WORK PROCESS

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Administrative Denials
PAGE: 1 of 5	**REPLACES DOCUMENT:**
APPROVED DATE: 08/2016	**RETIRED:**
EFFECTIVE DATE: 08/2016	**REVIEWED/REVISED:** 03/17, 3/18, 7/18, 1/19, 1/20**, 7/20**
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.07.01

SCOPE:
Corporate and Health Plan Medical Management Departments.

PURPOSE:
The purpose of this document is to outline a process and guidelines for issuance of administrative denials.

All untimely requests for services and procedures and/or inpatient admissions should be reviewed for items such as events that substantially interfere with normal business operations such as pending or retroactive member eligibility, etc., **prior to issuing an administrative denial**. (See Corporate Qualifiers attachment.)

This does not apply to Emergent or Urgent Care, PPO Plan services or those services specifically exempt from prior authorization by contract, (i.e., family planning, etc.).

WORK PROCESS:

I. An administrative denial may be issued for non-clinical reasons based on:
   - **A.** Member ineligibility.
   - **B. Any request for a member that is enrolled in the Coordinated System of Care (CSoC) program**
     - **~~A.~~ i. The only exception is for a service that CSoC doesn't cover (i.e. Residential services); ~~and/or~~**
   - **~~B.~~C.** No clinical information received (symptoms and/or diagnoses are considered enough clinical information to conduct a review for medical necessity).
   - **~~C.~~D.** A request for services not submitted in a timely manner (per timeframes outlined in the Provider Manual).
   - **~~D.~~E.** A request for observation stay greater than 48 hours that does not convert to an acute inpatient admission. See further details below.
     i. The entire observation stay may not exceed 48 hours duration with the exception that we will not administratively deny any hours that result from coordination between the managed care organization (MCO) and the facility to provide additional medical services needed for a member prior to discharge in accordance with Health Plan Advisory (HPA) 18-9.

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F. A request from any Community Psychiatric Supportive Treatment (CPST)/Psychosocial Rehabilitation (PSR) provider that has not gone through the LHCC Plan credentialing process

i. Includes:

1. Any location that has not been credentialed

2. Any provider that is not licensed to provide the requested level of care (ACT 582)

G. Delay in Transition of Care/Discharge Planning (See Section V below)

H. Retrospective authorization request where a claim was previously submitted for same service and dates of services and denied for no authorization on file

i. The provider should file a claims dispute form, as this should be processed as a claims dispute/appeal

~~**E.**~~

II. Service and Procedure Untimely Notification Process:

A. If the provider requests authorization in less than the number of days outlined in the "Timeframes for Prior Authorization Requests and Notifications" section in the provider manual, but the request is still pre-service, the designee should ask if the request is **urgent**.

i. If the request is **urgent**, the designee will perform the review as expeditiously as possible, not to exceed the state's turnaround time for an urgent request, as outlined in state regulations. The designee will educate the provider and a decision will be made as quickly as possible, however, will not exceed the **urgent** turnaround time.

ii. If the request is **standard**, the designee will perform the review as expeditiously as possible, not to exceed the state's turnaround time for a **standard** request, as outlined in state regulations. The designee will educate the provider and a decision will be made as quickly as possible, however, will not exceed the **standard** turnaround time.

iii. If the procedure/service is scheduled before the allowed turnaround time and a determination has not been made, the provider should be advised to reschedule or risk the possibility of no payment or reimbursement.

III. Inpatient Untimely Notification Process:

A. If the provider requests authorization in less than the number of days outlined in the "Timeframes for Prior Authorization Requests and Notifications" section in the provider manual, and reasons for the

untimely request falls under one of the Corporate Qualifiers, all days must be reviewed for medical necessity through discharge.

B. If the request **does not meet** one of the Corporate Qualifiers, and the member is still inpatient, days **prior to notification** are not retrospectively reviewed, but are administratively denied, and medical necessity review applies to date of notification forward.

IV. Timely Notification Inpatient Admission – Post Discharge:

A. When a request is made for inpatient authorization and the member has been discharged, but the request is still within the required inpatient admission notification timeframe of **one (1) business day**, the designee will request the information needed and conduct a Level I Review. Post-service decision and notification timelines apply.

B. If an obstetrical admission is non-routine, requiring additional days of service, a Level I review is conducted on the additional dates of service and authorized as appropriate. If the member remains inpatient at the time of notification, urgent concurrent decision and notification timelines apply. If the member has been discharged at time of notification, post-service review decisions and notification timelines apply.

V. Delay in Transition of Care/Discharge Planning from an Inpatient Admission:

A. When a delay in transition of care or discharge planning occurs during an inpatient admission, and the cause of this delay is not Health Plan or coverage related, the Medical Director(s) may issue an Administrative Denial. This Administrative Denial would be for the concurrent days in which the member remains at an inappropriate level of care due to one or more of the following:

i. Facility administrative or operational delays that directly impact the ability of the Plan to facilitate transition of care or discharge planning from the current level of care

ii. Lack of a treatment plan or discharge plan which includes targeted goals and timelines

REFERENCES:
UM.05 – Timeliness of UM Decisions and Notifications
UM.07 – Adverse Determination (Denial) Notices
Current NCQA Health Plan Accreditation Standards
Provider Manual

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Louisiana Medicaid Hospital Services Provider Manual – Section 25.3
HPA 18-9
ACT 582

ATTACHMENTS:


Corporate Qualifiers
HIM.UM.07.01.docx

Corporate Qualifiers List


HPA18-9.pdf

HPA 18-9

DEFINITIONS:

REVISION LOG

REVISION	DATE
Added Delay in Transition of Care/Discharge Planning from an Inpatient Admission	03/17
No revisions	3/18
Updated to maintain compliance with the new LDH Common Hospital Observation Policy. These changes include increasing the allowed number of observation hours from 30-48 and also adding an exception to the administrative denial if the extension of observation hours is related to a health plan network/contracting issue in which a member is awaiting services for discharge that the health plan is unable to provide.	7/18
Deletion of "which are not eligible for the appeals process" from the Purpose section. Minor formatting changes.	1/19
Removed Certificate of Coverage	1/2020
Updated administrative denial issues for non-clinical reasons **Added ACT 582** **Added CSoC members**	**7/2020**
Clarified the retro claims section H	**6/2021**

WORK PROCESS APPROVAL

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The electronic approval retained in RSA Archer, ~~Centene's P&P management software,~~ is considered equivalent to an actual signature on paper.

~~Sr. VP, Population Health: Electronic Signature on File~~
~~Chief Medical Officer: Electronic Signature on File~~