AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Concurrent Review/Observation Care	Page:	1 of 37
Department:	Medical Management	Policy Number:	7200.05
Subsection:	Concurrent Review	Effective Date:	02/01/2015
Applies to:	■ Medicaid Health Plans		

PURPOSE:

The purpose of this policy is to define Aetna Better Health business standards for the concurrent review and observation review process.

STATEMENT OF OBJECTIVE:

The objectives of Aetna Better Health's concurrent review process are to:

- Confirm eligibility and benefits
- Reduce occurrences of misuse, over- or under-utilization of services
- Establish medical necessity
- Define responsibilities of health professionals involved in the medical necessity decision making process
- Confirm that decisions about the member's care (to admit, discharge, or transfer) are finalized efficiently and do not exceed the time limit for observation care
- Confirm that the member receives appropriate, efficient, and timely services[1]
- Manage services to promote utilization of best, evidence-based and informed practices and to improve access and deliver high quality services[2]
- Screen for potential quality, risk, or utilization issues
- Document authorizations, review updates, clinical consultations, and decisions accurately and in a timely manner
- Confirm that member discharge planning begins on admission, includes the member's and his/her support system's input, and assists with coordination of post-discharge services including community supports and services
- Identify alternative levels of care or treatment setting (e.g., skilled nursing facility, home health, rehabilitation unit, hospice care, intensive outpatient program [IOP], as applicable) and share this information with the discharge planner or treating practitioner
- Identify and refer members who could benefit from Aetna Better Health's Integrated Care Management program or other community programs
- Identify underlying factors, such as social determinants of health, that are impeding a member's ability to stay safe and/or stable in less restrictive services

[2] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 6.4.3

- Identify potential clinical issues based on established criteria and present them to the chief medical officer or designated medical director for discussion with the member's primary care practitioner or treating practitioner/provider
- Confirm that the facility complies with Aetna Better Health's notification requirements
- Identify other payers (e.g., third party liability, Medicare liability) for coordination of benefits
- Identify and initiate referrals related to potential quality of care issues and/or high-cost cases for reinsurance notification if appropriate

DEFINITIONS:

Administrative Denial	Denials of requests for coverage of services or supplies that are not covered based on federal or state law, a contractual or benefit exclusion, limitation or exhaustion and do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation.
Aetna Clinical Policy Bulletins (CPBs)	Statements of Aetna's policy regarding the experimental and investigational status and medical necessity of medical technologies that may be eligible for coverage under Aetna medical plans. CPBs also state what medical technologies Aetna considers cosmetic. CPBs apply to all Aetna medical benefit plans and are used in conjunction with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for Aetna's members. Aetna CPBs are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies.

Aetna Clinical Policy Council	Evaluates the safety, effectiveness and appropriateness of medical technologies (i.e., drugs, devices, medical and surgical procedures used in medical care, and the organizational and supportive systems within which such care is provided) that are covered under Aetna medical plans, or that may be eligible for coverage under Aetna medical plans. In making this determination, the Clinical Policy Council will review and evaluate evidence in the peer-reviewed published medical literature, information from the U.S. Food and Drug Administration and other Federal public health agencies, evidence-based guidelines from national medical professional organizations, and evidence-based evaluations by consensus panels and technology evaluation bodies.
American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition	The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies®; 2013.
Child and Adolescent Level of Care Utilization System (CALOCUS©), Version 20	A nationally recognized clinical guideline for making decisions regarding medical necessity for behavioral health treatment. CALOCUS was developed for children and adolescents by the American Association of Community Psychiatrists (AACP).
Clinical Personnel	Clinical personnel are defined as nurses, social workers, counselors, therapists, psychologists, chiropractors, pharmacists, dentists (DDS and DMD), and physicians, including temporary employees, who make clinical determinations as part of the benefit determination process, or who participate in the medical management process.
Concurrent Review	A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if Aetna Better Health did not previously approve the earlier care. All inpatient concurrent requests are considered urgent. Concurrent reviews are typically associated with inpatient care, residential behavioral care, and ongoing ambulatory care.

Denial, Reduction, or Termination of Financial Responsibility	The non-authorization of care or service at the level requested based on either medical appropriateness or benefit coverage. Partial approvals (modifications) and decisions to discontinue authorization when the practitioner or member does not agree are also denials.
Level of Care Utilization System (LOCUS©) Version 20	A nationally recognized clinical guideline for making decisions regarding medical necessity for behavioral health treatment. LOCUS was developed for adults by the American Association of Community Psychiatrists (AACP).
MCG®	MCG, including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives.
Medical Necessity Determination	A decision about coverage for a requested service based on whether the service is clinically appropriate and/or needed based on a member's circumstances. The National Committee for Quality Assurance (NCQA) requires a medical necessity review and appropriate practitioner review of "experimental" or "investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan.
Medically Necessary	This term refers to services or supplies for diagnosing, evaluating, treating or preventing an injury, illness, condition or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Determination of medical necessity is based on specific criteria.[3] **Note:** This definition is based on the Centers for Medicare & Medicaid Services (CMS) and American College of Medical Quality (ACMQ) definitions.

[3] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.11

Notice of Action (NOA)	Written notification of decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, specific to the member's clinical condition, utilizing language that is easily understood by the member and practitioner/provider. The notification includes a reference to the criterion, rationale for the decision and member appeal rights.
Observation Care	Observation care may be appropriate for patients requiring short-term evaluation for a condition, treatment for a known condition, or monitoring for recovery. It can also be appropriate when repeat testing or re-evaluation is necessary to determine the patient's diagnosis and care needs. Observation care can encompass both shorter emergency department observation and care provided in a dedicated observation unit or other specified hospital-based observation care setting. Observation care usually is completed within forty-eight (48) hours, generally requiring diagnostic testing or treatment that exceeds usual outpatient care. **Note:** Scheduled procedures or treatments that require a hospital stay of less than twenty-four (24) hours are considered outpatient procedures, not observation services; similarly, routine stays after outpatient surgery are considered recovery room extensions and are not observation services.
Peer-to-Peer Consultation	A discussion between a requesting practitioner and a medical director/physician reviewer concerning a denial of coverage based on medical necessity. A peer-to-peer review is optional for a requesting provider and is not part of a prerequisite for an appeal.
Post-Service Decision	Any review for care or services that have already been received (i.e., retrospective review).
Practitioner	A licensed or certified professional who provides medical or behavioral healthcare services.
Primary Care Practitioner	An individual, such as a physician or other qualified practitioner, who provides primary care services and manages routine health care needs.

Provider	An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.
Role Based Access Control (RBAC)	Role Based Access Control (RBAC) is a company-wide process developed to ensure employees have access only to those systems necessary to perform their job. RBAC models are defined specifically for common groupings of jobs and system needs. Employees are assigned to a model based upon the requirements of the job.

LEGAL/CONTRACT REFERENCE:

- 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK
- Aetna Better Health's contract agreements including those regarding the confidentiality of member information
- Applicable federal and state laws, regulations and directives, including the confidentiality of member information (e.g., Health Insurance Portability and Accountability Act [HIPAA])
- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans
- Policy 7000.30 Process for Approving and Applying Medical Necessity Criteria

FOCUS/DISPOSITION:

The concurrent review process is the mechanism used to confirm eligibility and to evaluate the medical necessity of continued services. The concurrent review process may apply to both inpatient and outpatient/ambulatory settings. Aetna Better Health's concurrent review process includes multiple steps in order to complete a determination. The request can be either telephonic, facsimile, review of hospital electronic records, or on-site reviews.

Plan Responsibilities

Aetna Better Health develops and maintains policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization. Aetna Better Health submits UM policies and procedures to LDH for

written approval prior to any revisions.[4] The UM Program policies and procedures meet NCQA standards and include medical management criteria and practice guidelines that:[5]

- Are adopted in consultation with contracting health care professionals;[6]
- Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;[7]
- Are considerate of the needs of the members;[8] and
- Are reviewed annually and updated periodically as appropriate.[9]

Aetna Better Health service authorization includes, but is not limited to, prior authorization, concurrent authorization and post authorization.[10] Aetna Better Health UM Program policies and procedures include service authorization policies and procedures consistent with 42 CFR §438.210, 42 CFR Part 441 Subpart D, and state laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of Chisholm v. Kliebert Gee and Wells v. Kliebert Gee for initial and continuing authorization of services that include, but are not limited to, the following:[11]

- Written policies and procedures for processing requests for initial and continuing authorizations of services, where a service authorization member's request is for the provision of a service if a provider refuses a service or does not request a service in a timely manner[12]

[4] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.1
[5] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.2
[6] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.2.1
[7] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.2.2
[8] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.2.3
[9] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.2.4
[10] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.4.1
[11] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.4.2
[12] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.4.2.1

- Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate[13]
- Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease[14]
- Provide a mechanism in which a member may submit, whether oral or in writing, a service authorization request for the provision of services. This process will be included in its member manual and incorporated in the grievance procedures[15]

Aetna Better Health's service authorization system provides the authorization number and effective dates for authorization to participating providers and applicable non-participating providers.[16] Aetna Better Health's service authorization system has the capacity to electronically store and report the time and date all service authorization requests are received, decisions made by Aetna Better Health regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions.[17]

Aetna Better Health's chief medical officer (CMO) is responsible for directing and overseeing the concurrent review function. Concurrent review clinicians and medical directors that are qualified by training, experience and certification/licensure in accordance with state and federal regulations are responsible for carrying out the daily inpatient concurrent review operations, including timely and accurate documentation of review activities (e.g., authorizations, updates,

[13]2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.4.2.2
[14] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.4.2.3
[15] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.4.2.4
[16] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.4.2.5
[17] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.4.2.6

consultations) per contractual agreements.[18] Concurrent review clinicians include licensed nurses, physicians, physician assistants, licensed mental health professionals, licensed addiction counselors, board certified psychiatrists, and board certified addictionologists.[19] Determinations of medical necessity are made by qualified and trained practitioners in accordance with state and federal regulations.[20] Only an appropriately licensed health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.[21]

Aetna Better Health has sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. Aetna Better Health provides UM staff specifically assigned to:

- Specialized behavioral health services, and
- PSH to ensure appropriate authorization of tenancy services[22]

Levels of care subject to concurrent review include acute (medical/surgical and behavioral health), observation care, subacute/residential, acute & subacute rehabilitation, skilled nursing, outpatient rehabilitation, partial hospital programs, and intensive outpatient programs. Licensed clinicians working under the direction of the CMO or designated medical director complete initial reviews of members' admissions within seventy-two (72) hours of Aetna Better Health's receipt of notification of admission.[23] Subsequent reviews are conducted on a schedule determined by the member's reason for admission, kind of facility and its location.

[18] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK8.1.13, 8.1.14
[19] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 4.3.2 and 4.3.2.1
[20] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.14
[21] NCQA HP 2019/2020 UM4 A
[22] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.10, 8.1.10.1, 8.1.10.2
[23] NCQA HP 2019/2020 UM5 A1, C1

Aetna Better Health 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's health condition made by the provider.[24]

When initiating or returning calls regarding utilization management (UM) issues, Aetna Better Health requires UM staff to identify themselves by name, title, and organization name,[25] and upon request, verbally informs member, facility personnel, the attending practitioner and other ordering practitioners/providers of specific UM requirements and procedures.[26] Aetna Better Health identifies the qualification of staff who will determine medical necessity.[27]

Individuals who conduct clinical review related to the utilization review process are appropriate health professionals who possess an active professional relevant license. Aetna Better Health ensures that licensed health professionals are available to non-clinical administrative staff who support the prior authorization and concurrent review process.

- Medical directors: Licensed professional who provides oversight of clinical components of the UM process including UM decision-making. Medical directors conduct peer-to-peer reviews and make medical necessity determinations.
- Director of clinical health services: Licensed professional who is available to UM staff either on site or by telephone and provides oversight of day-to-day activities including but not limited to: Staff training, consistent application of UM criteria for each level and type of UM decision and adequacy of UM documentation.
- Prior authorization and concurrent review managers/supervisors: Licensed professionals who, under the direction of the director of clinical health services, supervise and train staff and monitor consistency in decision making processes.

Concurrent review clinicians are responsible for:

- Applying clinical criteria based on request for service

[24] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.3.2
[25] NCQA HP 2019/2020 UM3 A3
[26] NCQA HP 2019/2020 UM2 B2
[27] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.13

- Reviewing cases for appropriate level of services including reduction in level of care or potential denial
- Reviewing potential denials or reductions in service level with the medical director
- Discharge planning facilitation and avoidable re-admission prevention
- Reviewing requested services against member benefits for benefit limits and benefit limit exceptions
- If reimbursements for services are denied or reduced:
  - Notifying the treating practitioners of decisions to deny or terminate reimbursement within the required turnaround time of the decision
  - Initiating the production of the decision letter and confirming documentation in the appropriate business application system
- Non-clinical administrative staff: Aetna Better Health limits use of non-clinical administrative staff to:
  - Review of service request for completeness of information
  - Collection and transfer of non-clinical data
  - Acquisition of structured clinical data
  - Activities that do not require evaluation or interpretation of clinical information
- Non-clinical staff are responsible for:
  - Documentation of incoming prior authorization requests and initial screening for member enrollment, eligibility, and practitioner/provider affiliation
  - Approval of services that do not require clinical review
  - Forwarding requests that require medical necessity review to a clinical reviewer

Aetna Better Health will provide a mechanism to reduce inappropriate and duplicative use of health care services. Services will be sufficient in an amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan. Aetna Better Health will not arbitrarily deny or reduce the amount, duration or scope of required services solely because of diagnosis, type of illness or condition of the member. Aetna Better Health may place appropriate limits on a service on the basis of medical necessity or for the purposes of utilization control (with the exception of EPSDT services), provided the

services furnished can reasonably be expected to achieve their purpose in accordance with 42 CFR §438.210.[28]

If there is a disagreement between a hospital or other treating facility and Aetna Better Health concerning whether the member is stable enough for discharge or transfer from the Emergency Department (ED), the judgment of the attending emergency physician(s) at the hospital or other treating facility at the time of discharge or transfer prevails and is binding on Aetna Better Health. This subsection does not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.[29]

Medical Director Reviewer Responsibilities[30]

Authorization requests that do not meet criteria for the requested service, or for which there are no established medical necessity criteria, or those meeting certain administrative thresholds (e.g., high dollar cases) are presented to a medical director for review. Aetna Better Health will ensure that only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease will determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.[31] No adverse determination will be made regarding any medical procedure or service outside of the scope the medical director's expertise.[32] The medical director making these determinations will have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character.[33] The medical director will not deny continuation of higher level services

[28] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.16, 8.1.17, and 8.1.18
[29] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 6.8.1.6
[30] NCQA HP 2019/2020 UM4 B-D
[31] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.15
[32] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK8.1.17, 8.4.2.3
[33] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.16

(e.g., inpatient hospital or residential services) for failure to meet medical necessity unless the service can be provided through an in-network or out-of-network provider for a lower level of care.[34]

The medical director conducting the review must have clinical expertise in treating the member's condition or disease and be qualified by training, experience and certification/licensure to conduct the authorization functions in accordance with state and federal regulations. The medical director reviews the service request, the member's need, and the clinical information presented. Using the approved criteria and the medical director's clinical judgment, a determination to approve or deny coverage for the service is made. Only a medical director can reduce or deny a request for service coverage based on a medical necessity review.

If criteria is not clear enough to make a determination or the requested service is not addressed by the Aetna CPBs, the medical director may submit an email request for a position determination to the Aetna Clinical Policy Council., The policy council researches literature applicable to the specific request and, when a determination is reached, responds to the medical director.

In accordance with 42 CFR §456.111 and §456.211, Aetna Better Health Utilization Review (UR) plan will provide that each enrollee's record includes information needed for the UR committee to perform UR required under this Section. This information will include, at least, the following:[35]

- Identification of the enrollee;[36]
- The name of the enrollee's physician;[37]

[34] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.4.3, 6.30.3
[35] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.23
[36] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.23.1
[37] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK8.1.23.2

- Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;[38]
- The plan of care required under 42 CFR §456.80 and §456.180;[39]
- Initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133, §456.233 and §456.234;[40]
- Date of operating room reservation, if applicable; and[41]
- Justification of emergency admission, if applicable.[42]

When criteria is present but unclear in relation to the situation, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area before making a determination of medical necessity.[43]

Practitioners/providers are notified in the denial letter (i.e., NOA) that they may request a peer-to-peer consultation to discuss non-behavioral and behavioral healthcare denied authorizations with the medical director reviewer by calling Aetna Better Health.[44] All medical director discussions and actions, including discussions between medical directors and treating practitioners/providers are documented in the Aetna Better Health authorization system.

As part of Aetna Better Health's appeal procedures, Aetna Better Health includes an Informal Reconsideration process that allows the member (or provider/agent on behalf of a member

[38] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.23.3
[39] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.23.4
[40] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.23.5
[41] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.23.6
[42] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.23.7
[43] NCQA HP 2019/2020 UM4 F1
[44] NCQA HP 2019/2020 UM7 A, D

with the member's written consent) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing.[45]

In a case involving an initial determination or a concurrent review determination, Aetna Better Health provides the member or a provider acting on behalf of the member and with the member's written consent an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination [§438.402(b)(ii)].[46]

The informal reconsideration will occur within one (1) working day of the receipt of the request and will be conducted between the provider rendering the service and the Aetna Better Health 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) working day.[47] The Informal Reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.[48]

Observation (Physical and Behavioral Health)

All acute inpatient admissions are reviewed for observation based on the applicable clinical guideline. If the applicable observation criteria are met, the case is sent to medical director review for potential denial/downgrade to observation.

If the member cannot be discharged and the attending practitioner is requesting coverage for acute inpatient admission, the provider notifies Aetna Better Health and provides the clinical information. The case is reviewed based on the applicable clinical criteria for inpatient and sent

[45] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.3.1
[46] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.3.2
[47] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.3.3
[48] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.3.4

to medical director review with a recommendation to uphold or overturn the denial/downgrade. The attending practitioner may also exercise the option of requesting a peer-to-peer consultation.

Beginning July 1, 2018, Aetna Better Health began utilizing a common hospital observation policy that was developed and is maintained collectively by the Healthy Louisiana Managed Care Organizations personnel with approval of LDH. The common hospital observation policy will be reviewed annually in its entirety. Any revisions will be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation.[49] Additional information about Aetna Better Health's observation policy is contained in the Common Hospital Observation Policy.

Inpatient Admissions (Physical and Behavioral Health)

Acute Inpatient

Concurrent reviews of acute hospitalizations or observation stays are conducted as dictated by the member's clinical condition, either on-site or by telephone or facsimile, and may occur up to seven (7) days a week on a schedule dictated by the member's diagnosis or condition or contractual obligation. Aetna Better Health will make ninety-five percent (95%) of concurrent review determinations within one (1) business day and ninety-nine-point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.[50]

The facility providing the inpatient/observation services should notify the Aetna Better Health Prior Authorization department within one business day of the member's admission.[51] Aetna Better Health does not require service authorization for emergency services or post-stabilization services, whether provided by an in-network or out-of-network provider; the first forty-eight (48) hours of hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries; EPSDT screening services; or the first 30 days of the

[49] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.4.4
[50] NCQA HP 2019 UM5 A1, C1
[51] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.5.4.2

continuation of medically necessary covered services of a new member transitioning into the health plan.[52]

Aetna Better Health may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery and ninety-six (96) hours after caesarean section.[53] Aetna Better Health may require notification by the provider of inpatient emergency admissions within one (1) business day of admission.[54]

Aetna Better Health will perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of-state, or state mental hospitals.[55] Aetna Better Health will ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each enrollee referred for psychiatric admissions to general hospitals. Aetna Better Health will comply with the requirements set forth in the Louisiana Register, Vol. 21, No. 6, page 575.[56]

Concurrent utilization reviews are administrative in nature and are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, LDH does reserve the right to recoup reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.[57]

[52] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.5.4.2, 6.8.1.1
[53] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.5.4.2
[54] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.5.4.2
[55] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.4.5
[56] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.4.5.1
[57] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.4.5.2

Aetna Better Health may authorize covered and medically necessary inpatient/observation services provided that the following criteria are met:

- The member is enrolled and eligible on the date(s) of service
- The observation services are ordered by a participating or nonparticipating practitioner
- Aetna Better Health's notification and prior authorization requirements are met
- Concurrent or retrospective review of the member's records indicates that the inpatient or observation placement is appropriate based on medical necessity criteria

In addition, Aetna Better Health may authorize covered and medically necessary observation services provided the observation services are provided efficiently and the stay does not exceed the time limit stated in this policy. Observation services apply to non-obstetrical services provided to Aetna Better Health members in an observation setting (including emergency department observation) in participating or nonparticipating facilities.
Aetna Better Health will utilize a common hospital observation policy that is developed and maintained collectively by Aetna Better Health personnel with approval of LDH. The common hospital observation policy will be reviewed annually by Aetna Better Health in its entirety. Any revisions will be reviewed and approved by LDH at least thirty (30) calendar days prior to implementation.[58]

Rehabilitation (Physical and Behavioral Health)

Concurrent reviews of members in rehabilitation units or facilities are conducted as clinically appropriate and dictated by the member's diagnosis and condition, either on-site or by telephone or facsimile, depending on the volume of members and/or location of the facility.

Skilled Nursing

Concurrent reviews of members receiving skilled services in nursing facilities (NFs) non-custodial stay are reviewed on a schedule dictated by the member's diagnosis and condition. Reviews are conducted, either on-site, by telephone or facsimile, depending on the volume of members and/or location of the facilities.
Outpatient Treatment Programs (Physical and Behavioral Health)

[58] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.4.4

Concurrent reviews of members receiving specialized treatment in a program (e.g., cardiac rehabilitation, neurological rehabilitation, behavioral health (mental health or substance use) partial hospital or intensive outpatient program) are conducted as clinically appropriate and dictated by the member's diagnosis and condition, either on-site or by telephone or facsimile, depending on the volume of members and/or location of the facility.

Concurrent utilization review includes:

- The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;[59]
- The data sources and clinical review criteria used in decision making;[60]
- The appropriateness of clinical review will be fully documented;[61]
- The process for conducting informal reconsiderations for adverse determinations;[62]
- Mechanisms to ensure consistent application of review criteria and compatible decisions;[63]
- Data collection processes and analytical methods used in assessing utilization of health care services;[64]
- Provisions for assuring confidentiality of clinical and proprietary information;[65]
- Service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan;[66]

[59] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.1
[60] , 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.2
[61] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.3
[62] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.4
[63] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.5
[64] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.6
[65] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.7
[66] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.8

- Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from Aetna Better Health for an Emergency Inpatient Psychiatric Hospital Screen will be made immediately. The screen to determine appropriate treatment will be completed within one (1) hour after request is received by an emergency room for post stabilization treatment or three (3) hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized.
- Provision of an Urgent Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening is initiated if the individual meets one (1) criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from Aetna Better Health for an Urgent Inpatient Psychiatric Hospital Screen will be made within twenty-four (24) hours after the referral and full medical information is received by Aetna Better Health. The screen to determine appropriate treatment will be completed within twenty-four (24) hours of the Aetna Better Health's referral after the referral and full medical information is received by Aetna Better Health. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized.
  Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, Aetna Better Health will notify the provider and individual requesting the screen of the results in writing within forty-eight (48) hours of receipt of the request by Aetna Better Health. If denied, Aetna Better Health will notify the individual requesting the screen immediately, and within forty-eight (48) hours of

receipt of the request by Aetna Better Health, provide written notification of the results to the provider and individual requesting the screen. The notification will include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.[67]

Coordination of Discharge Services (Physical and Behavioral Health)

The concurrent review staff works in conjunction with the facility (including, but not limited to admissions, observation care, long term care, rehabilitation) to identify the services required for the member's discharge planning needs. The concurrent review clinician collaborates with the case manager for those members engaged in Integrated Care Management, Community Based Care Management, or Integrated Long-Term Care Management programs in order to transition the discharge planning requirements into the member's care plan. System of care services are included to address social determinants of health not covered by health care.

The concurrent review staff also collaborates with:

- OJJ, DCFS and schools to coordinate the discharge and transition of children and youth in out-of-home placement for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including the referral to necessary providers or a WAA if indicated;[68]
- Hospitals, nursing home facilities, and inpatient facilities to coordinate aftercare planning prior to discharge and transition of members for the continuance of behavioral health services and medication prior to reentry into the community, including referral to community providers;[69]
- The Department of Corrections and criminal justice system in Louisiana to facilitate access to and/or continuation of prescribed medication and other behavioral health

[67] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.4.5.1
[68] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.9
[69] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.10

services prior to reentry into the community, including referral to community providers;[70] and

- Nursing facilities in Louisiana to coordinate the discharge and transition of members into the community for continuance of prescribed medication and other behavioral health services prior to re-entry into the community, including referral to community providers.[71]

Information Required for Review

The admitting or treating practitioner or provider is responsible for complying with Aetna Better Health's concurrent review requirements, policies and procedures and making the following information available for concurrent review:

- Current, applicable codes, which may include:
  - Current Procedural Terminology (CPT)
  - International Classification of Diseases, 10th Edition (ICD-10)
  - CMS Common Procedure Coding System (HCPCS) codes
  - National Drug Code (NDC)
- Name, date of birth, sex, and identification number of the member
- Primary care practitioner or treating practitioner/provider
- Name, address, phone and fax number and signature, if applicable, of the referring practitioner or provider
- Name, address, phone and fax number of the consulting practitioner or provider
- Reason for the request
- Presentation of supporting objective clinical information, such as clinical notes, comorbidities, complications, progress of treatment, psychosocial situation, home environment, laboratory and imaging studies, and treatment dates, as applicable for the request[72]

[70] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.11
[71] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.3.12
[72] NCQA HP 2019/2020 UM6 A, B

Aetna Better Health will have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures will be given verbally to the covered person or health care provider when requested. The procedures will outline the process to be followed in the event Aetna Better Health determines the need for additional information not initially requested.[73] Aetna Better Health will have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, Aetna Better Health may deny authorization of the requested service(s) within two (2) business days.[74]

Aetna Better Health is responsible for eliciting pertinent medical record information from the treating health care provider(s), as needed and/or as requested by LDH, for purposes of making medical necessity determinations.[75] If the provider or member does not release the necessary information, the request will be reviewed by the medical director and authorization may be denied.[76] Aetna Better Health will take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe.[77]

Providers who do not provide requested medical information for purposes of making medical necessity determinations, for a particular item or service, are not be entitled to payment for the provision of such item or service.[78] Should a provider fail or refuse to respond to Aetna Better Health's request for medical record information, at Aetna Better Health's discretion or directive

[73] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.8, 8.11.1
[74] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.9
[75] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.11.1
[76] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section, 8.11.3, 8.11.4
[77] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.11.2
[78] RFP # 305PUR-LDHRFP-BH-MCO-2014-MVA, Section 8.11.3

by LDH, Aetna Better Health will, at a minimum, impose financial penalties against the provider as appropriate.[79]

Medical Necessity Criteria (Physical and Behavioral Health)

Aetna Better Health will cover medically necessary services that address:

- The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability;[80]
- The ability for a member to achieve age-appropriate growth and development; and[81]
- The ability for member to attain, maintain, or regain functional capacity.[82]

Aetna Better Health uses LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determination. Aetna Better Health makes medical necessity determinations that are consistent with the State's definition.[83]

To support concurrent review decisions, Aetna Better Health uses nationally recognized, evidence-based criteria, which are applied based on the needs of individual members and characteristics of the local delivery system.[84] Service authorization staff that make medical necessity determinations are trained on the criteria and the criteria are accepted and reviewed according to Aetna Better Health policies and procedures.[85]

[79] RFP # 305PUR-LDHRFP-BH-MCO-2014-MVA, Section 8.11.4
[80] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 6.1.9.1
[81] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 6.1.9.2
[82] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 6.1.9.3
[83] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.11
[84] NCQA HP 2019/2020 UM2 A1-3
[85] NCQA HP 2019/2020 UM2 A5

Any member committed under an emergency certificate to inpatient treatment by a facility that provides mental health services must be evaluated by a psychiatrist or medical psychologist in the admitting facility within twenty-four hours of arrival at the admitting facility. After the psychiatric evaluation, payment will be determined by medical necessity. "Admitting facility" is defined as a crisis receiving center, acute treatment hospital or facility, distinct part psychiatric unit, or free-standing psychiatric hospital or facility[86].

All court-ordered Medicaid behavioral health services are subject to medical necessity review. In order to be eligible for payment, the service must be medically necessary and a covered benefit/service, as determined by Aetna Better Health within the Louisiana Medicaid's medical necessity definition (Title 50, Part 1, Chapter 11) and are subject to medical necessity review.[87]

No medically necessary service limitation can be more restrictive than those that currently exist under the Louisiana Medicaid State Plan including quantitative and non-quantitative treatment limits.[88]

A listing of medical review criteria as well as the process for review and application of criteria is described in policy *7000.30 Process for Approving and Applying Medical Necessity Criteria*.

Aetna Better Health will identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to[89]

- The vendor will be identified if the criteria was purchased;[90]
- The association or society will be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;[91]

[86] LA Rev Stat § 28:53 (2018)
[87] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.13.1
[88] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 6.1.10
[89] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK Section 8.1.6
[90] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.6.1
[91] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.6.2

- The guideline source will be identified if the criteria are based on national best practice guidelines;[92] and
- The individuals who will make medical necessity determinations will be identified if the criteria are based on the medical training, qualifications, and experience of the Aetna Better Health medical director or other qualified and trained professionals.[93]

The Utilization Management Program medical management criteria and practice guidelines are posted to Aetna's website, www.Aetna.com. When Aetna uses proprietary software that requires a license and may not be posted publicly according to associated licensure restrictions, Aetna will post the name of the software only on its website. Upon request by an enrollee, their representative, or LDH, Aetna will provide the specific criteria and practice guidelines utilized to make a decision and will not refuse to provide such information on the grounds that it is proprietary.[94] Guidelines are distributed by mail, e-mail or fax. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply will be consistent with the guidelines.[95]

Administrative Denial

All denials of service requests require a medical director review with the exception of administrative denials.

Administrative denials may be rendered for:

- An individual who is not a member at the time the service or supply is provided
- A limited benefit that is exhausted
- An excluded benefit
- Breach of contract (e.g., when the Aetna Better Health contract requires notification of an admission within a specified timeframe and no notification is received)

[92] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.6.3
[93] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.6.4
[94] NCQA HP 2019 UM2 B2
[95] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.7

Timeliness of Decisions and Notification to Practitioners, Providers and/or Members

Aetna Better Health makes utilization decisions and notifies practitioners and/or providers and applicable members in a timely manner. Aetna Better Health adheres to the concurrent review decision/notification time standards. Aetna Better Health will notify the requesting provider of a decision 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. Aetna Better Health will notify the notify the provider rendering the service, whether a health care professional or facility or both, 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 will provide documented confirmation of such written notification to the provider within two (2) business days of making the initial certification.[96]

Received Date: This is defined as the initial date the request is received by call, the earliest date and time on fax receipt or the date and time on the voice mail message or the date stamp on mail, or email[97]. The date of the receipt of the fax within the Precertification Department is considered the receipt of the request. Staff contacts the provider and notifies the provider that initial medical and behavior health precertification requests are accepted via phone or electronic data interface (EDI) and documents this communication in the UM event.

Written Notification Date: The date staff generates the system letter. Refer to the *Decision/Notification Requirements* table below[98].

Departments that handle pre-service authorizations must meet the timeliness standards appropriate to the services required.

[96] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.2.2
[97] NCQA HP 2020 UM12A F1
[98] NCQA HP 2020 UM12A F2

Decision/Notification Time Standards[99]

[99] NCQA HP 2019 UM5 A1, A4, B1, B4, C1, C4, D1, D4, H1, H4 /NCQA HP 2020 UM5 A1, A4, B1, B4, C1, C3,

Decision	Decision/notification timeframe	Notification to:	Notification method
Urgent concurrent (inpatient) approval	**One hundred** ~~Ninety-five~~ percent (**100**~~95~~%) within one (1) **calendar**~~business~~ day of receipt of appropriate medical information**, not to exceed 72 hours from receipt of request.** ~~Ninety-nine-point five percent (99.5%) within (2) business days of receipt of appropriate medical information~~[100]	Practitioner/Provider	Oral notification provided within one (1) business day of decision. Electronic/written notification provided within two (2) business days of decision, not to exceed seventy-two (72) hours from receipt of request[101]

[100] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.1.**3**~~2~~
[101] NCQA HP 2019 UM5 B2, D2; 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.1.1, 8.5.4.1.1.2

Urgent concurrent (inpatient) denial	**One hundred** ~~Ninety-five~~ percent (**100**~~95~~%) within one (1) **calendar**~~business~~ day of receipt of appropriate medical information**, not to exceed 72 hours from receipt of request.** ~~Ninety-nine point five percent (99.5%) within (2) business days of receipt of appropriate medical information~~[102]	Practitioner/Provider	Oral notification provided within one (1) business day of decision. Electronic/written notification provided within two (2) business days, not to exceed seventy-two (72) hours from receipt of request[103]
Post-service (inpatient) approval	Thirty (30) calendar days from receipt of the request[104]	Practitioner/Provider	Electronic/written notification provided within one (1) business day of decision, not to exceed thirty (30) days from receipt of request [105]
Post-service (inpatient) denial	Thirty (30) calendar days from receipt of the request[106]	Practitioner/Provider	Oral notification provided within one (1) business day of decision. Electronic/written notification provided within (2) business days of decision, not to exceed thirty (30) days from receipt of request[107]

Post-service (Retrospective) Reviews of Authorization

When making post-service reviews, Aetna Better Health bases reviews solely on the medical clinical information available to the attending practitioner or ordering practitioner/provider at the time the health care services were provided. Post-service determinations are reviewed against the same criteria as concurrent determinations for the same service.

Notice of Action Requirements

Aetna Better Health provides the practitioner/provider and, when required or applicable, the member with written notification (i.e., NOA) of any non-behavioral or behavioral healthcare decision to deny, reduce, suspend or terminate a service authorization request, or to authorize coverage for a service in the amount, duration or scope that is less than requested or denies payment, in whole or part, for a service.[108]

An NOA sent to a member must be in writing and at or below a sixth-grade reading level. The notice must include:[109]

- The action Aetna Better Health has taken or intends to take and the effective date of that action
- The specific reason for the action, customized to the member's circumstances, and in easily understandable language

[102] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.1.3~~2~~
[103] NCQA HP 2019 UM5 B2, D2; 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.2.2
[104] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.3.1
[105] NCQA HP 2019 UM5 B5, D5; 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.1.1
[106] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.3.1
[107] NCQA HP 2019 UM5 B5, D5; 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.2.2
[108] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.2.2
[109] NCQA HP 2019/2020 UM7 A-F

- A reference to the benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- Notification that, upon request, the practitioner/provider or member, if applicable, may obtain a copy of the benefit provision, guideline, protocol, or other similar criterion on which the denial decision was based
- Notification that practitioners have the opportunity to discuss UM (physical health and behavioral health) denials based on medical necessity with a physician or other appropriate reviewer[110]
- A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
- An explanation of the appeal process, including the right to member representation and the timeframes for deciding appeals
- A description of the next level of appeal, either within the organization or to an independent external organization, as applicable, along with any relevant written procedures
- The right of the member or practitioner/provider (with written permission of the member) to request a Medicaid Fair Hearing and instructions about how to request a Medicaid Fair Hearing
- A description of the expedited appeals process for urgent concurrent denials
- Notification that expedited external review can occur concurrently with the internal appeals process for urgent care
- The circumstances under which expedited resolution is available and how to request it
- The member's right to request continued benefits pending resolution of the appeal, or pending a Medicaid Fair Hearing, how to request continued benefits and the circumstances under which the member may be required to pay the costs of these services
- Translation service information
- The procedures for exercising the rights specified in this section

[110] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.5.4.1.3.1, 8.5.4.1.3.2

Monitoring

Aetna Better Health will ensure that compensation to individuals or entities that conduct UM activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR §438. 3 (i) and 42 CFR §422.208.[111]

Aetna Better Health will report fraud and abuse information identified through the UM program to DHH in accordance with 42 CFR §455.1(a)(1).[112]

Monthly the CMO, in conjunction with the director of Medical Management, is responsible for analyzing utilization data, identifying areas of concern in the plan's performance and identifying recommendations for action planning. At a minimum, the CMO or designee presents quarterly summaries of this information to the Quality Management/Utilization Management (QM/UM) Committee. The QM/UM committee provides feedback to the CMO and approves action plans including adjustments to the Quality Assessment Performance Improvement (QAPI) program.

OPERATING PROTOCOL:

Systems

The business application system has the capacity to electronically store and report the time and date all service authorization requests are received, decisions made by Aetna Better Health regarding the service authorization requests, clinical data to support the decision, and timeframes for notification of decisions to practitioners/providers and members.[113] The service authorization system also provides the authorization number and effective dates of authorization to providers.[114]

[111] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.21
[112] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.1.22
[113] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section.8.4.2.6
[114] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.4.2.5

The business application system clinical module is used to document the following concurrent review information:

- Initial prior authorization or notification of an admission to the Prior Authorization department
- Information updates related to concurrent review, level of care changes, discharge planning, or applicable referral information (such as Integrated Care Management referrals) by concurrent review clinician or designated staff
- Daily/weekly discharge and level-of-care reconciliation

The business application system has the capacity to electronically store and report all service authorization requests, decisions made by Aetna Better Health regarding the service authorization requests, clinical data to support the decision, and timeframes for notification of decisions to practitioners/providers and members. The applicable application system documentation includes member demographics and information supporting clinical and benefit coverage determinations. All electronically stored data is housed within Aetna's business applications and are not outsourced to external vendors.

Access to the Aetna business application system is limited to applicable staff through Role Based Access Control (RBAC). Access is limited to the minimum necessary security to perform their job function. For the management of RBAC activities see policy *Services Operations RBAC Management Policy 300-001.003*

When denials are issued, system controls are in place to make sure field entries are locked (e.g., initial date/time of receipt of request, date/time of decision, date/time of system entry notes, written notification date) and prohibit all staff the ability to modify the field entry. Access to the denial database is password protected.

The process for password-protecting electronic systems, includes user requirements to utilize strong passwords, avoid writing down passwords and use different passwords for different accounts.

Aetna company-wide procedures requires users to change passwords every 90 days. Changing or withdrawing passwords, including alerting appropriate staff who oversee computer security, to

change passwords when appropriate and disable or remove passwords of employees who leave the organization[115].

For system control auditing see policy 7000.25 *Medical Management Staff Quality Review*

Measurements

- Bed days per 1000, monthly
- One-two (1-2) day stays compared to observation stays
- Outlier day reviews
- Readmissions
- Consistency of application of medical review criteria as measured through the inter-rater reliability assessment tool
- Quality/utilization management indicators
- Consistency in documentation (by department file audits)

Reporting

Aetna Better Health submits utilization management reports as specified by LDH.[116] Reports are submitted to the Aetna Better Health chief executive officer and/or CMO, including:

- Monthly inpatient admits per 1000
- Monthly percent of one or two (1-2) day stays that are paid at an observational rate
- Daily reports (Bed Days, Daily Census, etc.)
- Monthly Inpatient Bed Days per 1000 Report
- Weekly reconciliation of discharges
- Annual report of inter-rater reliability assessments
- Consistency of documentation by department file audits at least quarterly
- Monthly readmissions

Utilization tracking and trending is reviewed by the CMO on a monthly basis and is reported at least quarterly to the QM/UM Committee.

[115] NCQA HP 2019/2020 UM12 A
[116] 2020 LOUISIANA MEDICAID MANAGED CARE ORGANIZATION STATEMENT OF WORK, Section 8.3

INTER-/INTRA-DEPENDENCIES:

Internal

- Chief medical officer
- Claims
- Compliance
- Finance
- Information Technology
- Medical director
- Medical Management
- Member Services
- Provider Services
- Quality Management
- Quality Management/Utilization Management Committee

External

- Members
- Practitioners/providers
- Regulatory bodies

AETNA BETTER HEALTH®

d/b/a Aetna Better Health of Louisiana

Policy

Policy Name:	Concurrent Review/Observation Care	Page:	37 of 37
Department:	Medical Management	Policy Number:	7200.05
Subsection:	Concurrent Review	Effective Date:	02/01/2015
Applies to:	■ Medicaid Health Plans		

Aetna Better Health

Richard C. Born
Chief Executive Officer

Madelyn M. Meyn
Chief Medical Officer

Review/Revision History	
04/2016	Removed LTSS and Medicare language; Inserted accurate reading level for denials and valid contract section
07/2017	Reviewed and updated to template
02/2018	Annual Review
12/2018	Updated to template; Removed LTSS and Medicare language; Inserted updated contract language
05/2019	Added contract language and references, updated NCQA references, updated CMO signatory line and header
04/2020	Changed CASII citation to CALOCUS; inserted updated contract language
11/2020	Added language from Louisiana state law
03/2021	**Updated turnaround times to reflect contract amendment**