Title

UCSMM.01.11 Document Oversight and Adherence

Applicability

UnitedHealthcare Clinical Services Medical Management **(USCMM)** Program

Statement

The **U**tilization **M**anagement **(UM)** program will maintain and adhere to written operational policies and procedures that establish accountability for quality services. Organizational documents will align with corporate policy, state/federal laws and regulations, and accreditation requirements. Organizational documents will follow a consistent process for creation, revision, approval, archiving and annual review.

Terms used within organizational documents will be consistent with an approved list of definitions that are reviewed for compliance with **the more stringent/restrictive applicable accreditation**, state**/**federal **law**, government **contracts or** program**s.** ~~and accreditation requirements.~~

Purpose

- To provide written documentation of program functions and accountabilities
- To establish oversight for document development and review
- To establish approved terminology consistent with applicable laws/regulations/accreditation programs and corporate definitions and acronyms

Definitions

Refer to **UCSMM** ~~UnitedHealthcare Clinical Services Medical Management~~ Approved Definitions which are maintained in accordance with operational policy UCSMM.01.11 Document Oversight and Adherence.

Provisions

PROCEDURAL GUIDELINES for POLICY COMPLIANCE

A. Document Creation/Revision

1. UnitedHealthcare Clinical Services Business Standardization and Advancement (BSA) department will coordinate document creation.
2. Organizational documents will consistently and accurately reflect the **UM** ~~utilization management~~ program operation by recording accountabilities in the form of policy/procedure, letters, forms, workflows, job aids, flow charts and marketing material.
3. The need for document creation or revision is identified through process improvement projects, customer service needs, regulatory changes or other business changes impacting policy or process.
4. Staff members who identify changes that require document creation or revision should elevate the need through management to operational leadership who will coordinate with the UnitedHealthcare Clinical Services **(UHC)** quality committee responsible for document oversight.

B. Document Controls

1. UnitedHealthcare Clinical Services designates UnitedHealthcare Clinical Services BSA to oversee standardization of written ~~UnitedHealthcare Clinical Services Medical Management (~~UCSMM~~)~~ operational policies and procedures with reporting requirement to the quality oversight committee.
2. All functional areas within UCSMM are responsible for interfacing with UnitedHealthcare Clinical Services BSA staff for document creation, development and revision.
3. UnitedHealthcare Clinical Services BSA responsibility:
    i. Develop and maintain current, compliant and accurate written operational policies and procedures that are based on **the more stringent/restrictive of applicable accreditation, state/federal law, government contracts or programs** ~~applicable laws, regulations, corporate and accreditation standards~~, and are approved by the quality oversight committee.
    ii. Manage the oversight of document creation, development and revision and report results to the quality oversight committee.
    iii. Provide content review and index documents to ensure no duplication or inconsistency.
    iv. Ensure documents establish accountability for providing quality services.
    v. Maintain a master list of policies, procedures and policy attachments and their histories.
    vi. Review documents for compliance with regulatory/accreditation requirements.
    vii. Ensure all documents outline effective dates, most recent revision date and review dates.
    viii. Ensure documents are reviewed and revised as needed on an annual basis.
    ix. Ensure compliance with the quality oversight committee review and approval process.
    x. Retain and store documents in compliance with UCSMM operational policy UCSMM.03.10 Information Security.

C. Document Review and Approval

1. Document review is a collaborative process between UnitedHealthcare Clinical Services BSA, the utilization management program operation and other departments, e.g., compliance and legal, when revisions are needed and no less than annually.
2. UnitedHealthcare Clinical Services BSA submits final versions of operational policies to the benefit organizations that are impacted to obtain approvals, and then, to the quality oversight committee for adoption.
3. Documents that are developed for new process implementation are approved by the applicable functional area leadership and adopted by the document quality committee.

D. Document Accessibility

1. UnitedHealthcare Clinical Services BSA will publish operational policies and procedures, so they are accessible to all staff members.
2. The **UM** ~~utilization management~~ program operation will notify staff members when new or revised policies or procedures are published and how to access.

E. Adherence to Policies and Procedures

1. All staff members are responsible for adhering to policies and procedures that apply to their jobs.
2. Operations managers are responsible for monitoring staff adherence to applicable policies and procedures.

F. List of Approved Definitions

1. Definitions of terms are consistent with **UHC** ~~UnitedHealthcare~~ terms and comply with accreditation and regulatory requirements.
2. Written policies will have a Definitions addendum that aggregates the approved definitions of terms

used throughout UCSMM documents.

3. Definitions will have legal review and approval.
4. The list of Approved Definitions will be reviewed by the quality oversight committee annually.

APPLICABLE ACCREDITATION STANDARDS

- ~~URAC v3.2: Core 3 (a,b,c,di,dii) Policy and Procedure Maintenance, Review and Approval~~
- ~~URAC v3.2: Core 28a Staff Operational Tools and Support~~
- **URAC v8.1: RM 1: Regulatory Compliance and Internal Controls, OPIN 1-1: Policy and Process Maintenance**

More stringent/restrictive applicable state/federal laws/regulations/contracts will take precedence over UnitedHealthcare Clinical Services Medical Management Policy.

UCSMM 01.11 Document Oversight and Adherence	
Louisiana Medicaid Contract Requirements	State/Federal Medicaid Rules
Attachment A – Model Contract – FINAL round – 8.5.2022 PART 1: GLOSSARY AND ACRONYMS Glossary * Denotes terms for which the Contractor must use the State-developed definition. Adverse Benefit Determination – Any of the following: • The denial or limited authorization of a requested service, including, but not limited to, determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. • The reduction, suspension, or termination of a previously authorized service. • The denial, in whole or in part, of payment for a service. • The failure to provide services in a Timely manner, as defined by the State. • The failure of the Contractor to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals. • The denial of an Enrollee's request to dispute a financial liability, including Cost Sharing, copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities. Appeal* – A request for a review of an Adverse Benefit Determination.	§ 438.408 Resolution and notification: Grievances and appeals. (b) Specific timeframes – (1) Standard resolution of grievances. For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance. 42 U.S.C. §1396d(r) (r) EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES The term "early and periodic screening, diagnostic, and treatment services" means the following items and services: (1) Screening services— (A) which are provided— (i) at intervals which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care and, with respect to immunizations under subparagraph (B)(iii), in accordance with the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines, and (ii) at such other intervals, indicated as medically necessary, to determine the existence of certain physical or mental illnesses or conditions; and (B) which shall at a minimum include— (i) a comprehensive health and developmental history (including assessment of both physical and mental health development),
Appeal Procedure – A formal process whereby an Enrollee can contest an adverse determination rendered by the Contractor, which results in the denial, reduction, suspension, termination or delay of health care benefits/services. The Appeal Procedure shall be governed by Federal and State laws, regulations, rules, policies, procedures, and manuals, and all applicable court orders and consent decrees. Business Day –Monday, Tuesday, Wednesday, Thursday, and Friday, excluding State-designated holidays. Business Hours – 8:00 a.m. – 5:00 p.m. Central Time on Business Days. Calendar Days – All seven (7) days of the week. Unless otherwise specified, the term "day" in the Contract refers to Calendar Days. Can – A term that denotes an allowable activity, but not a mandatory requirement.	(ii) a comprehensive unclothed physical exam, (iii) appropriate immunizations (according to the schedule referred to in section 1396s(c)(2)(B)(i) of this title for pediatric vaccines) according to age and health history, (iv) laboratory tests (including lead blood level assessment appropriate for age and risk factors), and (v) health education (including anticipatory guidance). (2) Vision services— (A) which are provided— (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and (B) which shall at a minimum include diagnosis and treatment for defects in vision, including eyeglasses.

Chisholm Class Members – All current and future Beneficiaries in the State of Louisiana under age twenty-one who are now on or will in the future be placed on the Developmental Disabilities Request for Services Registry. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) – All medically necessary Section 1905(a) services that correct or ameliorate physical and mental illnesses and conditions are covered for EPSDT-eligible Beneficiaries ages birth through twenty (20), in accordance with 42 U.S.C. §1396d(r). This includes but is not limited to, conditions which are discovered through EPSDT Well Child screening services, whether or not such services are covered under the State Plan. [42 U.S.C. §1396d(r)(5) and the CMS State Medicaid Manual.] Emergency Medical Condition* – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.	(3) Dental services— (A) which are provided— (i) at intervals which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and (B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health. (4) Hearing services— (A) which are provided— (i) at intervals which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and (ii) at such other intervals, indicated as medically necessary, to determine the existence of a suspected illness or condition; and
Emergency Room Care* – Emergency Services provided in an emergency department. Emergency Services* – Covered inpatient and outpatient services that are as follows: (a) furnished by a provider that is qualified to furnish these services under Title 42 of the Code of Federal Regulations and Title XIX of the Social Security Act; and (b) needed to evaluate or stabilize an Emergency Medical Condition. Grievance* – An expression of Enrollee dissatisfaction about any matter other than an Adverse Benefit Determination as defined in this Contract. Examples of grievances include, but are not limited to, dissatisfaction with quality of care, quality of service, rudeness of a provider or a network employee and network administration practices. Administrative grievances are generally those relating to dissatisfaction with the delivery of administrative services, coverage issues, and access to care issues. Grievance System – The manner in which Enrollee Grievances, Appeals, and access to the State's fair hearing system are managed. Health Care Professional – A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with State law. Immediate – In an immediate manner; instant; instantly or without delay, but not more than twenty-four (24) hours. May – A Denotes an allowable activity, but not a mandatory requirement.	(B) which shall at a minimum include diagnosis and treatment for defects in hearing, including hearing aids. (5) Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan. Nothing in this subchapter shall be construed as limiting providers of early and periodic screening, diagnostic, and treatment services to providers who are qualified to provide all of the items and services described in the previous sentence or as preventing a provider that is qualified under the plan to furnish one or more (but not all) of such items or services from being qualified to provide such items and services as part of early and periodic screening, diagnostic, and treatment services. The Secretary shall, not later than July 1, 1990, and every 12 months thereafter, develop and set annual participation goals for each State for participation of individuals who are covered under the State plan under this subchapter in early and periodic screening, diagnostic, and treatment services. § 438.114 Emergency and poststabilization services. (b) Coverage and payment: General rule. The following entities are responsible for coverage and payment of emergency services and poststabilization care services. (1) The MCO, PIHP, or PAHP.

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."	(2) The State, for managed care programs that contract with PCCMs or PCCM entities (c) Coverage and payment: Emergency services. (1) The entities identified in paragraph (b) of this section - (i) Must cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the MCO, PIHP, PAHP, PCCM or PCCM entity; and (ii) May not deny payment for treatment obtained under either of the following circumstances: (A) An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (1), (2), and (3) of the definition of emergency medical condition in paragraph (a) of this section. (B) A representative of the MCO, PIHP, PAHP, PCCM, or PCCM entity instructs the enrollee to seek emergency services. (2) A PCCM or PCCM entity must allow enrollees to obtain emergency services outside the primary care case management system regardless of whether the case manager referred the enrollee to the provider that furnishes the services. (d) Additional rules for emergency services. (1) The entities specified in paragraph (b) of this section may not –
Must – Denotes a mandatory requirement. Nurse Practitioner (NP) – An advanced practice registered nurse educated in a specified area of care and certified according to the requirements of a nationally recognized accrediting agency such as the American Nurses Association's American Nurses Credentialing Center, National Certification Corporation for the Obstetric, Gynecologic and Neonatal Nursing Specialties, or the National Certification Board of Pediatric Nurse Practitioners and Nurses, or as approved by the Louisiana State Board of Nursing and who is authorized to provide primary, acute, or chronic care, as an advanced nurse practitioner acting within his/her scope of practice to individuals, families, and other groups in a variety of settings including, but not limited to, homes, institutions, offices, industry, schools, and other community agencies. Physician Services* – The services provided by an individual licensed under State law to practice medicine or osteopathy. It does not include services that are offered by physicians while admitted in the hospital, and charges that are included in the hospital Claim.	(i) Limit what constitutes an emergency medical condition with reference to paragraph (a) of this section, on the basis of lists of diagnoses or symptoms; and (ii) Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services. (2) An enrollee who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. (3) The attending emergency physician, or the provider actually treating the enrollee, is responsible for determining when the enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment. (e) Coverage and payment: Poststabilization care services. Poststabilization care services are covered and paid for in accordance with provisions set forth at § 422.113(c) of this chapter.

Post-Stabilization Care Services – Medicaid Covered Services, related to an Emergency Medical Condition, that are provided after an Enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in 42 CFR §438.114, to improve or resolve the Enrollee's condition. Prior Authorization – The process of determining medical necessity for specific services before they are rendered. Prospective Review – Utilization review conducted prior to an admission or a course of treatment. Registered Nurse (RN) – Person licensed as a Registered Nurse by the Louisiana State Board of Nursing. Second Opinion – Subsequent to an initial medical opinion, an opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed health service, to assess the clinical necessity and appropriateness of the initial proposed health service.	In applying those provisions, reference to "MA organization" and "financially responsible" must be read as reference to the entities responsible for Medicaid payment, as specified in paragraph (b) of this section, and payment rules governed by Title XIX of the Act and the States. (f) Applicability to PIHPs and PAHPs. To the extent that services required to treat an emergency medical condition fall within the scope of the services for which the PIHP or PAHP is responsible, the rules under this section apply.
Service Authorization – A utilization management activity that includes pre-, concurrent, or post review of a service by a qualified health professional to authorize, partially deny, or deny the payment of a service, including a service requested by the Enrollee. Service authorization activities must consistently apply review criteria. Shall – Denotes a mandatory requirement. Should –Denotes a desirable action, but not a mandatory requirement. State Fair Hearing – The process set forth in 42 CFR Subpart E.	
Timely – Existing or taking place within the designated period or within the time required by applicable Federal and State laws, regulations, rules, policies, procedures, and manuals, the State Plan, Waivers, and this Contract. Utilization – The rate patterns of service usage or types of service occurring within a specified time. 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. Utilization Management is inclusive of Utilization Review and service authorization. Utilization Review (UR) – Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review. Week – The entire seven (7) day week, Monday through Sunday. Will – A term that denotes a mandatory requirement.	

2023 UCSMM Policy Revisions

Policy Number/Title	Revisions
UCSMM.01.11 Document Oversight and Adherence	No content revision. Applicable Accreditation Standards: Updated URAC standards