POLICY AND PROCEDURE

DEPARTMENT: ~~Medical Management~~Population Health and Clinical Operations	**DOCUMENT NAME**: Clinical Information and Documentation
PAGE: 1 of 4	**REPLACES:**
APPROVED DATE: Sept 2011	**RETIRED:**
EFFECTIVE DATE: Jan 2012, Feb 2015, Jan 2023	**REVIEWED/REVISED:** 10/12; 11/13, 01/14, 11/14; 8/15; 8/16, 8/17, 7/18, 6/19, 4/20, 2/21; 3/22; 10/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.06

SCOPE: Louisiana Healthcare Connections (Plan) ~~Medical Management~~Population Health and Clinical Operations Department

PURPOSE: To ensure that Utilization Management (UM) decisions are based on relevant clinical information and appropriately documented.

POLICY: Plan will require prior authorization for those procedures which have either a significant financial or quality of care impact that can be favorably influenced by the authorization. Corporate Medical Management department will review the Prior Authorization List (PAL) regularly to determine if any services should be added or removed from the list.

For medical services that the Plan has determined shall require prior authorization, only the minimally necessary information will be obtained. The information required will not be overly burdensome for the ~~member~~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 will be documented and maintained in TruCare®.

PROCEDURE:

A. Information for UM Decision Making

1. In accordance with 42CFR §456.111 and §456.211, each request for authorization requires collection of relevant information for consideration. Information from any reasonably reliable source that assists in the certification process will be accepted. Basic information needed to perform the review may include, as applicable, but is not limited to, the following information: ~~(Emergency Contract section 8.1.23):~~ (RFP Model Contract 2.12.1.2.5)
   - Identification of the ~~member~~enrollee (name, date of birth, ~~social security number~~enrollee ID, address, etc.)
   - Specific order or referral for services if requesting Outpatient (OP) Services
   - Office and hospital records
   - ~~Member~~Enrollee's admitting/treating physician
   - Date of admission
   - Justification of emergency admission if applicable
   - A history of the presenting problem
   - Clinical 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
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- 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
- Patient characteristics and information
- Information from responsible family ~~member~~enrollees

2. Only information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services will be collected.
3. Providers will be 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
4. Copies of complete medical records for all reviews will not be routinely requested.
5. The Plan is responsible for eliciting pertinent health record information from the treating health care provider(s), as needed and/or as requested by LDH, for purposed of making Service Authorization determinations. (RFP Model Contract 2.12.3.6.1.1
6. Only the section of the medical record necessary to certify medical necessity or appropriateness of the requested care or service will be required. Additional medical records will only be requested when criteria has not been met or there is difficulty in making the UM determination by the Medical Advisor. (RFP Model Contract 2.12.3.6.2)
7. To avoid duplicate requests for information on individual ~~member~~enrollees, clinical and demographic information is located in TruCare®, 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:

1. Appropriate Plan UM Clinical Reviewers (CRs) conducting onsite facility reviews must wear a Plan identification badge at all times while conducting reviews. The identification badge will include a picture ID, the full name of the

UM Clinical Reviewer (CR) and the name of the Plan. In addition, UM CRs will follow facility specific identification procedures.

2. UM CRs will schedule onsite reviews at least one 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).
3. While conducting onsite facility reviews, UM CRs will adhere to applicable facility rules, including checking in with designated facility staff. UM CRs will participate in an initial facility orientation to review facility rules, as mandated by the facility.

C. Documentation of Information:

UM CRs will request clinical information applicable to the case and document it in TruCare®. 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 document attempts to obtain the additional information. In cases where the provider or ~~member~~enrollee will not release necessary information, the Plan may deny authorization of the requested service(s) within two (2) business days. ~~(Emergency Contract 8.1.9)~~

D. Secure Medical Records:

1. In alignment with applicable compliance and security policies, records containing confidential and proprietary information will be securely maintained, controlled, and protected to prevent unauthorized access.
2. 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 Department for utilization and care management processes.
3. Hard copy medical records mailed/faxed to the Plan for purposes of utilization or care management will be scanned and attached to the applicable authorization, case, or referral file in TruCare® within 48 hours of receipt.

REFERENCES:
~~LA MCO RFP Amendment 11 – Section 8 Utilization Management~~
LA MCO RFP Model Contract
LA.UM.06.01 – Documentation of Clinical Decisions (TruCare®)
TruCare®Training Manual
Current NCQA Health Plan Standards and Guidelines

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PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.06

ATTACHMENTS

DEFINITIONS:

REVISION LOG	**DATE**
Language added to comply with Louisiana state contractual requirements	11/13
Updated for NCQA 2013 Guidelines	01/14
LA Procurement 2015 Policy Update, update references to reflect LA policies	11/2014
Updated NCQA date to current	8/15
Removed referral and definition	8/16
Updated what is needed within the clinical information and updating medical director asking for additional information.	8/17
No Revisions	07/2018
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	6/19
Removed Corporate Authorization List section as removed from corporate policy Renumbering sections Changed providers will not to providers will be require to provide numerical diagnosis codes Changed RFP to Emergency Contract Added Secure Medical Records section	4/2020
Format change Added required documentation from Emergency contract section 8.1.23	2/21
No changes	3/22
Changed MM to PHCO Changed member to enrollee Updated contract language and references	10/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer is considered equivalent to a physical signature.