POLICY AND PROCEDURE

DEPARTMENT: ~~Medical Management~~Population Health and Clinical Operations	**DOCUMENT NAME**: Timeliness of UM Decisions and Notifications
PAGE: 1 of 12	**REPLACES DOCUMENT:**
APPROVED DATE: 9/11	**RETIRED:**
EFFECTIVE DATE: 1/12, 2/15, 12/15, 1/23	**REVIEWED/REVISED:** 09/13; 11/13; 1/14,11/14, 2/15, 5/15, 9/15; 5/16, 8/16, 5/17, 6/17, 5/18, 8/18, 9/18, 5/19, 8/19, 10/19, 08/20, 12/20, 3/22; 12~~0~~/22
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.05

SCOPE:

Louisiana Healthcare Connections (Plan) ~~Medical Management~~Population Health and Clinical Operations Department and Behavioral Health Services.

PURPOSE:

To promote utilization management (UM) decisions made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care.

POLICY:

The Plan service authorization process is consistent with 42 CFR §438.210 and state laws and regulations for initial and continuing authorization of services. The Plan has timelines in place for providers to notify the Plan of service requests and for the Plan to make utilization management decisions and notifications to the ~~member~~enrollee and provider. Timeframes apply to all UM decisions (i.e. approvals and denials) resulting from medical necessity review.

Reasonable attempts (minimum of one attempt) are made in all cases to obtain complete clinical information. Administrative denials for lack of clinical information are not issued for any requests where insufficient information has been received if at minimum, a diagnosis is included in the request. For denials due to insufficient clinical information, the decision is a medical necessity ~~decision~~decision, and the denial notice must describe the specific information needed to make the decision (e.g. history and physical exam documentation, lab values, current nursing notes, etc.) The Plan will 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~~enrollee's health condition made by the provider. (Model contract 2.12.3.6.1.2 & 2.12.6.3.2)

Louisiana Department of Health (LDH) will conduct random reviews to ensure that ~~member~~enrollees are receiving all notices in a timely manner.

PROCEDURE:

A. Timeliness of Provider Notification to Plan

- For all pre-scheduled services requiring prior authorization, providers must notify the Plan within seven (7) days prior to the requested service date or as soon as need is identified.
- Prior authorization is *not required* for emergent and post stabilization services.
- Facilities are required to notify the Plan of all inpatient admissions within one (1) business day following the admission. ~~(Emergency Contract 8.5.4.2)~~
- Once the ~~member~~enrollee's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required as stated above.
- The Plan may require notification by the provider of obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery or ninety-six (96) hours after Caesarean section. The Plan 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 for vaginal delivery or ninety-six (96) hours for Caesarean section. In this case, the Plan may only deny the portion of the claim related to the inpatient stay beyond forty-eight (48) hours for vaginal deliveries or ninety-six (96) hours for Caesarean sections. ~~(Emergency Contract 8.5.4.2)~~

B. **Timeliness of UM Decision Making and Notifications** – all time frames are maximum time frames; UM decisions should be made as expeditiously as the ~~member~~enrollee's health condition requires. Untimely service authorization constitutes a denial and thus an adverse action.

1. Standard / Non-urgent decisions:

- The Plan shall make eighty percent (80%) of standard service authorizations determinations within two (2) business days~~,~~ of obtaining appropriate medical information that may be required regarding a proposed admission, procedure or service requiring a review determination, with the following exceptions:
  - All inpatient hospital service authorizations for which the standard for determination is two (2) calendar days of obtaining appropriate documentation; and (~~Emergency Contract Amendment 3 section 8.5.1.1.1~~Model Contract 2.12.6.1.1.1)
  - Community Psychiatric Support Treatment (CPST) and Psychosocial Rehabilitation (PSR) services for which the standard for determination is within five (5) ~~calendar days of obtaining appropriate medical~~

~~information. (Emergency Contract Amendment 3 section 8.5.1.1.2~~Model Contract 2.12.6.1.1.2)

- 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. (Model Contract 2.12.6.1.1.3~~Emergency Contract Amendment 11 8.5.1.1.3~~)

- All standard service authorization determination shall be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension has been requested. (~~Emergency Contract Amendment 3 section 8.5.1.2)~~(Model Contract 2.126.1.2) Refer to graph to ensure that the most stringent turnaround time is met
  a. The service authorization decision may be extended up to fourteen (14) additional calendar days if:
     - The ~~member~~enrollee, or the provider, requests the extension, or
     - The Plan justifies (to LDH upon request) a need for additional information and how the extension is in the ~~member~~enrollee's interest. (~~Emergency Contract Amendment 3 section 8.5.1.2.1 - 8.5.1.2.1.2~~Model Contract 2.12.6.1.3.1-2.12.6.1.3.2))
  b. Time of receipt is when the request is made to the Plan according to the Plan's filing procedures, regardless of whether the Plan has all the information necessary to make the decision and whether the Plan is open for business on the date the request is received. Requests received after normal business hours will be processed on the next business day.
  c. If the Plan is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to an additional 14 calendar days.
     - Within 14 calendar days of the original request, the ~~member~~enrollee or ~~member~~enrollee's authorized representative is notified of the extension and the expected date the determination will be made.
     - UM decisions should be made as expeditiously as the ~~member~~enrollee's health condition requires and no later than the date the extension expires.
  d. If a determination cannot be made due to lack of necessary information, the Utilization Manager clinical reviewer (UMCR)- will make at least two documented attempts to obtain the additional information within the

original 14 calendar--day time frame. If there is no response or continued lack of necessary information, a determination is made based on the available information. The ~~member~~enrollee (or ~~member~~enrollee's representative) and/or the requesting practitioner will be notified of the denial no later than the date the timeframe expires (day 14 for standard/non-urgent authorization requests.) The appeal process may be initiated at this time if desired.

e. The Medical Advisor and/or Utilization Manager clinical reviewer (UMCR) documents all relevant information related to the clinical decision in the authorization system. When notifying by telephone, the Medical Advisor and/or Utilization Manager clinical reviewer (UMCR) documents the date and time of the notification in the authorization system, as well as who was notified of the decision.

f. For any determination, the Medical Advisor, UM clinical reviewer (UMCR) or designee will notify the provider rendering the service, whether a health care professional or facility or both and the ~~member~~enrollee, verbally, by fax, or as expeditiously as the ~~member~~enrollee's health condition require, within one (1) business day after the determination has been made and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial determination. (Model Contract 2.12.6.4.1.1 & 2.12.6.4.1.2)~~Emergency Contract 8.5.4.1.1.1, Emergency Contract 8.5.4.1.1.2~~, Current NCQA Health Plan Standards and Guidelines)

- Faxing of the determination letter will fulfill both the NCQA and Emergency Contract standards

2. Expedited / Urgent decisions:

a. For expedited service authorization decisions where a provider indicates, or the Plan determines, that following the standard timeframe could seriously jeopardize the ~~member~~enrollee's life or health or ability to attain, maintain, or regain maximum function, the Plan shall make an expedited authorization decision and provide notice as expeditiously as the ~~member~~enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service. Time of receipt is when the request is made to the Plan according to the Plan's filing procedures, regardless of whether the Plan has all the information necessary to make the decision. The date/time of receipt is documented

for all requests. (~~Emergency Contract 8.5.2.1~~Model Contract 2.12.6.2.1 and Current NCQA Health Plan Standards and Guidelines)

b. The Plan may extend the seventy-two (72) hour time period by up to fourteen (14) calendar days if the ~~member~~enrollee requests the extension or if the Plan justifies to LDH a need for additional information and how the extension is in the ~~member~~enrollee's best interest. (~~Emergency Contract 8.5.2.2~~Model Contract 2.12.6.2.2)

- Within 24 hours of the receipt of the request, the Plan notifies the ~~member~~enrollee (or the ~~member~~enrollee's authorized representative) and/or requesting practitioner in writing of the need for an extension and the specific information necessary to make the decision.
- A specified time frame for submission of the additional information, of at least 48 hours, must be given.
- The Plan makes a decision within 48 hours of receiving the additional information (even if the information is incomplete) or within 48 hours of the end of the specified period given to supply the additional information (even if no response is received), whichever is earlier.
- The Plan may deny the request if all necessary information is not provided within this time frame. The appeal process may be initiated at this time if desired.

c. The Medical Advisor and/or Utilization Manager clinical reviewer (UMCR) documents all relevant information related to the clinical decision in the authorization system.

d. For any determination, the Medical Advisor, UM clinical reviewer or designee will notify the provider rendering the service, whether a health care professional or facility or both and the ~~member~~enrollee, verbally, by fax, or as expeditiously as the ~~member~~enrollee's health condition require, within one (1) business day after the decision is made and shall provide documented confirmation of such notification to the provider within two (2)business days of making the initial determination, not to exceed 15 calendar days of the receipt of the request. (~~Emergency Contract 8.5.2.1., Emergency Contract 8.5.2.2, and~~ Current NCQA Health Plan Standards and Guidelines)

- ~~Faxing of the determination letter will fulfill both the NCQA and Emergency Contract standards~~

3. Urgent Concurrent decisions (Expedited Continued Stay):

a. An urgent concurrent review is a review of medical necessity, appropriateness of care, or level of care conducted during a patient's inpatient stay or course of treatment.

b. The Plan shall make all concurrent review determination within one (1) calendar day of obtaining the appropriate medical information that may be required (~~Emergency Contract Amendment 3 section 8.5.1.3~~Model Contract 2.12.6.1.4), not to exceed 72 hours or 3 calendar days from the date of request (Current NCQA Health Plan Standards and Guidelines).

- Following the NCQA timeliness standard will ensure that the Emergency Contract timeliness standard is met.

c. Time of receipt is when the request is made to the Plan according to the Plan's filing procedures (LA.UM.03). The date/time of receipt is documented for all requests. For concurrent care, the date/time of the ongoing review is documented.

d. If the request to extend a course of ongoing ambulatory treatment beyond the period of time or number of treatments previously approved does not meet the definition of "urgent care", the request may be handled as a new request and be handled under the applicable time frame (i.e., pre-service or post-service request).

- The Plan considers the content of the request when determining if an outpatient concurrent request meets the definition of "urgent care", and determines whether applying non-urgent time frames could lead to adverse health consequences for the ~~member~~enrollee and/or cause an unnecessary disruption in care.

e. If the request for non-emergency admission, procedure or service request, extended stay or additional service authorization is approved or if the determination results in a denial, the Medical Advisor, UM clinical reviewer or designee will notify the provider rendering the service, whether a health care professional or facility or both and the ~~member~~enrollee, verbally, by fax, or as expeditiously as the ~~member~~enrollee's health condition requires, within one (1) business day after the decision is made and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial determination, not to exceed 72 hours (3 calendar days) of the receipt of the request. (~~Emergency~~

~~8.5.4.1.1.1, Emergency Contract 8.5.4.1.1.2~~Model Contract 2.12.6.4.1.1 & 2.12.6.4.1.2, Current NCQA Health Plan Standards and Guidelines)

- Faxing of the determination letter will fulfill both the NCQA and Emergency Contract standards.

f. The Medical Advisor and/or UM clinical reviewer documents all relevant information related to the clinical decision in the authorization system.

4. Retrospective / Post-service decisions

a. Retrospective review is review for medical necessity conducted after services have been provided to a patient~~,~~ but shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.

b. Request for retrospective reviews will only be considered when prior authorization and/or notification to the Plan was not obtained due to extenuating circumstances related to the ~~member~~enrollees presentation (i.e. ~~member~~enrollee was unconscious at presentation, ~~member~~enrollee did not have Medicaid card or otherwise indicate Medicaid coverage, services authorized by another payor who subsequently determined ~~member~~enrollee not eligible at time of service).

c. All medical necessity reviews are conducted according to the process as outlined in the Clinical Decision (LA.UM.02) and Medical Necessity Review (LA.UM.02.01) policies and based solely on the medical information available to the attending physician or ordering provider at the time the care or service was provided.

d. Requests and supporting clinical information for review may be submitted by phone, facsimile or web portal (as available) from the servicing/ managing provider or facility.

e. Medical necessity post-service decisions and subsequent written ~~member~~enrollee and provider notification will occur no later than 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) days from the date of receipt of request for service authorization~~for the date of service~~. Authorization will not be retracted 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 enrollee's health condition made by the provider. (~~Emergency Contract 8.5.3.1~~ Model Contract 2.12.6.3.1 & 2.12.6.3.2 and Current NCQA Health Plan Standards and Guidelines)

f. If a determination cannot be made due to lack of necessary information, the review nurse or designee makes at least two (2) documented attempts to obtain the additional information within the original 30 calendar day timeframe. If there is no response or continued lack of necessary information, the ~~member~~enrollee (or ~~member~~enrollee's representative), the requesting practitioner and attending practitioner are notified of the administrative denial decision in writing within 14 calendar days of the original post-service request. The appeal process may be initiated at this time if desired.

REFERENCES:

~~MCO Contract – Section 6 2.12Utilization Management~~
MCO ~~RFP~~ Model Contract
Health Plan Advisory 12-9 April 25, 2013: Clarification of Provider Disputes Relative to Denied Claims and Services
Louisiana Title 37, Part XIII, §6217 - §6219
LA.UM.07 - Denial (Adverse Determination) Notices
LA.UM.08 – Appeal of UM Decisions
LA.UM.02.13 Tracking Disclosure of Medical Necessity Criteria
Current NCQA Health Plan Standards and Guidelines
Code of Federal Regulations – 42 CFR 422
HB 424/Act 330
Louisiana Medicaid Care Organization Statement of Work Dated 9/5/2019
Louisiana Medicaid Care Organization Contract Amendment #3 Dated 12/1/2020

ATTACHMENTS:


LA.UM.05_TAT CHART_122020.pdf


LA.UM.05_ Attachment_TAT CHA

DEFINITIONS:

24 hours: NCQA considers 24 hours to be equivalent to 1 calendar day
72 hours: NCQA considers 72 hours to be equivalent to 3 calendar day
Medical Advisor: MD or PhD member of the Medical Affairs team

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PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.05

REVISION LOG	**DATE**
1. Various adjusts were made to include reference to the following 2013 NCQA elements: UM5, A1; UM5, B1; UM5, B2; UM5, A2, UM5, B2; UM5, A3; UM5; B3; UM5, A4, and UM5, B4. 2. Changed statement referencing provider notification for Concurrent review decisions from "one working day" to "24 hours" 3. Changed statement referencing provision of documentation confirmations for Concurrent review decisions from "working days" to "business days"	08/13
PROCEDURE: A. **Timeliness of Provider Notification to Plan** Corrected sentence to read within seven (7) days instead of fourteen (14) For all pre-scheduled services requiring prior authorization, providers must notify the Plan within seven (7) days prior to the requested service date or as soon as need is identified.	09/12
B. **Timeliness of UM Decision Making and Notifications Corrected sentence to read** a. Determinations for non-urgent prior authorization requests are made within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure or service requiring a review determination. Standard service authorization determination will be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension has been requested. **(deleted 14 calendar days of receipt of the request)**	09/12
2. Expedited / Urgent decisions: (deleted 48 hours) c. If additional information is necessary prior to issuing a determination, a one-time extension of up to fourteen (14) calendar days may be implemented if the member or provider requests an extension or the Plan justifies to DHH a need for additional information and the extension is in the member's best interest.	09/12

3. Concurrent review decisions (changed working day to business day) For concurrent review determinations of medical necessity the Plan will make the decision within one (1) business day of obtaining the results of appropriate medical information that may be required.	09/12
No Revisions	09/13
Changed font and bold for clarification of needed information for Louisiana RFP	11/13
Added peer to peer process flow.	1/14
LA Procurement 2015 Policy Update	11/14
Section B1C added: acting on behalf of the member and with the member's written consent	2/15
Notification verbiage changed in section 1G to mirror the LA MCO RFP	5/15
Added reference to CCL 229 Added Behavioral Health Services to Scope	9/15
Added "Faxing of the determination letter will fulfill both obligations". Changed "case manager" to "review nurse" Grammatical Changes Under Policy: Removed statement duplicated in Section B.1	5/16
Removed TAT goal Removed verbiage that was not NCQA compliant Changed statement referencing provider notification for Concurrent review notification from "24 hours" to "1 calendar day from receipt of request and not determination" Added NCQA definitions Removed retro notification verbiage that was not NCQA compliant Changed DHH to LDH	8/2016
Grammatical Changes only	5/17
Updated to comply with LHCC reporting requirements	6/17
Grammatical Changes Changed Retro Decision and Notification timeframe from 30 days to 14 days	5/18

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PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.05

Changed Appeals timeframe from 30 days to 60 days	
Updated NCQA verbiage for notification to include the word "written" per most recent NCQA Standards Updated retro decision and notification time from 14 Days to 30 days per most recent NCQA Standards Updated urgent concurrent decision and notification timeframe from 24 hours to 72 hours or 3 calendar days per most recent NCQA standards. Updated RFP references	8/18
Informal Reconsideration / Peer to Peer, Section 5.e. removed. Removed reference to CCL.229	9/18
Added statement referencing requirements from RFP Amendment 11 regarding Informal Reconsiderations	5/2019
Added notation related to new process for provider release of criteria and applicable timeframes as per new House Bill 424- Act 330 requirement Added reference to LA.UM.02.13 Tracking Disclosure of Medical Necessity Criteria Added reference to HB 424/Act 330	8/19
Changed review nurse to UM clinical review Removed verbiage regarding informal reconsideration Removed the HBA 424 as this is in LA.UM.02.13 Added NCQA verbiage Added TAT Chart with emphasis on stringency Added CPST/PSR TAT Removed the documentation of documenting all clinical received	10/19
Added timeframe applicable to all determinations Added attempts to request additional information Added language regarding administrative denial due to lack of information Changed RFP to Emergency Contract Changed specific NCQA standards to general Current NCQA Health Plan Standards and Guidelines Changed Medical Director to Medical Advisor Defined Medical Advisor	08/2020
Add Inpatient Service determination	12/2020

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Updated Concurrent Review determination Added Amendment #3 Reference Updated attached TAT Chart	
Added turnaround time for BH crisis services from Emergency contract Amendment 11 Removed medical information from Emergency contract amendment 11	03/2022
Changed MM to PHCO Changed member to enrollee Updated verbiage and contract references	120/2022

POLICY AND PROCEDURE APPROVAL

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