POLICY AND PROCEDURE

POLICY NAME: Clinical Information and Documentation	**POLICY ID:** LA.UM.06
BUSINESS UNIT: ~~LA~~ Louisiana Healthcare Connections	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 09/01/2011	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 10/12, 11/13, 01/14, 11/14, 8/15, 8/16, 8/17, 7/18, 6/19, 4/20, 2/21, 3/22, 12/01/22, 01/23, 11/2023	
REGULATOR MOST RECENT APPROVAL DATE(S): N/A	

POLICY STATEMENT:

All areas and departments within Centene Corporation and its subsidiaries must have written Policies and Procedures that address core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.

~~This policy outlines clinical information and documentation.~~

PURPOSE:

The purpose of this policy and procedure is to ensure that Utilization Management (UM) decisions are based on relevant clinical information and appropriately documented.

SCOPE:

This policy applies to employees of the UM Department. This includes officers, directors, consultants, and temporary workers (collectively, the "Plan").

~~This policy and procedure apply to Louisiana Healthcare Connections (also referred to as the "Plan") Population Health and Clinical Operations (PHCO) UM Department.~~

DEFINITIONS: N/A

POLICY:

The Plan requires prior authorization for those procedures which have either a significant financial or quality of care impact that can be favorably influenced by the authorization. The Corporate UM Department reviews the prior authorization list (PAL) regularly to determine if any services should be added or removed from the list.

For medical services ~~that are~~ determined ~~shall~~ to require a referral, ~~require~~ prior authorization, and/or certification, only the minimally necessary information is obtained. The information required ~~will not be~~is not overly burdensome for the enrollee, the practitioner/staff, or the health care facility staff. Clinical information received, as well as rationale for the medical necessity determination and/or leveling of care is documented and maintained in the clinical documentation system.

All medical record information used to make a decision, is attached to the member's record in the clinical documentation system to allow for recreation of the decision-making processes of the member case, utilizing the actual information that was reviewed.

PROCEDURE:

~~A.~~ Information for UM Decision Making

~~In accordance with 42CFR §456.111 and §456.211, e~~Each request for authorization requires collection of relevant information for consideration. Information from any reasonably reliable source that assists in the certification process are accepted. Basic information needed to perform the review may include, as applicable, but is not limited to, the following information: (Model Contract 2.12.1.2.5)

- Identification of the enrollee (name, date of birth, enrollee ID, address, etc.)

- Specific order or referral for services if requesting outpatient (OP) services.
- Office and hospital records.
- Enrollee's admitting/treating physician.
- Date of admission.
- Justification of emergency admission if applicable.
- A history of the presenting problem.
- Clinical or mental status exam.
- Diagnostic testing results.
- Treatment plans and progress notes per 42 CFR §456.80 and §456.180.
- Initial and subsequent continued stay review dates described under 42 C.F.R. §456.128, §456.133, §456.233 and §456.234.
- Patient psychosocial history or assessment/situation.
- Information on consultations with the treating practitioner.
- Evaluations from other healthcare practitioners and providers.
- Photographs.
- Criteria related to the request (i.e., Level of Care Utilization System (LOCUS), Child and Adolescent Level of Care Utilization System (CALOCUS), or other level of care assessment).
- Physical or behavioral health screenings and results.
- Date of operating room reservation, if applicable.
- Operative and pathological reports.
- Rehabilitation evaluations.
- Printed copy of criteria related to the request.
- Information regarding benefits for service or procedure.
- Information regarding the local delivery system available to the member that could include:
    - Availability of alternative levels of care (intensive outpatient (IOP), OP detoxification programs, residential) in the service area to support the enrollee after discharge from an acute hospitalization.
    - Benefit coverage for alternative levels of care (i.e., IOP, OP detoxification, or residential) where needed.
    - The ability of the treatment team to provide all recommended services within the estimated length of stay.
    - Member characteristics and information.
    - Information from responsible family members
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- Patient characteristics and information (i.e., age, medical, behavioral, and substance abuse co-morbidities, complications, etc.)
- Information from responsible family enrollees
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~~Only information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services will be collected.~~

~~Providers are required to numerically code diagnoses or procedures to be considered for certification, but codes may be requested if needed to determine the specific services being requested or to determine a specific diagnosis.~~

~~Copies of complete medical records for all reviews will not be routinely requested.~~

The Plan is responsible for eliciting pertinent health record information from the treating health care provider(s), as needed and/or as requested by the Louisiana Department of Health (LDH), for purposed of making service authorization determinations. (Model Contract 2.12.3.6.1.1)

Only the section of the medical record necessary to certify medical necessity or appropriateness of the requested care or service ~~will be~~is required.~~ ~~Additional medical records ~~will only be~~are only requested when criteria ~~has~~have not been met or there is difficulty in making the UM determination ~~by the Medical Advisor~~. (Model Contract 2.12.3.6.2)

To avoid duplicate requests for information on individual enrollees, clinical and demographic information is located in the clinical documentation system, ~~a centralized location,~~ in order to be accessed by all clinical and administrative staff with proper authority to view the information and that have a 'need to know'.

~~B.~~ Onsite Facility Reviews~~:~~

~~Appropriate Plan~~ UM clinical reviewers (UMCRs) conducting onsite facility reviews ~~must~~ always wear ~~a~~ their Plan identification badge ~~at all times~~ while conducting reviews. The identification badge includes a picture ID, the full name of the UMCR ~~clinical reviewer (CR)~~ and the name of the Plan. In addition, UM-CRs follow facility specific identification procedures.

UM-CRs schedule onsite reviews at least one (1) business day in advance with the indicated facility staff, unless otherwise agreed upon. Onsite reviews at large volume hospitals may be setup in advance, as part of a preset routine schedule (e.g., weekly on Monday, Wednesday, and Friday).

While conducting onsite facility reviews, UM-CRs adhere to applicable facility rules, including checking in with designated facility staff. UM-CRs participate in an initial facility orientation to review facility rules.~~ ~~Orientation includes review of applicable contract language and facility rules/procedures with which UM staff are expected to comply.~~as mandated by the facility.~~

C. Documentation of Information:

UM-CRs request clinical information applicable to the case and document it and clinical criteria rationale used to make the decision in the clinical documentation system. ~~The clinical criteria rationale used to make the decision shall also be documented according to Work Process, LA.UM.06.01 Documentation of Clinical Decisions (TruCare®).~~ If a determination cannot be made due to lack of necessary information, the UM-CR ~~must~~ documents their attempts to obtain the additional information. In cases where the provider or enrollee will not release necessary information, the Plan may deny authorization of the requested service(s) within two (2) business days (Model Contract 2.12.3.6.1.2).

~~D.~~ Secure Medical Records~~:~~

In alignment with applicable compliance and security policies, records containing confidential and proprietary information ~~will be~~are securely maintained, controlled, and protected to prevent unauthorized access.

Medical records include but are not limited to: information created or received in any form including emails, paper documents, electronic documents, database, or application information and/or other electronic or photographic media received by the ~~Medical Management~~UM Department for utilization and care management processes.

Hard copy medical records mailed/faxed to the Plan for purposes of utilization or care management are scanned and attached to the applicable authorization, case, or referral file in the clinical documentation system within ~~two (2) business~~48 hours ~~days~~ of receipt.

REFERENCES:
LA MCO Model Contract

2.12.1.2.5
2.12.3.6.1.1
2.12.3.6.1.2
2.12.3.6.2~~LA.UM.06.01 – Documentation of Clinical Decisions (TruCare®)~~
~~TruCare® Training Manual~~
~~Current~~ NCQA Health Plan Standards and Guidelines UM6: Clinical Information
42 CFR §456 Utilization Control

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: Louisiana Revised Statute §46:460.54 applies to material changes for this policy.~~N/A~~

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Language added to comply with Louisiana state contractual requirements	11/2013
Annual Review	Updated for NCQA 2013 Guidelines	01/2014
Ad Hoc Review	LA Procurement 2015 Policy Update, update references to reflect LA policies	11/2014
Annual Review	Updated NCQA date to current	08/24/15
Annual Review	Removed referral and definition	08/24/16
Annual Review	Updated what is needed within the clinical information and updating medical director asking for additional information.	08/24/17
Annual Review	No Revisions	07/24/18
Annual Review	Grammatical changes Changed Clinical Authorization System and Clinical Documentation System (CDS) to TruCare® Changed Medical Director to Medical Advisor Changed UM Staff to UM Clinical Reviewers (CRs) and UM designee to UM Clinical Reviewer (CR) Removed LA.UM.06.02 UM Documentation in TruCare® Notes from References Changed Product Type to Medicaid	06/24/19
Annual Review	Removed Corporate Authorization List section as removed from corporate policy Renumbering sections Changed providers will not to providers will be required to provide numerical diagnosis codes Changed RFP to Emergency Contract Added Secure Medical Records section	04/24/20
Annual Review	Format change Added required documentation from Emergency contract section 8.1.23	02/25/21
Annual Review	No changes	03/28/22
Ad Hoc Review	Changed MM to PHCO Changed member to enrollee Updated contract language and references Reformatted to new policy template	12/01/22
Annual Review	Replaced TruCare with clinical documentation system; updated Functional Area to Utilization Management; updated Reference Section Clarifying time on secure medical records item 3	01/13/23
Annual Review	Updated Policy statement and Scope, style guide changes, removed incorrect references, added information under local delivery system, replaced medical management with UM, updated regulatory reporting requirement,	11/2023

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company's P&P management software, is considered equivalent to a signature.