtains additional information as needed regarding the network affiliation of the specialist or facility where the service or procedure is to be performed;
   b) Confirms timeliness of the request. ~~Precertification requests are required to be submitted a minimum of seventy-two (72) hours before services are rendered. Requests made less than this timeframe may result in an administrative denial;~~ [WJL3]
   c) Determines the clinical appropriateness of the service based upon medical necessity criteria, local delivery system, and the individual member's needs;
   d) Consults with the requesting provider when applicable based on the mode of communication the practitioner initiated the request (i.e., by telephone or facsimile);
   e) Updates the UM system per documentation standards and releases the reference number to the requesting/servicing provider if the submitted clinical information and requested services are medical necessary;
   f) Routes the request to the Medical Director (or qualified practitioner) for review and determination if the clinical information provided does not meet precertification due to any of the criteria listed below:
      i) Medical necessity is not established based on application of criteria against presenting clinical information, and/or services are not clinically appropriate;
      ii) The member is not eligible for the proposed procedure, or it is not a covered benefit or service;
      iii) The member's benefit cap or maximum limitation has been met; or
      iv) The specialist or facility is OON and the provider or member refuses re-direction to an in-network provider or facility.
   g) If the clinical information provided does not meet precertification at the requested level of service, an appropriate, alternative service or level of care may be offered. If accepted by the provider, precertification of the alternative level of care is approved. If the alternative service is not accepted, the request is referred for review and determination by the Medical Director (or qualified practitioner).
   h) If a health condition is identified during the precertification process that is amenable to planning and coordination of services prior to admission (i.e., operative procedures), the licensed UR documents the information so that appropriate services can proactively be coordinated to enhance the availability of care during the post-hospitalization period.

i) The licensed UR is responsible for ensuring all appropriate systems are completed and updated per documentation standards.

4) The following precertification requests require different or additional actions:
   a) **Member not in the system:** Contact the Enrollment Area of Financial Operations to review the member's eligibility. Enrollment notifies the associate of the outcome. If the member is not enrolled with Healthy Blue, the requesting/servicing provider is informed that the "member is not enrolled with the organization per the current enrollment information in the system." If the member is in the system (regardless of eligibility), the licensed UR completes the precertification process.
   b) **OON specialist/facility:** If there is a specialist/facility within geo-access, and the member or provider refuses redirection to an in-network provider, the request requires review and determination by the Medical Director (or qualified practitioner). Upon request by the OON provider (or when applicable), approvals are routed to the health plan single case agreement (SCA) specialist for rate negotiation and completion of an SCA. If the OON provider accepts the Medicaid fee-for-service (FFS) or standard OON rate, there is no need for an SCA.
      i) OON approvals pending an SCA can be released with the disclaimer that it is "Approved as medically necessary; however, pending rate negotiations. If services are rendered before rates are negotiated, the reimbursement will be applicable to the Fee Schedule and contract standards."
      ii) Refer to *Out-of-Area, Out-of-Network Care – LA* and *Out-of-Network Authorization Process* for additional details regarding OON processes.
   c) **Other health insurance (OHI) discrepancy:** The NCC or health plan associate obtains as much information about the OHI as offered by the provider or member. If there is a discrepancy between the information on file in the claims payment system and the information provided with the precertification request, the associate notifies the Cost Containment Unit via email (ccuohi@amerigroupcorp.com) for review of the member's OHI. The associate proceeds with processing the pre-certification request regardless of the member's OHI as long as the member is eligible.
   d) **One-time sick visit:** The NCC associate determines if the practitioner is in-network, documents the request as notification only, and precertifies the one-time sick visit request.
   e) **Precertification ~~D~~date ~~S~~span:** Precertification requests entered into the UM system are allowed extension of services up to six (6) months. If services are still required after the expiration of the authorization, the NCC or health plan associate enters a new precertification for services upon receipt of a new request.
   ~~e)~~f) **Services are not covered:** Refer to *Non-Covered and Cost-Effective Alternative Services – LA* for information regarding excluded, non-covered, and in lieu of services.

5) Precertification determinations are made according to **State contractual time standards**. **NOTE:** Where State or Federal time standards differ from National Committee for Quality Assurance (NCQA), the more stringent time standard applies. NCQA timelines are listed in #6 below.
   a) Eighty percent (80%) of standard service authorization determinations are made within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed procedure or service requiring a review determination, with the following exceptions:
      i) All inpatient hospital pre-service authorizations are made within two (2) calendar days of obtaining appropriate medical information.
      ii) All Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services authorizations are made within five (5) calendar days of obtaining appropriate medical information.
   b) All standard service authorization determinations are made no later than fourteen (14) calendar days following receipt of the request for service.
      i) The authorization decision may be extended up to fourteen (14) additional calendar days if the member, or the provider, requests the extension, or Healthy Blue justifies the need for additional information and how the extension is in the member's interest.
   c) In the event the provider indicates, or the Healthy Blue determines, that the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, an expedited authorization determination is made as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request.
      i) The seventy-two (72) hour time period may be extended up to fourteen (14) calendar days if the member requests the extension, or Healthy Blue justifies a need for additional information and how the extension is in the member's best interest.
   d) Retrospective review determinations are made 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 service.
      i) Healthy Blue shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the member's health condition made by the provider.
      ii) Healthy Blue shall not use a policy with an effective date subsequent to the original service authorization request date to rescind its prior authorization.
   e) For service authorization approval for a non-emergency admission, procedure or service, Healthy Blue notifies 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.

f) For service authorization approval for extended stay or additional services, Healthy Blue the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, 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 shall provide written notification to the provider within two (2) business days of making the determination.

g) Healthy Blue notifies the requesting provider of a decision 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. Written notification is provided to the member and the provider rendering the service, whether a health care professional or facility or both, within two (2) business days of making the determination.

h) As part of appeal procedures, the informal reconsideration process allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing. Providers or agents acting on behalf of a member regarding a precertification denial require the member's written consent (refer to *Informal Reconsideration – LA*).

6) Precertification determinations are made in compliance with **NCQA time standards**. **NOTE:** Where State or Federal time standards differ from NCQA, the more stringent time standard applies. State contractual timelines are listed in #5 above.

a) Non-urgent pre-service decisions and notifications are made within fourteen (14) calendar days of receipt of the request;

b) Urgent pre-service decisions and notifications are made within seventy-two (72) hours (or ~~/~~three (3) calendar days) of receipt of the request.

i) The following criteria must be met to qualify for an urgent review: A member, or any physician (regardless of whether the physician is affiliated with Healthy Blue), may request that the health plan expedite a determination when the member or his/her physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

ii) A date of service is less than fourteen (14) calendar days from the request date, does not solely justify or meet criteria for an expedited/urgent/STAT review.

~~b) There are certain circumstances under which the above standard NCQA timelines may be extended. Practitioners and members are notified when an extension is made. Unless State or Federal standards mandate otherwise, NCQA extension timelines are as follows:~~

~~iv)~~iii) The urgent pre-service timeframe may be extended due to lack of necessary information, once, up to fourteen (14) calendar days[WJL4][RBM5][RBM6] ~~for forty-eight (48) hours~~, under the following conditions:

- The member requests the extension.
- Healthy Blue justifies (to the State agency, upon reques) a need for additional information and how that extension is in the member's best interest.
- Healthy Blue documents it made at least (1) attempt to obtain the necessary information.
- The member or the member's authorized representative is notified of the decision no later than the expiration of the extension. ~~Within twenty four (24) hours of receipt of the urgent preservice request, the member or authorized representative is notified of what specific information is required to make the decision.~~
- ~~The member or representative is given at least forty-eight (48) hours to provide the information.~~
- ~~The extension period, within which a decision must be made, begins when the additional information is received (even if all requested information is not provided), or at the end of the forty-eight (48) hours given when no response is received.~~

~~viii)~~iv) Non-urgent pre-service requests that lack necessary information (this includes situations beyond the plan's control (e.g., waiting for an evaluation by a specialist) may be extended once, up to fourteen (14) calendar days, under the following conditions:

- Within fourteen (14) calendar days of the request, the member or authorized representative is notified of what specific information is required to make the decision.
- The member or authorized representative is given at least forty-five (45) calendar days to provide the information.
- The fourteen (14) calendar day extension period, within which a decision must be made, begins when the additional information is received (even if all requested information is incomplete or not provided), or at the end of the forty-five (45) calendar days given when no response is received.
- Healthy Blue may deny the request if it does not receive the information within the timeframe, and the member may appeal the denial.

EXCEPTIONS:

1) Healthy Blue shall not require service authorization for emergency services or post-stabilization services as described in the Contract, whether provided by an in-network or out-of-network provider.
2) Healthy Blue shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.
3) Healthy Blue shall not require service authorization or referral for EPSDT screening services.

4) Healthy Blue shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the health plan, regardless of whether such services are provided by an in-network or out-of-network provider, however, prior authorization of services may be required beyond thirty (30) calendar days.
5) Healthy Blue is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first thirty (30) days of a newly enrolled member's linkage to the plan.
6) Healthy Blue shall not require a primary care physician (PCP) referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the plan for routine and preventive women's healthcare services and prenatal care.
7) Healthy Blue shall not require a PCP referral for in-network eye care and vision services.
8) Healthy Blue may require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.
9) Healthy Blue may require notification by the provider of obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding forty-eight (48) hours after vaginal delivery. In this case, only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours is denied.
10) Healthy Blue may require notification by the provider of obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, only the portion of the claim related to the inpatient stay beyond ninety-six (96) hours is denied.
~~10)~~11) Healthy Blue may require notification by the provider of inpatient emergency admissions within one (1) business day of admission. Healthy Blue is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission, if the provider does not notify Healthy Blue of inpatient emergency admission within one (1) business day of admission.[WJL7]

~~Refer to *Non-Covered and Cost-Effective Alternative Services – LA* for additional information regarding excluded, non-covered, and in-lieu of services.~~[WJL8]
In compliance with Act 79[WJL9], relative to the payment of claims made prior to credentialing, Healthy Blue shall consider a new healthcare provider joining an in-network group or facility to be an in-network or participating provider for the purposes of UM or prior authorization processes. The new provider is referred to as a "joining provider (JP)" prior to being fully credentialed (FC).

REFERENCES:

A08 – Pharmacy Prior Authorization
Associates Performing Utilization Review – LA

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management – Utilization Management	**Precertification of Requested Services – LA**

CFR Title 42
Clinical Criteria for Utilization Management Decisions – Core Process
Clinical Information for Utilization Review – LA
Continuity of Care – LA
Durable Medical Equipment – LA
Health Care Management Denial – LA
Home Health Services – LA
Informal Reconsideration – LA
Louisiana Medicaid Managed Care Organization (MCO) Manual
Louisiana State Contract
Managed Care Organization (MCO) Manual – LA
Medical Transportation – LA
NCQA Accreditation Standards and Guidelines
Non-Covered and Cost-Effective Alternative Services – LA
Out-of-Area, Out-of-Network Care – LA
Out of Network Authorization Process
Pediatric Day Health Care and Personal Care Services – LA
Prior Authorization Liaison (PAL) Policy – LA
Second Opinion
Specialty Referral
Standing Referral – LA
Staff Availability
Use of Board Certified Consultants (Medical/Behavioral Health) – Core Process
Utilization Management Clinicians Responsibilities (Health Plan/Region)
Utilization Management Support Staff

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management – Utilization Management

Secondary Department(s):
Behavioral Health
Claims
Enrollment Services
National Customer Care Organization
Provider Services

Section (Primary Department) **Health Care Management – Utilization Management**	**SUBJECT (Document Title)** **Precertification of Requested Services – LA**

REVISION HISTORY:

Review Date	Changes
06/02/2015	• Louisiana specific removed from Corporate policy
09/03/2015	• Louisiana Bayou Health Contract Amendment 4 Behavioral Health changes review
07/05/2016	• For annual review • Definitions placed in alphabetical order
08/10/2017	• For annual review • References placed in alphabetical order • Secondary department placed in alphabetical order • Claims removed as a secondary department
02/12/2018	• Off cycle review • Revised to incorporate Amendment 11 contact changes
08/08/2018	• Annual review • Definitions section updated • Includes Amendment 12 and 13 changes • Cost Containment department removed as secondary
09/13/2018	• Off cycle review • Edits to procedure section with current contract language • Reference section updated • Exceptions section updated
07/14/2020	• Annual Review • Placed on updated template • Updated Policy, definitions, procedure, exceptions, and references • Primary department updated from HCM to HCM-UM • Updated Secondary Departments to include Behavioral Health • "Appropriate Practitioner" definition replaced by the LDH-approved "Qualified Practitioner" definition • "Qualified practitioner" replaced "appropriate practitioner" throughout
12/28/2020	• Off-Cycle Review • Updated the procedure to reflect Contract Amendment 3 revisions
06/23/2021	• Annual Review • Updated to align with current State resources and corporate-owned policy • Added Act 79 language effective June 4, 2021 • Added Claims as a secondary responsible department

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