UnitedHealthcare Community Plan of Louisiana, Inc.	DEPARTMENT: **Clinical Operations – Behavioral Health**
	LINE OF BUSINESS: **UHC C&S Louisiana**
POLICY TITLE: **Utilization Management of Behavioral Health Benefits**	POLICY NUMBER:
EFFECTIVE DATE:	PAGE: **Page 1 of 50**
REVIEW DATE: **09/ /2019**	REVISION DATE:
REPLACES POLICY# / DATED:	AUTHORIZED BY:

A. SCOPE:

This addendum to the National Medicaid policy Management of Behavioral Health Benefits applies to members whose benefit coverage is provided through the Louisiana Medicaid plan and whose behavioral/mental health benefits are managed by UnitedHealthcare Community Plan of Louisiana (UHCCP LA).

II. PURPOSE:

National requirements as found in the Code of Federal Regulations, other applicable Federal regulations such as the Mental Health Parity and Addiction Equity Act, as well as NCQA and URAC are reflected in the National Medicaid Policy.

This addendum is to reflect unique requirements governing utilization management of behavioral health as described in the contract between the State of Louisiana Department of Health and Hospitals and UnitedHealthcare of Louisiana, regulatory requirements of the State of Louisiana, the Medicaid State Plan and waivers, and the court-ordered requirements, including byt not limited to, United States v. State of Louisiana (DOJ Agreement- Case 3:18-cv-00608) of Chisholm v. Gee (Case 2:97-cv-03274).

III. DEFINITION(S)[1]:

- **Medically Necessary Services – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be:**
  - **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**
  - **those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the beneficiary. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiary requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary."**

[1] Unless otherwise noted, definitions are from the contract.

- Utilization Management (UM) – Refers to the process to evaluate the medical necessity, appropriateness, and efficiently of the use of health care services, procedures, and facilities. Utilization Management is inclusive of utilization review and service authorization.

- Refer to the UnitedHealthcare Community and State Standard Definitions.

- For other defined terms, refer to the *National Medicaid Policy: Definitions List* and the *National Policy: Definitions List.*

IV. POLICY:

A) General Provisions:

1) When an accrediting organization provides guidance that differs from State requirements, UCHCP LA may apply the accrediting organization's guidance when it is beneficial and/or less restrictive to the enrollee[2].

2) UHCCP LA has service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan. UHCCP LA's Clinical Criteria are disseminated to all affected providers, and upon request, to enrollees and potential enrollees.

3) UHCCP LA's Clinical Criteria are posted to its website. Posts for proprietary software that requires a license and which may not be posted publically according to associated licensure restriction include the name of the software only. Upon request by an enrollee, their representative, or the Louisiana Department of Health (LDH), UHCCP LA provides the specific Clinical Criteria utilized to make a decision.

4) UHCCP LA identifies the source of the Clinical Criteria used for the review of service authorization requests and includes:

a) The vendor if the Clinical Criteria was purchased;

b) The association if the Clinical Criteria are developed/recommended or endorsed by a national or state health care provider association or society;

c) The Clinical Criteria source is identified if the criteria are based on national best practice guidelines; and

d) The individuals who make medical necessity determination if the criteria are based on the medical training, qualifications, and experience of UHCCP LA's medical director or other qualified and trained professionals.

[2] UHCCP Standard

5) **UHCCP LA makes its decisions for utilization management, enrollee education, coverage of services, and other areas to which the Clinical Criteria apply in a manner consistent with the Clinical Criteria.**

6) **UHCCP LA makes decisions regarding medical necessity using LDH's definition of medically necessary services.**

7) **UHCCP LA has sufficient, appropriately qualified and trained clinical staff to apply service authorization Clinical Criteria.**

8) **UHCCP LA ensures that only clinical professionals with appropriate clinical expertise in the treatment of an enrollee's condition or disease determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested.**

   a) **Individual(s) making these determinations 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.**

   b) **The individual making these determinations attests that no adverse determination is made regarding any medical procedure or service outside of the scope of such individual's expertise.**

9) **UHCCP LA has a plan for addressing the long-term stay of enrollees in emergency departments based on limited availability for necessary behavioral health services**[KF1]**.**

   a) **Behavioral health staff assist the emergency department staff locate appropriate behavioral health placement and/or services for the enrollee to avoid long term utilization of the Emergency room.**

   ~~a)~~b) **In-network and out-of-network providers are accessed, as needed, to ensure availability and time placement and/or services.**

~~9)~~10) **Upon request, UHCCP LA provides LDH with documentation supporting how it has placed appropriate limits on a service on the basis of medical necessity for individuals determined by LDH to need specialized behavioral health services.**

~~10)~~11) **UHCCP LA performs 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.**

~~11)~~12) **UHCCP LA ensures that inpatient psychiatric hospital and concurrent utilization reviews are completed by a Licensed Mental Health Professional**[KF2] **(LMHP) for each**

enrollee referred for psychiatric admissions to general hospitals. UHCCP complies with the requirements set forth in state administrative rules.

13) **A member or member's authorized representative may submit, orally or in writing, a service authorization request for the provision of services.**

14) **UHCCP LA does not deny authorization of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless UHCCP LA can provide the service through an in-network or out-of-network provider for a lower level of care.**

15) **For the first 30 days of a newly enrolled member's linkage to the plan UHCCP LA does not:**

   a) **Require authorization for the continuation of medically necessary covered services of a new member transitioning into UHCCP LA, regardless of the network status of the provider:**

   b) **Deny prior authorization solely on the basis of the provider being an out-of-network provider.**

16) **UHCCP LA does not require service authorization or referral for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening services.**

B) **Coordinated System of Care (CSoC)**

1) **UHCCP LA conducts utilization management and review functions for the CSoC population, including:**

   a) **Appling initial risk screen for CSoC eligibility;**

   b) **When indicated, refer calls via seamless transfer to the contracted administrator of the CSoC program, who applies Brief CANS assessment tool to assess for CSoC presumptive eligibility; and**

   c) **Document in the child's health record:**

      i) **whether or not (according to CSoC contracted administrator) the child met criteria for CSoC presumed eligibility;**

      ii) **when the child was referred to the Wraparound Agency;**

      iii) **the date on which the Freedom of Choice was signed;**

      iv) **if the child does not become enrolled in CSoC the reason:**

         a **the youth and family refuse CSoC services; or**

         b **the youth does not meet clinical eligibility based on the comprehensive CANS; or**

c **other reason.**

d) **For youth who screened positively on the initial risk screen, but who do not complete enrollment in CSoC, UHCCP LA offers voluntary participation in Case Management, and/or other behavioral health services to meet the child and family's presenting needs.**

C) **Court-Ordered Treatment**

1) **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 UHCCP LA.**

D) **Turnaround Time Requirements for Authorization and Non-Coverage Determinations**

1) **UHCCP LA makes 80% of standard service authorization determinations within 2 business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure, or service requiring a review determination.**

2) **All standard service authorization determinations are made no later than 14 calendar days following receipt of the request for service with the following exceptions:**

a) **CPST and PSR services for which the standard for determination is within 5 calendar days of obtaining appropriate medical information.**

b) **Service authorization decision may be extended up to 14 additional calendar days if:**

i) **The member or the provider requests the extension; or**

ii) **UHCCP LA justifies (to LDH upon request) the need for additional information and how the extension is in the member's interest.**

3) **UHCCP LA makes 95% of concurrent review determinations within 1 business day and 99.5% of concurrent review determinations within 2 business days of obtaining the appropriate medical information that may be required.**

4) **UHCCP LA makes post-service (retrospective) review determinations within 30 days of obtaining the results of any appropriate medical information that may be required, but in no instance later than 180 days from the date of receipt of request for service authorization.**

5) **UHCCP LA does not subsequently retract an authorization after services have been provided or reduce payment or an item or service(s) 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.

6) **UHCCP LA does not use a policy with an effective date subsequent to the original service authorization request date to rescind its prior authorization.**

E) Notice of Action

1) **Approval**

a) **For service authorization approval for a non-emergency admission, procedure or service, UHCCP LA notifies the provider verbally or as expeditiously as the enrollee's health condition requires, but not more than 1 business day of making the initial determination and provides written notification to the provider within 2 business days of making the determination**

b) **For service authorization approval or extended stay or additional services, UHCCP LA notifies 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 1 business day of making the initial determination and shall provide written notification to the provider within 2 business days of making the determination.**

2) **Adverse Action**

a) **UHCCP LA notifies the enrollee, in writing using language that is easily understood by the enrollee, of decisions 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 *Enrollee Grievances, Appeals and State Fair Hearings* section in the contract. The notice of action to enrollees shall be consistent with requirements in 42 C.F.R. §438.404, §438.10 and §438.210, the *Marketing and Education* section of the contract for member 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.**

b) **UHCCP LA notifies 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. UHCCP LA provides written notification to the provider rendering the service, whether a health care professional or facility or both, within 2 business days of making the determination.**

F) Member Choice Form

1) **Members may only receive Mental Health Rehabilitation (MHR) services from one provider at a time with the following exceptions:**
   a) **A member is receiving tenancy support through the Permanent Supportive Housing Program.**
   b) **The UHCCP LA medical director makes the determination that it is medically necessary and clinically appropriate to receive services from more than one MHR provider. The justification must be supported by the member's assessment and treatment plan. This decision must be reviewed at each medical necessity review.**
2) **All members must complete and sign a Member Choice Form prior to the start of MHR services and when transferring from one MHR provider to another. UHCCP LA will notify the previous provider upon receipt of the new Member Choice form. The Member Choice Form is required to be submitted with the initial Level of Care Utilization System (LOCUS)/ Child and Adolescent Service Intensity Instrument (CASII)/ Early Childhood Service Intensity Instrument (ECSII), be a part of the member's clinical record, and is subject to audit upon request.**
3) **Providers must notify the member's health plan immediately if it is suspected that a member is receiving MHR services from more than one provider.**
4) **In most situations, during a transfer the initial provider is given a service end date while the new provider is given a start date to prevent a gap in services. UHCCP LA will monitor the duplication of services via prior authorization, ALERT and Practice Management.**

VI. RELATED POLICIES:

- **Management of Behavioral Health Benefits: Medicaid**
- **National Medicaid Policy: *Definitions List***
- **National Policy: *Definitions List.***
- **UnitedHealthcare Community and State Mixed Services Protocol**
- **UnitedHealthcare Community and State Standard Definitions.**
- **UnitedHealthcare Community Plan of Louisiana policy: Integration of Physical and Behavioral Health Utilization Management**

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X. APPROVED BY:

10/9/2019

Jose Calderon-Abbo, M.D.
UHC Medical Director for Behavioral Health **Date**

P&P Revision Control Log

Revision Date	Summary of Revision(s) (Bullets what has changed, Include Page #)	Reason(s) for Revision	Approved by QMC
September, 2016	Pages 38-39: added TAT requirements related to standard authorizations and denials.	Contractual requirement	
October, 2016	Table 3A on page 38	Contractual requirement	
October 2019	Addended to the Optum Management of Behavioral Health Benefits: Medicaid Removed non contractual and procedural elements and references pertaining to case management, Human Resources and Training Updated to align with current contract	Annual Review and Contractual Changes	

~~I. SCOPE:~~

~~This policy applies to members whose benefit coverage is provided through the Healthy Louisiana Medicaid plan and whose behavioral/mental health benefits are managed by UnitedHealthcare of Louisiana (UHC LA).~~

~~This policy is based on the statutory requirements, prohibitions, and procedures set forth in *Code of Federal Regulations* and on the specific requirements in the contract between the State of Louisiana Department of Health and Hospitals and UnitedHealthcare Community Plan of Louisiana, and complies with the standards and regulations set forth by NCQA, URAC, and HIPAA, regulatory requirements of the State of Louisiana[3], and the court-ordered requirements of Chisolm v. Kliebert and Wells v. Kleibert.~~

~~II. PURPOSE:~~

[3] ~~42 CFR §438, *Managed Care*~~

~~The purpose of this policy is to describe the mechanisms and processes designed to:~~

- ~~Promote consistency in the management of behavioral health benefits.~~
- ~~Ensure that members receive appropriate evidence-based, recovery-oriented, resiliency-focused and comprehensive individualized person-centered behavioral health services in a timely, culturally competent manner.[4]~~

~~III. DEFINITION(S):~~

~~Refer to the UnitedHealthcare Community and State Standard Definitions.~~

[4] ~~42 CFR §438.206(c) (2) *Cultural considerations*~~

~~IV. POLICY:~~

- ~~UHC LA has formal systems and workflows designed to process pre-service, post-stabilization, continued stay and post-service requests for coverage and authorization of services provided to its members by in-network and out-of-network (OON) practitioners, facilities and agencies.~~
- ~~UHC LA screens members to determine level of need for the purpose of service authorization based on medical necessity. Based on this medical necessity determination, UHC LA authorizes Medicaid State Plan services as appropriate.~~
- ~~UHC LA manages services to promote utilization of best, evidence-based and informed practices and to improve access and deliver efficient, high quality services.~~
- ~~UHC LA has sufficient, appropriately qualified and trained clinical staff to evaluate clinical appropriateness and ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.[5]~~
    - ~~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.[6]~~
- ~~UHC LA does not arbitrarily deny or reduce the amount, duration, or scope of a required service but may place appropriate limits on a service based on criteria applied under the benefit plan, and on the individual member's needs through fair and culturally competent decision-making to provide equitable access to the best available care for the member and ensure proper, efficient and effective administration of the Medicaid plan.[7]~~
- ~~UHC LA has service authorization criteria for specialized behavioral health services that are consistent with the Medicaid State Plan.~~
- ~~Behavioral health and medical staff at UHC LA collaborate to annually develop an integrated Utilization Management Program Description and annual Quality~~

[5] ~~42 CFR §438.210 *Coverage and authorization of services*~~
[6] ~~42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210~~
[7] ~~42 CFR §438.210 *Coverage and authorization of services*~~

~~Improvement Work Plan structured to monitor and evaluate the Utilization Management Program.~~

~~V. PROCEDURE:~~

~~C) General Practices:~~

~~13) A member or member's authorized representative may submit, orally or in writing, a service authorization request for the provision of services.~~

~~14) UHC LA makes authorization decisions, provides immediate notification when required, and issues Notices of Action as expeditiously as the member's health condition requires and within applicable timeframes.~~

~~a) Members with limited English proficiency may request that the Notice of Action and other written information be translated.~~

~~b) All informational materials are written at the 6.9-grade reading level to takes into consideration the needs of those who have limited reading proficiency, in prevalent languages as well as in other languages on request, and in alternative formats (such as large print, Braille, audio formats) or in a modality that meets the needs of members with special needs.[8]~~

~~c) UHC LA also makes oral interpretation services for all non-English languages available free of charge to the member.[9]~~

~~15) UHC LA offers the requesting provider an opportunity for consultation with UHC LA Peer Reviewers to discuss authorization decisions when appropriate.[10]~~

~~16) UHC LA will ensure certificate of need (CON) is completed for certification and recertification of PRTF services in Louisiana.~~

~~17) UHC LA also provides a process for informal reconsideration.~~

~~a) Reconsiderations occur prior to the appeal process.~~

~~[8] 42 CFR §438.10 *Information requirements*~~
~~[9] 42 CFR §438.10 (5)(i)~~
~~[10] 42 CFR §438.210 (b)(2)(ii)~~

b) A request for reconsideration must be received in writing within 24 hours of decision notification.

c) Requests must be supported by written documentation with additional clinical information.

d) Requests must include the member's written consent.

e) The member's provider must have participated in peer review.

f) The process for informal reconsideration includes the following:

(I) The member or member's provider/agent has a reasonable opportunity to present evidence, and allegations of fact of law, in person as well as in writing.

(II) In a case involving an initial determination or a concurrent review determination, UHC LA 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.[11]

(III) The informal reconsideration occurs within 1 business day of the receipt of request and is conducted between the provider rendering the service and the UHC LA physician authorized to make adverse determinations or clinical peer designated by the Medical Director if the physician who made the adverse determination cannot be available within 1 business day.

(IV) The informal reconsideration does not extend the 30-day required timeframe for a Notice of Appeal Resolution.

18) UHC LA does not withhold benefit coverage for an initial behavioral health evaluation.

19) UHC LA does not withhold benefit coverage for emergency services in situations where a member, believing there was a true emergency,

[11] 42 CFR §438.402(b)(ii).

~~obtained emergency room services without notifying UHC LA or obtaining pre-approval.[12]~~

20) ~~UHC LA requires that its providers provide timely access to care and services, taking into account the urgency of the need for services and make covered services available 24 hours a day, 7 days a week, when medically necessary.[13]~~

21) ~~UHC LA is responsible for coverage of post-stabilization services that were administered to maintain, improve or resolve the member's stabilized condition and that are not pre-approved, if UHC LA:~~

~~a) Does not respond to a request for pre-approval within one (1) hour;~~

~~b) Cannot be contacted; or~~

~~c) Cannot reach an agreement with the treating physician concerning the member's care and a UHC LA physician reviewer is not available for consultation.~~

~~(I) In this situation, UHC LA must give the treating physician the opportunity to consult with a UHC LA physician reviewer, and the treating physician may continue with care of the patient until a UHC LA physician reviewer is reached.[14]~~

[12] ~~42 CFR §438.10 (f)(6) (viii)(B)~~
[13] ~~42 CFR §438.206(c)(1) *Timely access*~~
[14] ~~42 CFR §438.114: *Emergency and Post-stabilization services.* Also see 42 CFR §422.113(c) *Maintenance care and post-stabilization care services* (hereafter together referred to as *"post-stabilization care services"*)~~

~~22) UHC LA allows at least 24 hours after an admission for a facility to request a pre-authorization, unless a longer period is required by contract. In situations that require notification, rather than pre-authorization, UHC LA allows up to 48 hours after an admission for a facility to provide notification~~

~~23) UHC LA does not reverse an authorization decision unless UHC LA receives new information that is relevant to the decision and that was not available at the time of the original decision.~~

~~a) The timeframe for issuing a Notice begins at the time the determination was made to reverse the approval of coverage, if an approval of coverage is reversed.~~

~~24) UHC LA does not deny authorization of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless UHC LA can provide the service through an in-network or out-of-network provider for a lower level of care.~~

~~25) Behavioral health staff in collaboration with medical staff maintains a formal process to address any expression of dissatisfaction from a member/member representative about any matter, including but not limited to the quality of care or services provided, or any action or inaction by UHC LA other than the denial or limited authorization of a requested service.~~

~~D) Transition of Care for Integration of Specialized Behavioral Health~~

~~13) For the period December 1, 2015 through February 28, 2016 UHC LA shall honor all Magellan authorization decisions at the level of service and duration approved prior to December 1, 2015. For services, if any, that were approved by Magellan beyond February 28, 2016 UHC LA will conduct a review for authorization of services beyond that date with notice of determination provided to the member and the provider no later than February 14, 2016. Otherwise, UHC LA will continue to honor existing Magellan authorizations beyond February 28, 2016 until such time as a determination for continued services is complete and the member and provider have been timely notified. These requirements will apply to all prior approvals regardless of the provider's status as a contracted or non-contracted provider.~~

~~E) Access to UHC LA Staff for Utilization Management (UM) Services~~

~~13) UHC LA personnel are available for members and practitioners seeking information about the Utilization Management process and the authorization of care[15].~~

~~14) UHC LA personnel are available to receive calls about UM services and specific UM cases from members and practitioners/facility representatives through a toll-free telephone number from at least 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.[16]~~

~~a) Outbound calls by UHC LA staff about UM and other issues are generally made during these time periods, but when necessary and appropriate, are made after normal business hours.~~

~~b) Outside of the stated hours, calls made to UHC LA are routed to an after-hours team on a 24-hour a day, seven-days a week basis.[17]~~

~~[15] NCQA MBHO Standard 2014: UM 3A.~~
~~[16] 42 CFR §438.6: Contract requirements. Also found in the State of Louisiana Department of Health and Hospitals' requirements..~~
~~[17] 42 CFR §438.206~~

~~15)When receiving, initiating or returning telephone calls, each UHC LA staff member is to identify himself/herself as a UHC LA employee and provide his/her name and title.~~

~~F) Roles of Staff~~

~~13)Utilization Management Staff:~~

~~a) Work under the direction of a Louisiana-licensed registered nurse, physician or physician's assistant, and are appropriately credentialed behavioral health professionals licensed to practice independently in their own state of residence, or in the state in which they work;[18]~~

~~b) Perform Utilization Management activities, specifically case reviews and approval of service requests:~~

~~(I) Clinical case reviews are conducted at a frequency based on the severity or complexity of the member's condition, but not routinely on a daily basis;[19]~~

~~c) Respond to requests for service, which may include ensuring the availability of appropriate covered services, screen and refer for CSoC eligibility, and when necessary, assisting with scheduling appointments for members for:~~

~~(I) Emergency Services: Immediately upon presentation at the emergency service. Emergency, crisis, or emergency behavioral health services must be available at all times, and an appointment shall be arranged within 1 hour of request.~~

~~(II) Urgent Care: Within 24 hours. Provisions must be available for obtaining urgent care 24 hours per day, 7 days per week. An appointment shall be arranged within 48 hours of request.~~

~~(III) Non-Urgent Care: Within 72 hours or sooner if the member's condition deteriorates into an urgent or emergency condition.~~

~~[18] NCQA MBHO Standard 2014: UM 4A.~~
~~[19] URAC HUM Standard: 26 (v. 7.0).~~

(IV) Routine Non-Urgent Care: Within 14 calendar days of referral.

d) Return routine phone calls to members within one (1) business day;

e) Collaborate with members and providers in treatment and discharge planning activities, including assisting in scheduling a follow-up appointment for the member when necessary, to promote members' recovery, resiliency, wellness and well-being;

f) Make coverage determinations based on the consistent application of appropriate clinical guidelines and review criteria for authorization decisions, such as the *UHC LA Level of Care Guidelines, Psychological and Neuropsychological Testing Guidelines, the ASAM Criteria,* and State-specific Guidelines;[20]

(I) Utilization Management staff are to consistently apply the appropriate guidelines and/or criteria in each case to ensure that an individualized treatment plan has been created to address the member's needs, obstacles and liabilities, as well as strengths, assets, resources and support systems.

g) Promote the delivery of services in a culturally competent manner taking into consideration the member's current condition, history of the problem/illness, desired outcomes and effectiveness of prior treatment if any; cultural and ethnic background, English language proficiency, the availability of community resources; the member's choices concerning available services/practitioners; available benefit coverage and any Advanced Directive executed by the member.[21]

h) Approve the most appropriate level and type of care based solely on the current information available at the time of the review, and give verbal notice of determinations, when required;[22] [23]

[20] 42 CFR §438.236 *Practice Guidelines* and 42 CFR §438.210 (b)(2)(i)
[21] 42 C.F.R §489.100 and the *Patient Self-Determination Act* (*PSDA*)
[22] NCQA MBHO Standard 2014: UM 2A and UM 5B.
[23] URAC HUM Standard: 1, 20 and 28 (v. 7.0).

~~i) Staff cases for which a coverage determination cannot be made to approve the requested service(s) with:~~

~~(I) A Peer Reviewer for clinical cases; or~~ [24] [25]

~~(II) A Clinical Operations Director or designee for an administrative review (based solely on the terms of the member's benefit plan).~~

~~j) Utilization Management staff conducting initial clinical review do not make non-coverage determinations.~~[26]

~~k) When Utilization Management staff is informed of the determination by the Peer Reviewer or Clinical Operations Director of designee:~~

~~(I) Utilization Management staff verbally inform the practitioner/facility, and requests that the facility inform the member/family of the non-coverage determination. (Telephone contact with a facility representative is considered a proxy for providing verbal notice to the member.)~~

~~(II) For a non-coverage determination based on clinical criteria, Utilization Management staff offer the practitioner/facility information about available appeal options.~~

~~(III)For a non-coverage determination based on administrative criteria, Utilization Management staff offer the practitioner/facility the opportunity to appeal the determination.~~

~~(IV) For a member admitted to an OON facility, when feasible and clinically appropriate, Utilization Management staff issue an authorization for ambulance transport to a network facility.~~

~~14)Peer Reviewers~~

~~a) Are licensed, and are appropriately credentialed doctoral-level psychologists, psychiatrists or addictionologists.~~[27]

[24] ~~NCQA MBHO Standard 2014: UM 4A.~~
[25] ~~URAC HUM Standards: 11, 13, 14 and 15 (v. 7.0).~~
[26] ~~URAC HUM Standard: 12 (v. 7.0).~~

b) Provide consultation with Utilization Management staff related to making coverage determinations.

c) Conduct Peer Reviews when requested by the practitioner/facility.[28]

(I) Only physicians conduct peer reviews for requests for facility-based services, and for outpatient services by a physician.

(II) Doctoral-level psychologists conduct peer reviews for non-facility-based outpatient services, including Intensive Outpatient Programs (IOPs) and psychological and neuropsychological testing services, except when the request is made by a physician.

d) A Peer Reviewer is to be available for a peer-to-peer review within a "reasonable" time frame.

(I) For urgent cases, allowing a two (2) to four (4) hour time frame for the treating practitioner to contact a Peer Reviewer is considered reasonable. However, the time period allotted for an urgent peer-to-peer review to take place is not to exceed the time remaining for making the determination within the turnaround time requirements.

(II) For non-urgent cases, allowing five (5) working days for the treating practitioner to contact a Peer Reviewer is considered reasonable.

(III)If the treating practitioner does not contact UHC LA for the peer-to-peer review within the stated time period, the Peer Reviewer or designee is to make an attempt to reach the practitioner by telephone prior to making a determination, and is to document the attempt in the member's electronic record.

(IV) If the Peer Reviewer is unable to make contact with the practitioner, or if the practitioner, attending psychiatrist or facility declines the offer of a peer-to-peer review, the Peer Reviewer is to make a coverage determination based on available information.

[27] NCQA MBHO Standard 2014: UM 4A.
[28] URAC HUM Standard: 16A (v. 7.0).

e) When a practitioner/facility requests an opportunity to discuss a non-coverage determination, UHC LA is to make a Peer Reviewer available within one (1) business day of the request.

f) When the Peer Reviewer makes a determination to approve the requested services, the Peer Reviewer returns the case to Utilization Management staff to resume the review process.

g) When the Peer Reviewer makes a non-coverage determination, Utilization Management staff:

(I) Notify the practitioner verbally and provides information about available appeal/dispute options.[29]

(II) Document the determination so that a written notice can be issued within the appropriate timeframe.

G) Staff Orientation and Ongoing Training

13) UHC LA provides systematic and comprehensive orientation as well as ongoing training for all personnel in clinical operations to ensure that all clinical operations personnel perform their duties in accordance with UHC LA policies and procedures, HIPAA privacy requirements as well as all applicable entity-specific, regulatory and accreditation standards.

a) All new employees are required to participate in a structured orientation as well as job role and department-specific training program before assuming their particular roles.

b) All personnel are also required to undergo ongoing training programs including but not limited to annual refresher courses, as determined by their role and/or in accordance with State/ entity requirements and accreditation standards.

c) All clinical personnel participate in regularly scheduled supervision and consultation meetings which include discussions of the appropriate application of applicable clinical guidelines and review criteria.

[29] URAC HUM Standard: 16 (v. 7.0).

d) All medical care managers will have access to training on identification and screening of behavioral health conditions and referral procedures.

e) In addition, staff may be mandated to undergo training programs provided by UHC LA in response to regulatory and other changes, to address potential issues in performance, or in accordance with the needs of the organization.

H) Case Reviews

13) Case reviews are conducted in response to requests for coverage for all levels of treatment services. They may be urgent or non-urgent, and they may occur prior to a member receiving services (Pre-Service), during the course of a member receiving services (Concurrent), or following a member receiving services (Post-Service).

14) Case reviews are conducted in a focused and time-limited manner to ensure that the immediate treatment needs of members are met, to identify alternative services in the service system to meet those needs; and to ensure the development of a person-centered plan, including advance directives.

15) Pre-Service Reviews

a) A pre-service review is conducted in response to a request for care or services in advance of a member receiving the care or services.

b) A pre-service review may be requested on an urgent or non-urgent basis.

16) Concurrent Reviews

a) A concurrent review is conducted in response to a request for an extension of a previously authorized ongoing course of treatment.

b) A concurrent review is always considered to be an urgent review.

~~17)Post-Service Reviews~~

~~a) A post-service review is conducted in response to a request for payment for services that have already been provided to a member.~~

~~b) A post-service review is always considered to be a non-urgent review.~~

~~I) Utilization Management Review Process~~

~~13)Gathering Information~~

~~a) Utilization Management staff gather only the critical clinical and psychosocial information needed to make a determination to authorize requested services or to forward the case for review by a clinical Peer Reviewer:[30]~~

~~(I) From reliable sources, such as the treating practitioner, facility personnel, the primary physician, and the member, or the authorized representative, as appropriate to determine a member's need;[31]~~

~~(II) To form a comprehensive, overall understanding of the member's situation (specific details involving interpersonal relationships that are not pertinent to making a coverage determination are not requested);~~

~~(III)To determine if the behavioral health diagnosis is accurate and can be supported by the current symptoms and behaviors displayed by the member;~~

~~(IV) To assess for risk of suicidality, homicidality, domestic violence, child abuse and elder abuse, as indicated by a member's clinical presentation;~~

~~(V) To collaborate with treatment and discharge planning; and~~

~~(VI) To make a coverage determination.~~

~~[30] URAC HUM Standards: 8, 10, 12, 27 and 28 (v. 7.0).~~
~~[31] NCQA MBHO Standard 2014: UM 6A.~~

b) ~~Medical records are not routinely requested, other than when additional information or corroboration is required. When medical records are needed, only relevant portions are requested, and reimbursement is made upon request, unless otherwise stated in a contractual agreement.[32]~~

c) ~~Requesting practitioners to numerically code diagnoses is not a routine part of the care review process.~~

14) ~~Documentation of Clinical Info:~~

a) ~~Clinical information gathered by Utilization Management staff and Clinical Peer Reviewers during discussions with treating practitioners/designees, members and member representatives, facility case review personnel and Primary Physicians, or by a review of written clinical records or treatment plans, is to be recorded in the member's electronic record.~~

(I) ~~UHC LA does not maintain information used to make Utilization Management decisions outside of the member's electronic record.~~

b) ~~The sufficiency of the clinical information gathered and documented by Utilization Management staff is confirmed through documentation audits.~~

c) ~~UHC LA clinical personnel document clearly the reason(s) for review decisions.~~

d) ~~Notes which refer to other UHC LA clinical staff such as Clinical Peer Reviewers are to include the title of the individual being referenced.~~

e) ~~Utilization Management staff and Peer Reviewers are to document only the clinical information that is necessary to make authorization decisions.~~

[32] ~~URAC HUM Standard: 27D and E (v. 7.0).~~

f) Documentation is to be recorded in the member's electronic record within one (1) business day. Whenever a note is entered late it is to be recorded in the text that it is a late entry.

g) Whenever it is necessary to correct a note after it has been saved, it is to be clearly documented.

J) Coverage Determination Types

13) The differentiation between whether a request will be reviewed against clinical or administrative criteria in making a coverage determination is important for two (2) reasons:

a) It determines the type of staff person who will perform the review:

(I) Cases reviewed on the basis of clinical considerations are reviewed by a Peer Reviewer.

(II) Cases reviewed on the basis of administration considerations are reviewed by a Clinical Operations Director or designee.

b) When a determination of non-coverage is made, it determines the information to be provided related to the options that are available to the member for appealing the determination.

14) Requests Requiring a Clinical Review and Determination

a) The requested service(s) require a determination of medical necessity;

b) The requested service(s) are considered experimental, investigational or unproven;

c) There is insufficient information to make a determination; or

d) The service is considered to be custodial, not acute.

15) Requests Requiring an Administrative Review and Determination

a) The member is not eligible for benefits; or

b) The member's benefits are exhausted.

~~16)Requests Requiring a Determination of whether the Review is Clinical or Administrative~~

~~a) The following table lists the request situations that require a consideration of whether the review is to be clinical or administrative.~~

~~Situation~~	~~Differentiation~~		~~Type of Review~~
~~**Lack of Prior Authorization within the timeliness requirements when Prior Authorization is required**~~	~~Allegation that extenuating circumstances prevented timely pre-authorization.~~	~~Yes~~	~~Clinical~~
		~~No~~	~~Administrative~~
	~~Allegation that the member's acute clinical condition (such as delusional thinking) resulted in a delayed request for prior authorization.~~	~~Yes~~	~~Clinical~~
		~~No~~	~~Administrative~~
~~**Request for Exception - to use OON services**~~	~~Allegation of a clinical need that cannot be met, or cannot be met within the required timeframe, by any in-network practitioner/facility and that therefore requires the use of an OON practitioner/facility.~~	~~Yes~~	~~Clinical~~
		~~No~~	~~Administrative~~
~~**Diagnosis excluded by the terms of the member's Benefit plan coverage**~~	~~There is a question about the accuracy of the diagnosis as stated, in that the member's condition, if accurately diagnosed, may not be among the excluded diagnoses.~~	~~Yes~~	~~Clinical~~
		~~No~~	~~Administrative~~
~~**Services excluded by the terms of member's Benefit plan**~~	~~The request for psychological testing for educational or legal purposes (for example, testing to rule out a learning disorder; or testing for a child custody case) and ***IS ALSO*** for the purpose of evaluation for treatment such as establishing a diagnosis and/or making a recommendation for treatment services.~~	~~Yes~~	~~Clinical~~
		~~No~~	~~Administrative~~

~~K) Insufficient Information~~

~~13) Whenever possible, UHC LA personnel make a coverage determination using the available clinical information rather than initiating the formal Insufficient Information process.~~

~~14) Utilization Management staff make at least two (2) attempts to gather information. If these attempts are unsuccessful, Utilization Management staff initiates one of the formal Insufficient Information processes outlined below.~~

~~15) For both urgent and non-urgent requests, the required information is to be requested, a coverage determination is to be made, and notice to the member or authorized representative, the practitioner and/or the facility is to be provided in compliance with the turnaround time requirements for processing urgent or non-urgent requests for approval of benefit coverage (excluding any suspended time).~~

~~16) Time Requirements for Urgent Cases~~

~~a) Utilization Management staff telephone or fax a Request for Information letter to the member, authorized representative, practitioner or facility making the request within 24 hours of the request.~~

~~b) The telephone call or fax is to outline the specific information that is required to complete the review.~~

~~c) The member or authorized representative has 48 hours from the receipt of the request for information to submit the requested information.~~

~~d) When a Request for Information letter has been sent, the time period for UHC LA to make a determination is suspended.~~

~~e) The suspension starts at the date and time the notice was sent.~~

f) ~~The suspension ends at the date and time UHC LA receives the requested information, not to exceed 48 hours from the date and time the Request for Information letter was sent.~~

17) ~~Time Requirements for Non-Urgent Cases~~

a) ~~Utilization Management staff send a Request for Information letter by mail to the member or authorized representative and the treating practitioner within five (5) calendar days from the receipt of the request for benefit coverage, outlining the specific information that is required to complete the review.~~

b) ~~The treating practitioner, member or authorized representative has 45 calendar days from the issuance of the Request for Information letter to submit the requested information.~~

c) ~~When a *Request for Information* letter has been sent, the time period for UHC LA to make a determination is suspended.~~

d) ~~The suspension starts on the date the notice was sent.~~

e) ~~The suspension ends on the date UHC LA receives the requested information, not to exceed 45 days from the date the Request for Information letter was sent.~~

18) ~~Upon receipt of the information, Utilization Management staff make a coverage determination or is to forward the case to a Peer Reviewer.~~

19) ~~If the information is not received, the case is to be forwarded to a Peer Reviewer to make a determination about whether there is sufficient information to make a coverage determination.~~

20) ~~A determination is to be made based on the available information, if the Peer Reviewer determines that there is sufficient information to make a determination.~~

21) ~~An NCD based on insufficient information is to be issued if the Peer Reviewer determines that clinical information is not sufficient to make a coverage determination.~~

~~22)It is not necessary to offer a peer-to-peer review prior to issuing an NCD based on insufficient information.~~

~~L) Management of Outpatient Services~~

~~13)The Algorithms for Effective Reporting and Treatment (ALERT) program is used to manage individual outpatient services provided to members, using member-completed Wellness Assessments and/or claims data.~~

~~14)The ALERT program identifies members with risk factors, atypical utilization patterns and/or atypical treatment responses.~~

~~15)Utilization Management staff conduct clinical reviews with outpatient practitioners for members identified by the ALERT algorithms.~~

~~M) Management of Special Health Care Needs (SHCN) populations~~

~~13)UHC LA personnel will be responsible for ensuring an assessment is completed on all members with Special Health Care Needs where service authorization is required.~~

~~14)Assessment will be completed within fourteen (14) calendar days of referral.~~

~~15)Annual recertification for services will be completed within 365 days of the most recent certification in order to assure that there is no lapse in service authorization or services to members who remain qualified.~~

~~16)UHC LA personnel will make service authorizations within five (5) business days following completion of the assessment/recertification where service authorization is required.~~

~~N) Mixed Services Protocol~~

~~13)UHC LA follows guidance in the Mixed Services Protocol to determine if UHC LA should managed under the behavioral health benefit when the service may be delivered by a medical or behavioral health provider, occurs in a medical or behavioral health setting, or is comprised of medical and behavioral health procedures.~~

~~O) Discharge Planning~~

~~13) Discharge planning focuses on a member's end-to-end experience by identifying opportunities to prevent the need for re-hospitalization and other out-of-home services.~~

~~14) Staff coordinates hospital and/or institutional discharge planning including after-care appointments following an inpatient, Psychiatric Residential Treatment Facility (PRTF), or other out-of-home stay, and assures that prior authorization for prescription coverage is addressed and or initiated before the member is discharged.~~

~~15) Prior authorization decisions are rendered before the member is discharged.~~

~~16) A Care Manager follows-up with the member within 72 hours of discharge.~~

~~17) Discharge is coordinated with the Department of Health and Hospitals, and other state agencies following an inpatient, PRTF, or other out-of-home stay. Coordination occurs timely when the member is not to return home.~~

~~18) Discharge of children and youth in out-of-home placement for the continuation of prescribed medication and other behavioral health services is coordinated with the Office of Juvenile Justice, Department of Children and Family Services, and schools prior to reentry into the community, including referral to necessary providers or a Wraparound Agency if indicated.~~

~~19) Staff collaborates with 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.~~

20) ~~Staff collaborates with jails and prisons in Louisiana to coordinate the discharge and transition of members involved in the justice system for the continuance of prescribed medication and other behavioral health services prior to reentry into the community, including referral to community providers.~~

21) ~~Staff collaborates with 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.~~

22) ~~Effective discharge planning includes the member, the current treating practitioner or facility, the practitioner or facility at the next level of care, and, as appropriate, the member's family, the Primary Physician, and relevant community resources.~~

23) ~~Discharge planning may consist of a number of related activities coordinated by Utilization Management staff, including:~~

a) ~~Ongoing person-centered treatment plan beginning with an assessment to identify areas of clinical need, personal resources, strengths and goals, and the most effective means by which these needs can be met;~~

b) ~~A plan of care will be developed by UHC LA personnel annually at a minimum and as needed for all members with a Special Health Care Need (SHCN). The plan of care will list all services and intensity of those services appropriate for the member. The POC will be inclusive of any required treatment plans. The POC will be integrated and will identify both physical and behavioral service needs. Additionally, the POC will include natural supports needed and referrals to other services.~~

c) Informing the member and, with the member's consent, the member's family, about the treatment process, beginning as early as possible and updating at regular intervals throughout a course of treatment or whenever a marked change occurs. This includes providing information pertaining to:

(I) The conditions that would result in the member's transfer to a lower or higher level of care;

(II) The alternatives to transfer to another level of care;

(III)The clinical basis for transfer to another level of care; and

(IV) The anticipated need for and length of continued care following transfer to another level of care;

24)Communicating, with the member's consent and in a timely manner, a discharge or transfer plan to the treating practitioner or facility at the next level of care and to the Primary Physician, as appropriate, that includes:

a) The care requested for the member;

b) The reason for transferring the member;

c) The member's bio-psychosocial status at the time of transfer;

d) A summary of the care and services provided to the member, as well as progress towards achieving the treatment goals; and

e) A list of the member's discharge medications, activity level, diet, and a list of other treating practitioners who are providing care to the member

25)Ensuring that the facility has scheduled for the member an outpatient appointment for follow-up care with an appropriately licensed outpatient practitioner within seven (7) days of discharge from the hospital, and, in the event that the facility has not done so, assisting the member, when necessary, with scheduling an appointment within seven (7) days of discharge;

~~26)Ensuring that the facility communicates a discharge or transfer plan to the treating practitioner or facility at the next level of care and to the Primary Physician, as appropriate;~~

~~27)Verifying post-discharge contact information for the member and/or representative;~~

~~28)Identifying ancillary resources that may further promote the member's recovery, such as transportation;~~

~~29)Ensuring that the facility develops a crisis plan and a medication adherence plan following discharge;~~

~~30)Providing relevant information to the member and, with the member's consent, the member's family, as to how to further the member's recovery;~~

~~31)Facilitating referral to Medical Case Management to meet medical health needs, as appropriate;~~

~~32)Assisting and coaching the member to engage in behavioral health services following discharge, as appropriate; and~~

~~33)Informing the member and the member's family, as appropriate, as to how to access additional community services, and coordinating services among community agencies as needed.~~

~~34)For members with Special Health Care Needs (SHCN), UHC LA personnel will conduct timely follow-up with members who miss appointments after discharge from a 24-hour facility.~~

~~P) Special Health Care Needs (SHCN) populations with behavioral health needs~~

~~13)A Plan of Care shall be developed by a UHC LA Care Advocate for this population annually at a minimum or as needed. The plan of care will list all services and intensity of those services appropriate for the individual. The Plan of Care serves as the basis of service authorization and shall be inclusive of all treatment plan elements requiring authorization by UHC LA. The Plan of Care shall be integrated and shall include natural supports needed and referrals to other services.~~

~~14)UHC LA will:~~

~~a) Ensure level of care evaluations/reevaluations and plans of care are developed timely and appropriately;~~

~~b) Ensure plans of care address members' assessed needs, health and safety risk factors, and personal goals and are consistent with the evaluation/assessment;~~

~~c) Ensure members are referred to service providers in accordance with freedom of choice requirement;~~

~~d) Ensure members receive services in accordance with their approved plan of care, including the type, scope, amount, duration, and frequency; and~~

~~e) Conduct timely follow-up with members who miss appointments or who are discharged from a 24-hour facility.~~

~~Q) Court-Ordered Treatment~~

~~13)In evaluating requests for court-order treatment services, UHC LA considers the member's acute symptoms and the precipitant for admission, the appropriateness of treatment, the terms of the member's benefit plan, the stipulations of the court order, and applicable state law.~~

~~14)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 UHC LA within Louisiana Medicaid's medical necessity definition and are subject to medical necessity review.~~

~~15)UHC LA personnel will coordinate with the court system and state child-serving agencies with regard to court- and agency-involved youth, to ensure that appropriate services can be accessed. This may include, but is not limited to, attending court proceedings at the request of DHH when there is a need to inform the court of available services and limitations, and participating in cross-agency staffing.~~

~~R) Emergency Medical Services and Prudent Layperson Considerations~~

~~13) UHC LA provides that emergency services, including those for specialized behavioral health, be rendered without the requirement of prior authorization. UHC LA covers and pays for emergency services regardless of whether the provider that furnishes the emergency services has a contract with UHC LA. If an emergency medical condition exists, UHC LA is obligated to pay for the emergency services.~~

~~14) UHC LA does not deny payment for treatment obtained when a member has an emergency medical condition[33], nor limit what constitutes an emergency behavioral health condition on the basis of behavioral health diagnoses or symptoms.~~

~~15) If a member seeks/sought benefit coverage for emergency room services without notifying UHC LA or obtaining pre-approval, believing a true emergency existed, benefit coverage for these services is not to be withheld.~~

~~16) If an authorized representative of the member or the health plan deems/deemed the situation to be/to have been urgent or emergent, benefit coverage for these services is not to be withheld.~~

~~17) The attending emergency physician, Licensed Mental Health Provider (LMHP), or the provider actually treating the member determines when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on UHC LA for coverage and payment.~~

~~a) This requirement does not apply to a disagreement concerning discharge or transfer following an inpatient admission once the member is stabilized.~~

~~[33] As defined in 42 CFR §438.114(a).~~

~~S) Out-of-Network (OON) Practitioners/Facilities~~ [34]

~~13) UHC LA personnel make referrals and authorizations to network practitioners and facilities; but a timely referral and an adequate authorization to a OON practitioner or facility may be considered when:~~

~~a) There is no network practitioner or facility that meets the clinical needs of the member within the appropriate geographic access standards;~~

~~b) There is no network practitioner or facility that can provide an appointment for the member within the required timeframe requirements for access to an appointment;~~

~~c) There is a clinical emergency, and there is no network practitioner or facility which can provide services for the member on an immediate basis;~~

~~d) Utilization Management staff determine that a member's clinical presentation requires a specialty practitioner or facility and there is no network practitioner or facility within the geographic access area with the appropriate clinical specialty; or~~

~~e) A specific treatment program at a network facility has not yet been included in the participation agreement with UHC LA.~~

~~14) All requests for authorization of services to non-contracted practitioners and facilities are to be approved by a senior leader of Clinical Operations or designee.~~

~~15) An admission to an inpatient level of care at an OON facility is to be reviewed based on clinical considerations to determine if it was due to an emergency, or if the member was unable to access inpatient services at a network facility.~~

~~a) UHC LA's policy is for the member to be transferred by ambulance to a network facility as soon as it is safe to do so.~~

~~[34] 42 CFR §438.52(b)(2)(ii), and §438.206 – *Availability of services.*~~

~~T) Member Protected Health Information (PHI)~~

~~13) Medical records and any other health and enrollment information that identifies a particular member are to be kept confidential[35].~~

~~14) UHC LA personnel are only to request enough clinical information to determine if the behavioral health diagnosis is accurate and can be supported by the current symptoms and behaviors displayed by the member.~~

~~15) The goal for obtaining clinical information is to have a comprehensive, overall understanding of the member's situation, as opposed to incident-specific detail, in order to make informed decisions that will produce safe and successful treatment outcomes.~~

~~16) Specific details regarding symptoms are pertinent in assessing risk factors and creating discharge plans that meet members' needs in a comprehensive manner.~~

~~17) Other pertinent information includes the nature of the symptoms, risk history, medications, response to current treatments and discharge planning.~~

~~U) Post-Service Reviews~~

~~13) Practitioners and members have up to 365 calendar days after the last date of service to file a claim for services or request a post-service (retrospective) review of services that have already been delivered and for which no claim was filed. Examples include:~~

~~a) A claim or a request for a review of services when there is no authorization on file;~~

~~b) A claim for services by an OON facility or practitioner under a benefit plan that does not require preauthorization, but that requires a clinical determination; and~~

~~[35] 42 CFR §438.224: *Confidentiality: Also see* §431 F and 45 CFR §160 and §164, subparts A & E, to the extent that these requirements are applicable.~~

c) A claim for services from an OON practitioner or facility when there are no OON benefits.

14) A request for services is to be processed as a non-urgent appeal/dispute review unless a non-coverage determination has been made, either through the CAC or the Claims Department.

15) Utilization Management staff conduct the initial post-service review and may authorize all of the care, if appropriate. However, if any part of the care cannot be authorized, a Peer Reviewer reviews the entire episode of care.

16) Practice of medicine requirements do not apply to retrospective reviews of services already provided.

V) Requirements for Notifications

13) Verbal and/or Electronic Notice of Coverage Determinations

a) When an immediate notice is required, the following information is provided verbally (as required by regulatory or other requirement) or by Secure Email (requests received through the provider portal):

(I) The date of the determination;

(II) The approval number, if applicable;

(III) The number of approved days, if applicable;

(IV) The date range of the approval, if applicable;

(V) The total number of days approved to date, if applicable; and

(VI) The date of admission or onset of services.

14) Any written notification is to be easily understood and made available in each prevalent non-English language, and in an appropriate format that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency[36].

[36] 42 CFR §438.10: Information Requirements.

~~15)Requirements for Written Authorization Notices~~

~~a) Written Authorization Notices are issued to the provider.[37]~~

~~b) The following elements are required for written notices of authorization for services:~~

~~(I) The authorization number;~~

~~(II) The type of service; and~~

~~(III)The date range of the authorization~~

~~16)Requirements for Written Non-Coverage Determination (NCD) Notices~~

~~a) The requesting provider must be notified and a written notice is issued to the member when UHC LA makes any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.[38]~~

~~b) The following elements are required for written NCD notices:~~

~~(I) The determination and the specific level of care or service that is being denied.~~

~~(II) A statement that the member can obtain the diagnosis and diagnostic code and description and the treatment (procedure) code and description upon request.~~

~~(III)The rationale for the determination:~~

~~(i) For a clinical Non-Coverage Determination the rationale is to cite the *Level of Care (LOC) Guidelines*, the *Psychological and Neuropsychological Testing Guidelines*, or other guideline required by contract or regulation, as appropriate, on which the non-coverage determination was based; and is to be written in language that is easily understandable to the member, and that addresses the member's specific clinical presentation.~~

~~[37] 42 CFR §438.210: Coverage and authorization of services~~
~~[38] 42 CFR §438.210 (c): Notice of adverse action.~~

~~(ii) For an administrative Non-Coverage Determination the rationale is to cite the appropriate section in the member's relevant plan documents on which the non-coverage determination was based.~~

~~(IV) Available Alternate Services (Clinical NCDs)~~

~~(i) A statement of alternative services that would be available and authorized.~~

~~(V) Information about requesting an appeal/grievance/dispute review~~

~~(i) A description and explanation of internal appeal/dispute rights, including urgent appeal/dispute rights, and any applicable time limits.~~

~~(ii) The member's rights to, and method for requesting, a State fair hearing to contest the denial, deferral or modification action;~~ [39]

~~(i) The member's right to represent himself/herself at the State hearing or to be represented by legal counsel, friend or other spokesperson;~~

~~(ii) Information about the member's right to have benefits continue pending resolution of an appeal or State fair hearing, how to request the continuation of benefits, and the circumstances under which the member may be required to pay the costs of continuing these benefits~~[40]~~.~~

~~(VI) A statement of the right of the treating practitioner, facility, member or authorized representative to submit written comments, documents or records relating to the claim or request.~~

[39] ~~42 CFR §438.404; Notice of action, §438.408 (f)~~
[40] ~~42 CFR §438.420~~

(VII) A statement of the right of the member, authorized representative and treating practitioner to request a copy, free of charge, of the relevant sections of the guidelines or the benefit plan provisions or other documents used in making the non-coverage determination;

(VIII) Information about the reviewer, including:

(i) The name and title (and for clinical NCDs), the credentials of the reviewer.

(ii) For clinical NCDs, the actual or an electronic copy of the signature of the clinical reviewer. For administrative NCDs, an actual or electronic signature of the reviewer is not required for the notice.

01. When it is not physically possible for the actual or electronic copy of the signature of the Peer Reviewer to be affixed to the NCD notice, it is permissible, with the agreement of the clinical reviewer, for a designee to sign for the reviewer.

W) Turnaround Time Requirements for Authorization and Non-Coverage Determinations[41]

13) The following tables outline the turnaround time and related requirements for processing requests for authorization of services Verbal and/or Electronic Notice of Coverage Determinations.

a) For facility cases, telephone contact with a facility representative is considered a proxy for providing verbal notice to the member.

[41] UHC LA may extend the timeframes for making standard and expedited decisions and issuing notice by up to 14 additional calendar days, if the member requests an extension, or UHC LA justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. See 42 CFR §438.210 (d) (2)(ii) Expedited authorization decisions & (1)(ii) Standard authorization decisions.

~~**Table 1A: Expedited Pre-Service Coverage Determinations (Authorizations)**~~[42]

~~**Process Component**~~	~~**TAT Requirement**~~	~~**When the Clock Starts**~~	~~**Required Recipients**~~
~~**Completion of Review and Determination**~~	~~As expeditiously as the member's health condition requires and, and in all cases **no later than 72 hours.**~~	~~From receipt of the request.~~	~~N/A~~
~~**Issuance of Written Notice**~~			~~• Treating practitioner • Facility~~

[42] ~~Medicaid allows three (3) business days for all urgent cases. See CFR § 438.210 (d)(2) Timeframe for decisions~~

~~**Table 1B: Expedited Pre-Service Non-Coverage Determinations (Denials)**~~

~~**Process Component**~~	~~**TAT Requirement**~~	~~**When the Clock Starts**~~	~~**Required Recipients**~~
~~**Completion of Review and Determination**~~	~~As expeditiously as the member's health condition requires, and in all cases **no later than 72 hours.**~~	~~From receipt of the request.~~	~~N/A~~
~~**Delivery of Verbal Notice (Required)**~~			~~• Treating practitioner • Facility • Member or authorized representative~~
~~**Issuance of Notice of Action**~~			

~~Table 1C: Post-Stabilization[43] - Authorizations and Actions (Denials)~~

~~Authorizations and Denials Process Component~~	~~TAT Requirement~~	~~When the Clock Starts~~	~~Required Recipients~~
~~**Completion of Review and Determination**~~	~~As expeditiously as the member's health condition requires and **no later than one (1) hour.**~~	~~From receipt of the request.~~	~~N/A~~
~~**Delivery of Verbal Notice (Required)**~~	~~**Immediately by telephone after the decision,** and **no later than one (1) hour from the request.**~~	~~From the decision.~~	~~• Requesting Provider~~
~~**Issuance of Written Notice or Notice of Action**~~	~~As expeditiously as the member's health condition requires and **within one (1) working day**.~~	~~From the initial notification by phone.~~	~~• Requesting Provider • Member or authorized representative~~

~~[43] 42 CFR §422.113(c): *Maintenance care and post-stabilization care services* (hereafter together referred to as "*post-stabilization care services*")~~

~~**Table 2A: Expedited Concurrent Coverage Determinations (Authorizations)**~~

~~**Process Component**~~	~~**TAT Requirement**~~	~~**When the Clock Starts**~~	~~**Required Recipients**~~
~~**Completion of Review and Determination**~~	~~**Within 72 hours.**~~	~~From receipt of the request.~~	~~N/A~~
~~**Delivery of Verbal Notice (as required by regulatory or other requirement) or by Secure Email when received through the provider portal (Required)**~~			~~• Treating practitioner • Facility~~
~~**Issuance of Written Notice**~~			~~• Treating practitioner • Facility~~

~~**Table 2B: Expedited Concurrent Non-Coverage Determinations (Denials)**~~

~~**Process Component**~~	~~**TAT Requirement**~~	~~**When the Clock Starts**~~	~~**Required Recipients**~~
~~**Completion of Review and Determination**~~	~~**Within 72 hours.**~~	~~From receipt of the request.~~	~~N/A~~
~~**Delivery of Verbal Notice (Required)**~~			~~• Treating practitioner • Facility~~
~~**Issuance of Notice of Action**~~			~~• Treating practitioner • Facility • Member or authorized representative~~

~~Table 3A: Standard Pre-Service and Concurrent Coverage Determinations – Outpatient (Authorizations)~~[44]

~~Process Component~~	~~TAT Requirement~~	~~When the Clock Starts~~	~~Required Recipients~~
~~Completion of Review and Determination~~	~~Within 14 calendar days.~~ • ~~80% of pre-service determinations are made within 2 business days of obtaining appropriate information.~~ • ~~95% of concurrent determinations are made within 1 business day of obtaining appropriate information.~~ • ~~99.5% of concurrent determinations are made within 2 business days of obtaining appropriate information.~~	~~14 Calendar Days: from receipt of the request.~~ ~~Other requirements are from receipt of appropriate information.~~	~~N/A~~
~~Delivery of Immediate Notice (Not Required)~~	~~N/A~~	~~N/A~~	~~N/A~~
~~Issuance of Written Notice (Open Authorizations)~~	~~Within 14 calendar days.~~	~~From receipt of the request.~~	• ~~Member or authorized representative~~
~~Issuance of Written Notice (Other than Open Authorizations)~~			• ~~Treating practitioner~~ • ~~Facility~~ • ~~Member or authorized representative~~

[44] ~~See 42 CFR §438.210(d)(1): Coverage and authorization of services~~

~~**Table 3B: Standard Pre-Service and Concurrent Non-Coverage Determinations (Denials)**~~

~~**Process Component**~~	~~**TAT Requirement**~~	~~**When the Clock Starts**~~	~~**Required Recipients**~~
~~**Completion of Review and Determination**~~	~~**Within 14 calendar days.**~~ • ~~80% of pre-service determinations are made within 2 business days of obtaining appropriate information.~~ • ~~95% of concurrent determinations are made within 1 business day of obtaining appropriate information.~~ • ~~99.5% of concurrent determinations are made within 2 business days of obtaining appropriate information.~~	~~14 Calendar Days: from receipt of the request.~~ ~~Other requirements are from receipt of appropriate information.~~	~~N/A~~
~~**Delivery of Verbal Notice (Not Required)**~~	~~N/A~~	~~N/A~~	~~N/A~~
~~**Issuance of Notice of Action**~~	~~**Within 14 calendar days.**~~	~~From receipt of the request.~~	• ~~Treating practitioner~~ • ~~Facility~~ • ~~Member or authorized representative~~

~~**Table 4A: Post-Service Coverage Determinations (Authorizations)**~~[45]

~~**Process Component**~~	~~**TAT Requirement**~~	~~**When the Clock Starts**~~	~~**Required Recipients**~~
~~**Completion of Review and Determination**~~	~~**Within 30 calendar days of receipt of information, but in no instance later than 180 days from the date of service.**~~	~~From receipt of information.~~	~~N/A~~
~~**Delivery of Immediate Notice (Not Required)**~~	~~N/A~~	~~N/A~~	~~N/A~~
~~**Issuance of Written Notice**~~	~~**Within 30 calendar days of receipt of information, but in no instance later than 180 days from the date of service.**~~	~~From receipt of information.~~	~~• Treating practitioner~~ ~~• Facility~~

[45] ~~42 CFR §438.210(d)(1) - Coverage and authorization of services~~

~~**Table 4B: Non-Urgent Post-Service Non-Coverage Determinations (Denials)**~~

~~Process Component~~	~~TAT Requirement~~	~~When the Clock Starts~~	~~Required Recipients~~
~~Completion of Review and Determination~~	~~Within 30 calendar days of receipt of information, but in no instance later than 180 days from the date of service.~~	~~From receipt of information.~~	~~N/A~~
~~Delivery of Verbal Notice (Not Required)~~	~~N/A~~	~~N/A~~	~~N/A~~
~~Issuance of Notice of Action~~	~~Within 30 calendar days of receipt of information, but in no instance later than 180 days from the date of service.~~	~~From receipt of information.~~	~~• Treating practitioner • Facility • Member or authorized representative~~

~~VI. RELATED POLICIES:~~

- ~~UHC Community Plan of Louisiana policy: Integration of Physical and Behavioral Health Utilization Management~~
- ~~UHC C&S-UBH Mixed Services Protocol~~