

<b>Document ID:</b> AETAMA-087725	<b>Title:</b> Aetna Medicaid Administrators LLC (AMA) 7200.03 Timeliness Standards and Decision Notification - Louisiana Amendment	
<b>Parent Documents:</b> AETAMA-075564		
<b>Effective Date:</b> See Document Information Page	<b>Last Review Date:</b> See Review and Revision History Section	<b>Business Process Owner (BPO):</b> Ld. Dir, Business Consulting, CS CI CM COE
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**Effective Date:** 08/21/2024  
**Last Review Date:** 08/21/2025  
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**PURPOSE**

This Amendment is written to meet regulatory and legislative requirements under Louisiana law/regulation that impact AMA 7200.03 UM Timeliness Standards and Decision Notification policy. This amendment will be used in conjunction with AMA 7200.03 to comply with Louisiana requirements.

**SCOPE**

Applies to Department:	<input type="checkbox"/> Care Management	<input type="checkbox"/> Precertification (including NME, SCPU, Specialty Medical Precert)	<input type="checkbox"/> NME Case Management	<input type="checkbox"/> Aetna Maternity Program
	<input type="checkbox"/> SCPU Case Management	<input type="checkbox"/> 24-Hour Nurse Line	<input type="checkbox"/> DM	<input type="checkbox"/> BH
	<input type="checkbox"/> Medical Management – Concurrent Review	<input type="checkbox"/> Medical Management – Prior Authorization	<input type="checkbox"/> Medical Management – Utilization Management	<input checked="" type="checkbox"/> Medical Management

Product:	<input type="checkbox"/> HMO	<input type="checkbox"/> EPO	<input type="checkbox"/> PPO	<input type="checkbox"/> MC/POS	<input type="checkbox"/> TC	<input type="checkbox"/> JV
	<input checked="" type="checkbox"/> Medicaid					

These requirements apply when the Controlling State is Louisiana.

**POLICY**

**Attachment A: Timeliness Standards for Decision and Notification –Medicaid**

Legislation	Policy/Procedure Language Change:
<b>2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section Permanent Supportive Housing Authorizations</b>	<b>Permanent Supportive Housing Authorizations</b>

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<p><b>2.7.14.2.2</b> Within one (1) Business Day of receipt of a request from designated LDH PSH Program staff, provide accurate information about current and past Service Authorizations and encounters for an Enrollee, particularly for behavioral health services such as Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), and Assertive Community Treatment (ACT);</p> <p><b>2.7.14.2.3</b> Ensure Timely Prior Authorization for PSH tenancy and pre-tenancy supports as applicable.</p> <p><b>2.12.6 Service Authorization Determination Timing and Notices</b></p> <p><b>2.12.6.1 Standard Service Authorization</b></p> <p><b>2.12.6.1.1</b> The Contractor shall make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate documentation that may be required regarding a proposed procedure, or service requiring a review determination, with the following exceptions:</p> <p><b>2.12.6.1.1.1</b> The MCO shall make all <b>inpatient hospital service authorizations</b> within two (2) calendar days of obtaining appropriate documentation; and</p> <p><b>2.12.6.1.1.2</b></p>	<p>Within one (1) Business Day of receipt of a request from designated State PSH Program staff provide accurate information about current and past Service Authorizations and encounters for a member, particularly for behavioral health services such as Community Psychiatric Support and Treatment (CPST), Psychosocial Rehabilitation (PSR), and Assertive Community Treatment (ACT);</p> <p>Ensure Timely Prior Authorization for Permanent Supportive Housing (PSH) tenancy and pre-tenancy supports as applicable.</p> <p>For standard service authorization Determination Timing and Notices</p> <p><b>Standard Service Authorization</b></p> <p>The health plan will make eighty percent (80%) of standard service authorization determinations within two (2) business days of obtaining appropriate documentation that may be required regarding a proposed procedure, or service requiring a review determination, with the following exceptions:</p> <p><b>Inpatient Hospital Authorizations</b></p> <p>The health plan will make all <b>inpatient hospital service authorizations</b> within two (2) calendar days of obtaining appropriate medical information documentation; and</p> <p><b>CPST and PSR Authorization Timeliness</b></p>
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<p>The Contractor shall make all <b>CPST and PSR Service Authorizations</b> within five (5) Calendar Days of obtaining appropriate documentation.</p> <p><b>2.12.6.1.1.3</b> The MCO shall make all determinations for <b>behavioral health crisis response services</b> 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.</p> <p><b>2.12.6.1.2</b> All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.</p> <p><b>2.12.6.1.3</b> The service authorization decision may be extended up to fourteen (14) additional calendar days if:</p> <p><b>2.12.6.1.3.1</b> The Enrollee, or the provider, requests the Extension; or</p> <p><b>2.12.6.1.3.2</b> The Contractor justifies (to LDH upon request) a need for additional information and how the extension is in the Enrollee’s interest.</p> <p><b>2.12.6.1.4</b> The Contractor shall make all concurrent review determinations within one (1)</p>	<p>The health plan will make all <b>Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehab (PSR) service authorizations</b> within five (5) calendar days of obtaining appropriate medical information documentation; and</p> <p><b>Behavioral Health Crisis Response Authorizations</b></p> <p>The health plan will make all determinations for <b>behavioral health crisis response services</b> that require prior authorization as expeditiously as the member / enrollee’s condition requires, but no later than one (1) calendar day after obtaining appropriate clinical documentation.</p> <p>All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.</p> <p><b>Standard Authorization Extension</b></p> <p>The service authorization decision may be extended up to fourteen (14) additional calendar days if:</p> <p>The member, or the provider requests the Extension; or</p> <p>The health plan justifies (to Louisiana Department of Health (LDH) upon request) a need for additional information and how the extension is in the member’s interest.</p> <p><b>Concurrent Review</b></p> <p>The health plan will make all concurrent review determinations within one (1) calendar day of obtaining the appropriate medical information that may be required.</p>
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<p>Calendar Day of obtaining the appropriate medical information that may be required.</p> <p><b>2.12.6.2.1</b> In the event a provider indicates, or the Contractor determines, that following the standard Service Authorization timeframe could seriously jeopardize the Enrollee’s life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization determination and provide notice as expeditiously as the Enrollee’s health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.</p> <p><b>2.12.6.2.2</b> The Contractor may extend the seventy-two (72) hour time period by up to fourteen (14) Calendar Days if the Enrollee requests the extension or if the Contractor justifies to LDH a need for additional information and how the extension is in the Enrollee’s best interest.</p> <p><b>2.12.6.3.1</b> The Contractor shall make retrospective review determinations 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 receipt of request for Service Authorization.</p> <p><b>2.12.6.4. Notices of Determination</b></p> <p><b>2.12.6.4.1 Service Authorization Approvals</b></p> <p><b>2.12.6.4.1.1</b></p>	<p><b>Expedited Review</b></p> <p>In the event a provider indicates, or the health plan determines, that following the standard Service Authorization timeframe could seriously jeopardize the Enrollee’s life or health or ability to attain, maintain, or regain maximum function, the health plan will make an expedited authorization determination and provide notice as expeditiously as the member’s health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.</p> <p><b>Expedited Extension</b></p> <p>The health plan may extend the seventy-two (72) hour time period by up to fourteen (14) Calendar Days if the member requests the extension or if the health plan justifies to the State a need for additional information and how the extension is in the member’s best interest.</p> <p><b>Retrospective Review</b></p> <p>The health plan will make retrospective review determinations 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 receipt of request for Service Authorization.</p> <p><b>Notices of Determination</b></p> <p>Notice of Determination for a Service Authorization Approval</p>
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<p>For Service Authorization approval for a non-emergent admission, procedure or service, the contractor shall notify the provider verbally or as expeditiously as the Enrollee'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.</p> <p><b>2.12.6.4.1.2</b></p> <p>For Service Authorization approval for extended stay or additional services, the Contractor shall notify the provider rendering the service, whether a health care professional or facility or both, and the Enrollee receiving the service, verbally or as expeditiously as the Enrollee's health condition requires but not more than one (1) Business Days of making the initial determination and shall provide written notification to the provider within two (2) Business Days of making the determination.</p> <p><b>Outpatient Pharmacy Medications Authorizations</b></p> <p>Under state Medicaid programs and the MA program, there are similar timing requirements for prior authorizations for coverage of drugs. MA plans are required to respond to expedited requests for Part B drugs within 24 hours (42 CFR 422.572) and to non-expedited requests as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receipt of the request (42 CFR 422.568). Further, MA-PD plans that cover Part A, B, and D benefits must comply with similar timelines in responding to prior authorization requests for</p>	<p>For service authorization approval for a non-emergent admission, procedure or service, the contractor shall notify 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.</p> <p>For Service Authorization approval for extended stay or additional services, the health plan will notify the provider rendering the service, whether a health care professional or facility or both, and the Enrollee 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 withing two (2) Business Days of making the determination.</p> <p><b>Outpatient Pharmacy Medication Authorizations</b></p> <p>Under state Medicaid programs there are similar timing requirements for prior authorizations for coverage of drugs. The health plans are required to respond to expedited requests for Part B drugs within 24 hours (42CFR 422.572). Similarly, under Medicaid (both FFS and managed Reference</p>
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<p>Part D prescription drugs (42 CFR 423.568, 423.572). Similarly, under Medicaid (both FFS and managed care), if a state requires prior authorizations for covered outpatient drugs, a response must be provided within 24 hours of the request for prior authorization (see section 1927(d)(5) of the Social Security Act (the Act) and 42 CFR 438.3(s)(6)). We acknowledge that other drugs do not meet the definition of “covered outpatient drugs,” including cancer drugs, special treatments, and other important medications, and thus are not subject to these prior authorization timeline requirements.</p> <p>Covered outpatient drugs is defined in 42 C.F.R. Chapter 4 Part 447.502 Subpart 1.</p> <p>Therefore, if the drug is paid for outside a per diem payment, DRG payment or cost-based reimbursement, it is considered a covered outpatient drug and requires a 24-hour PA turnaround time.</p> <p><b>2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section</b></p> <p><b><u>2.12.6.4.3.3 Informal Reconsideration</u></b></p> <p><b><u>The Contractor shall offer the Informal Reconsideration at a mutually agreed upon time, which shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the provider rendering the service and the Contractor’s physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) Business Day.</u></b></p>	<p>Covered outpatient drugs is defined in 42 C.F.R. Chapter 4 Part 447.502 Subpart 1</p> <p>Drugs paid outside a per diem payment, a DRG payment or cost-based reimbursement, it is considered a covered outpatient drug and requires a 24-hour prior authorization turnaround time.</p> <p><b><u>Informal Reconsideration</u></b></p> <p><b><u>The Health Plan will offer the Informal Reconsideration at a mutually agreed upon time, which shall occur within one (1) Business Day of the receipt of the request and shall be conducted between the provider rendering the service and the Contractor’s physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) Business Day.</u></b></p>
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	<p><b><u>The Health Plan’s fax decision notification to the provider will include the offer of an informal reconsideration or Peer to Peer and the member services phone number to request the reconsideration.</u></b></p>
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**Notice of Action Requirements**

Legislation	Policy/Procedure Language Change:
<p><b>2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section 2.2.7.2.3</b></p> <p>The Contractor shall ensure Enrollees receive a notice of Adverse Benefit Determination per 42 CFR §438.915(b) and other sections of this Contract which extend notice requirements beyond denials. The Contractor shall make available in hard copy upon request at no cost to the requestor and available on the Contractor’s website, the criteria for medical necessity determinations for mental health and substance use disorder benefits to any Enrollee, Potential Enrollee, or provider per 42 CFR §438.236(c) and §438.915(a).</p> <p><b>2.12.6.4.2.1</b></p> <p>The Contractor shall notify the Enrollee, in writing using language that is easily understood by the Enrollee, of determinations to deny a Service Authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the <i>Enrollee Grievances, Appeals and State Fair Hearing</i> section. The notice of action to Enrollees shall be consistent with requirements in 42 CFR 438.404, 438.10, and 438.210, the</p>	<p><b>Denial Notification</b></p> <p>The health plan will ensure the member receive a notice of Adverse Benefit Determination and other sections of this Contract which extend notice requirements beyond denials. The health plan shall make available in hard copy upon request at no cost to the requestor and available on the health plan’s website, the criteria for medical necessity determinations for mental health and substance use disorder benefits to any member / enrollee, Potential member / enrollee.</p> <p>The health plan will notify the member, in writing using language that is easily understood by the member, of determinations to deny a Service Authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and /or any other action as defined in the <i>Member Grievances, Appeal and State Fair Hearing</i> section.</p>

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<p>Marketing and Education section for Enrollee written materials, and any agreements that the Department may have entered into relative to the contents of Enrollee notices of denial or partial denial of services regardless of whether such agreements are related to legal proceedings or out-of-court settlements.</p> <p><b>2.12.6.4.2.2</b> The Contractor shall notify the requesting provider of a determination 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. The Contractor shall provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.</p> <p><b>2023 Chisholm Compliance Guide</b></p> <p>p.4 The MCO shall communicate with the EPSDT support coordinator if applicable.</p> <p>p. 7 All letters, notices and forms required for enrollees shall be approved by the Louisiana Department of Health (LDH) prior to being implemented and/or used.</p> <p>p.11 For all Chisholm denial, partial denials and partial approvals, the notices must be sent</p>	<p>The notice of action to members will include all federal requirements, the marketing and education section for member written materials and any additional agreements the State has educated the health plan relative to the member notices of denial or partial denial of services regardless of whether such agreements are related to legal proceedings or out-of-court settlements.</p> <p>The health plan will notify the requesting provider of a determination 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. The health plan will provide written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) Business Days of making the determination.</p> <p>Chisholm members are children under twenty-one (21) years old with chronic conditions who have received a Chisholm Designation from the Louisiana Department of Health (LDH) Office of Citizens for Developmental Disability (OCDD).</p> <p>The health plan shall communicate with the EPSDT support coordinator if applicable. The health plan includes the support coordinators on all member communications.</p> <p>All letters, notices and forms required for members will be approved by the Louisiana Department of Health (LDH) prior to being implemented and/or used.</p> <p><b>Chisholm Denial Notification</b></p>
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to LDH Chisholm Compliance staff for review and approval prior to being sent to the member.	All Chisholm denials, partial denials and partial approvals, the notices must be sent to LDH Chisholm Compliance staff for review and approval prior to being sent to the member. An extension letter will be sent to the member, provider, physician and support coordinator (if one is available) to notify them the potential denial request is being sent for state approval. The provider will be faxed a notification of the potential denial and will be offered the way to request an informal reconsideration.
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**PROCEDURE**

N/A

**DEFINITIONS**

<b>Legislation</b>	<b>Policy/Procedure Language Change:</b>
<p><b>2023 Louisiana Medicaid Managed Care Organization Statement of Work, Section</b></p> <p><b>Medically Necessary Services*</b> – 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</p>	<p><b>Medically Necessary Services*</b> – 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</p>

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<p>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.</p>	<p>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.</p>
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