POLICY AND PROCEDURE

POLICY NAME: Timeliness of Utilization Management~~UM~~ Decisions and Notifications	**POLICY ID:** LA.UM.05
BUSINESS UNIT: Louisiana Healthcare Connections	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 09/01/2011	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 09/13, 11/13, 1/14,11/14, 2/15, 5/15, 9/15, 5/16, 8/16, 5/17, 6/17, 5/18, 8/18, 9/18, 5/19, 8/19, 10/19, 08/20, 12/20, 3/22, 11/22, 12/22, 11/2023, 8/5/2024	
REGULATOR MOST RECENT APPROVAL DATE(S): Please refer to system of record – Archer	

POLICY STATEMENT:

All ~~a~~Areas and ~~d~~Departments within Centene Corporation and its subsidiaries must have written Policies and Procedures that address core business processes related to, among other things, compliance with laws and regulations, accreditation standards and/or contractual requirements.

PURPOSE:

The purpose of this policy is to promote utilization management (UM) decisions made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care.

SCOPE:

This policy applies to employees of the UM Department. This includes officers, directors, consultants, and temporary workers (collectively, the “Plan”).

DEFINITIONS:

24 hours: NCQA considers 24 hours to be equivalent to one (1) calendar day.

72 hours: NCQA considers 72 hours to be equivalent to three (3) calendar days.

Business Day: Monday, Tuesday, Wednesday, Thursday, and Friday, excluding ~~S~~state-designated holidays. In computing a period of time prescribed in business days, the date of the triggering act or event is not to be included. The last day of the period is to be included, unless it is a Saturday, a Sunday, or a ~~S~~state-designated holiday, in which event the period shall run until the end of the next day that falls on a business day.

Calendar Days: All seven (7) days of the week. Unless otherwise specified, the term “day” in the contract refers to calendar days. In computing a period of time prescribed in calendar days, the date of the triggering act or event is not to be included, and the last day of the period is to be included.

Concurrent ~~r~~Request: A request for coverage of medical care or services made while an enrollee is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Medical Advisor: MD or PhD member of the Medical Affairs Team.

Nonurgent ~~r~~Request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function and would not subject the enrollee to severe pain.

Preservice ~~r~~Request: A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.

Post ~~s~~Service ~~r~~Request: A request for coverage of medical care or services that have been received (e.g., retrospective review).

Time of Receipt: When the request is made to the Plan in accordance with reasonable filing procedures, regardless of whether the organization has all the information necessary to make the decision at the time of the request. Time of receipt for urgent requests does not have to occur during normal business hours, and the date/time of receipt is documented for all requests.

Urgent ~~r~~Request: A request for medical care or services where application of the time frame for making routine or non-life-threatening care determinations:

- Could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function, based on a prudent layperson's judgment, or
- Could seriously jeopardize the life, health or safety of the enrollee or others, due to the enrollee's psychological state, or
- In the opinion of a practitioner with knowledge of the enrollee's medical or behavioral condition, would subject the enrollee to adverse health consequences without the care or treatment that is the subject of the request.

POLICY:

The Plan service authorization process is consistent with 42 CFR §438.210 and state laws and regulations for initial and continuing authorization of services. The Plan has timelines in place for providers to notify the Plan of service requests and for the Plan to make UM decisions and notifications to the enrollee and provider. Timeframes apply to all UM decisions (i.e., approvals and denials) resulting from medical necessity review.

Reasonable attempts (minimum of one attempt) are made in all cases to obtain complete clinical information and the Plan may deny the request if all necessary information is not provided. Denials for lack of clinical information are not issued for any requests where insufficient information is received if at minimum, a diagnosis is included in the request (Model contract 2.12.3.6.1). The Plan ~~will~~ ~~is~~does 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 enrollee's health condition made by the provider~~.~~ (Model contract 2.12.6.3.2).

Louisiana Department of Health (LDH) ~~will~~ conducts random reviews to ensure that enrollees are receiving all notices in a timely manner.

PROCEDURE:

Timeliness of Provider Notification to Plan

For all pre-scheduled services requiring prior authorization, providers notify the Plan within seven (7) calendar days prior to the requested service date or as soon as need is identified.

Prior authorization is not required for emergent and post stabilization services.

Facilities are required to notify the Plan of all inpatient admissions within one (1) business day following the admission.

Once the enrollee's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required.

The Plan requires notification by the provider of obstetrical admissions exceeding ~~forty-eight (~~48~~)~~ hours after vaginal delivery or ~~ninety-six (~~96~~)~~ hours after caesarean section sections (MCO manual – Mother/Newborn/Nursery). ~~The Plan may deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for caesarean section. In this case, the Plan may only deny the portion of the claim related to the inpatient stay beyond forty-eight (48) hours for vaginal deliveries or ninety-six (96) hours for caesarean sections (MCO manual – Mother/Newborn/Nursery).~~

Timeliness of UM Decision Making and Notifications

All time frames are maximum time frames.~~;~~ UM decisions are made as expeditiously as the enrollee's health condition requires. Untimely service authorization constitutes a denial and thus an adverse action. Timeframes are based on the requirements of the accreditation body ((National Committee of Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC)) where state or contract requirements are either silent or less stringent.

~~Timeliness of notification is from the date when the Plan receives the request from the enrollee or the enrollee's authorized representative, even if the Plan does not have all the information necessary to make a decision, to the date when the notice was provided to the enrollee and practitioner, as applicable.~~

Reasonable attempts (minimum of one (1) attempt) are made in all cases to obtain complete clinical information; Plan~~s~~ may elect to make additional outreach attempts to obtain clinical information for urgent or complex requests, or to meet state requirements or business needs.

Administrative denials for lack of clinical information are not issued for any requests where insufficient information has been received if at minimum, a diagnosis is included with the request.

For denials due to insufficient clinical information, the decision is a medical necessity decision, and the denial notice must describe the specific information needed to make the decision (i.e., history and physical exam documentation, lab values, current nursing notes, etc.).

All notifications of UM decisions are documented in the clinical documentation system; if notification by telephone is provided, it includes the date and time of the notification, as well as who was notified of the decision.

- When verbally notifying the practitioner/provider of any approval, the UM designee gives the authorization number, authorization dates, number of units, and must recite the following "disclaimer":
    - "Authorization is not a guarantee of benefits or payment. Payment of benefits is subject to any subsequent review of medical information or records, patient's eligibility on the date the service is rendered and any other contractual provisions of the plan."

- When verbally notifying the enrollee or enrollee's representative, if voicemail is reached, the UM designee leaves a message using the following verbiage:
    - Hi, this is <insert name> from your health plan; your doctor sent in a request. We made a decision & I wanted you to know the outcome. You can call me back at xxx-xxx-xxxx, call enrollee services from 8 AM to 8 PM or follow up with your doctor to discuss this further. Thank you, have a great day!

~~The Plan documents the date when it receives the request, and the date of the decision notification, in the UM file. The request is received when it arrives at the organization, even if it is not received by the UM Department.~~

~~All types of requests received while the enrollee is receiving care may be reclassified as preservice or post service if the request does not meet the definition of "urgent." This includes a request to extend a course of treatment beyond the time period or number of treatments previously approved by the Plan. The request may be handled as a new request and decided within the time frame appropriate for the type of decision notification (i.e., preservice or post service).~~

~~The medical advisor and/or utilization manager clinical reviewer (UMCR) documents all relevant information related to the clinical decision in the authorization system. When notifying by telephone, the medical advisor and/or UMCR documents the date and time of the notification in the authorization system, as well as who was notified of the decision.~~

Standard / Non-~~u~~Urgent ~~d~~Decisions:

The Plan makes 80~~%~~ percent of standard service authorizations determinations within two (2) business days of obtaining appropriate medical information that is required regarding a proposed admission, procedure or service requiring a review determination, with the following exceptions (Model Contract 2.12.6.1.1):

- All inpatient hospital service authorizations for which the standard for determination is two (2) calendar days of obtaining appropriate documentation (Model Contract 2.12.6.1.1.1).
- Community Psychiatric Support Treatment (CPST) and Psychosocial Rehabilitation (PSR) services for which the standard for determination is within five (5) calendar days of obtaining appropriate documentation (Model Contract 2.12.6.1.1.2).
- The Plan makes all determinations for any behavioral health crisis services that require prior authorization as expeditiously as the enrollee's condition requires, but no later than one (1) calendar day after obtaining appropriate clinical documentation (Model Contract 2.12.6.1.1.3).
- All standard service authorization determinations are made no later than 14 calendar days following receipt of the request for service unless an extension is requested (Model Contract 2.12.6.1.2). The service authorization decision may be extended up to 14 additional calendar days if:
    - The enrollee, or the provider, requests the extension, or (Model Contract 2.12.6.1.3.1)
    - The Plan justifies (to LDH upon request) a need for additional information and how the extension is in the enrollee's interest (Model Contract 2.12.6.1.3.2, and 42 CFR §438.210(d)).

~~The service authorization decision may be extended up to 14 additional calendar days if:~~

- ~~The enrollee, or the provider, requests the extension, or (Model Contract 2.12.6.1.3.1)~~
- ~~The Plan justifies (to Louisiana Department of Health (LDH) upon request) a need for additional information and how the extension is in the enrollee's interest (Model Contract 2.12.6.1.3.2, and 42 CFR §438.210(d)).~~

In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), it may extend the nonurgent preservice and post service time frames once, for up to 15 calendar days, under the following conditions:

- Within 15 calendar days of a nonurgent preservice request, the Plan notifies the enrollee (or the enrollee's authorized representative) of the need for an extension and the expected date of the decision.

If a determination cannot be made due to lack of necessary information, the UM clinical reviewer~~UMCR~~ makes at least one documented attempt to obtain the additional information within the original time frame. If there is no response or continued lack of necessary information, a determination is made based on the available information.

Expedited / Urgent ~~d~~Decisions:

For expedited service authorization decisions where a provider indicates, or the Plan determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Plan makes an expedited authorization decision and provides notice as expeditiously as the enrollee's health

condition requires, but no later than 72 hours after receipt of the request for service (Model Contract 2.12.6.2.1). (42 CFR §438.210(d)).

- The Plan may extend the 72 hour time period by up to 14 calendar days if the enrollee requests the extension or if the Plan justifies to the State a need for additional information and how the extension is in the enrollee's best interest (Model Contract 2.12.6.2.2).

Urgent Concurrent dDecisions (Expedited Continued Stay):

An urgent concurrent review is a review of medical necessity, appropriateness of care, or level of care conducted during a patient's inpatient stay or course of treatment.

The Plan makes all concurrent review determination within one (1) calendar day of obtaining the appropriate medical information that is required (Model Contract 2.12.6.1.4), not to exceed 72 hours from the date of request (Model Contract 2.12.6.2.1).

Post-sService/Retrospective dDecisions

The Plan makes retrospective review decisions for services as outlined in LA.UM.05.01 Retrospective Review for Services Requiring Authorization.

Request for retrospective reviews are considered when prior authorization and/or notification to the Plan was not obtained due to extenuating circumstances related to the enrollee's presentation (i.e., enrollee was unconscious at presentation, enrollee did not have Medicaid card or otherwise indicate Medicaid coverage, services authorized by another payor who subsequently determined enrollee not eligible at time of service).

The Plan shall make retrospective review determinations within 30 calendar days of obtaining the results of any appropriate medical information that may be required, but in no instance later than 180 calendar days from the date of receipt of request for service authorization (Model Contract 2.12.6.3.1).

If the request lacks clinical information, the Plan may extend the post service time frame for up to 15 calendar days, under the following conditions:

- Before the end of the time frame, the Plan asks the enrollee or the enrollee's representative for the information necessary to make the decision, and
- The Plan gives the enrollee or the enrollee's authorized representative at least 45 calendar days to provide the information.
- The extension period, within which a decision must be made by the Plan, begins on the sooner of:
  - The date when the Plan receives the enrollee's response (even if not all the information is provided), or
  - The last date of the time period given to the enrollee to supply the information, even if no response is received from the enrollee or the enrollee's authorized representative.

The Plan may deny the request if it does not receive the information within the time frame, and the enrollee may appeal the denial.

Timeliness of Provider and/or Enrollee Notifications

Service Authorization aApprovals

For service authorization approval for a non-emergency admission, procedure or service, the Plan notifies the provider verbally or as expeditiously as the enrollee's health condition requires, but not more than one (1) business day of making the initial determination and provides written notification to the provider within two (2) business days of making the determination (Model Contract 2.12.6.4.1.1).

For service authorization approval for extended stay or additional services, the Plan 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 one (1) business day of making the initial determination and provides written notification to the provider within two (2) business days of making the determination (Model Contract 2.12.6.4.1.2).

Service Authorization dDenials

Enrollee Notification

The Plan notifies the enrollee, in writing using language that is easily understood by the enrollee, of determinations to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested (Model Contract 2.12.6.4.2.1).

Provider Notification

The Plan notifies the requesting provider of a determination to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. The Plan provides written notification to the provider rendering the service, whether a health care professional or facility or both, within two (2) business days of making the determination (Model Contract 2.12.6.4.2.2).

REFERENCES:
Louisiana Medicaid MCO Model Contract ~~MCO Model Contract~~
~~2.12.3.6.1~~
~~2.12.6.1-4~~
LA.UM.05.01 Retrospective Review for Services Requiring Authorization

NCQA Health Plan Standards and Guidelines UM 5: Timeliness of UM Decisions
42 CFR § 438.210 Coverage and Aauthorization of Sservices
Louisiana Medicaid MCO manual – Mother/Newborn/Nursery

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: Louisiana Revised Statute §46:460.54 applies to material changes for this policy.

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Various adjusts were made to include reference to the following 2013 NCQA elements: UM5, A1; UM5, B1; UM5, B2; UM5, A2, UM5, B2; UM5, A3; UM5; B3; UM5, A4, and UM5, B4. Changed statement referencing provider notification for Concurrent review decisions from “one working day” to “24 hours” Changed statement referencing provision of documentation confirmations for Concurrent review decisions from “working days” to “business days”	08/2013
Ad Hoc Review	PROCEDURE: A. Timeliness of Provider Notification to Plan Corrected sentence to read within seven (7) days instead of fourteen (14) For all pre-scheduled services requiring prior authorization, providers must notify the Plan within seven (7) days prior to the requested service date or as soon as need is identified. B. Timeliness of UM Decision Making and Notifications Corrected sentence to read a. Determinations for non-urgent prior authorization requests are made within two (2) business days of obtaining appropriate medical information that may be required regarding a proposed admission, procedure or service requiring a review determination. Standard service authorization determination will be made no later than fourteen (14) calendar days following receipt of the request for service unless an extension has been requested. (deleted 14 calendar days of receipt of the request) 2. Expedited / Urgent decisions: (deleted 48 hours) c. If additional information is necessary prior to issuing a determination, a one-time extension of up to fourteen (14) calendar days may be implemented if the member or provider requests an extension or the Plan justifies to DHH a need for additional information and the extension is in the member’s best interest.	09/2012
Ad Hoc Review	No Revisions	09/2013
Ad Hoc Review	Changed font and bold for clarification of needed information for Louisiana RFP	11/25/13
Ad Hoc Review	Added peer to peer process flow.	01/27/14
Ad Hoc Review	LA Procurement 2015 Policy Update	11/2014
Ad Hoc Review	Section B1C added: acting on behalf of the member and with the member’s written consent	02/23/15
Ad Hoc Review	Notification verbiage changed in section 1G to mirror the LA MCO RFP	05/27/15

Ad Hoc Review	Added reference to CCL 229 Added Behavioral Health Services to Scope	09/29/15
Ad Hoc Review	Added “Faxing of the determination letter will fulfill both obligations”. Changed “case manager” to “review nurse” Grammatical Changes Under Policy: Removed statement duplicated in Section B.1	05/24/16
Ad Hoc Review	Removed TAT goal Removed verbiage that was not NCQA compliant Changed statement referencing provider notification for Concurrent review notification from “24 hours” to “1 calendar day from receipt of request and not determination” Added NCQA definitions Removed retro notification verbiage that was not NCQA compliant Changed DHH to LDH	08/24/16
Ad Hoc Review	Grammatical Changes only	05/24/17
Ad Hoc Review	Updated to comply with LHCC reporting requirements	06/23/17
Ad Hoc Review	Grammatical Changes Changed Retro Decision and Notification timeframe from 30 days to 14 days Changed Appeals timeframe from 30 days to 60 days	05/24/18
Ad Hoc Review	Updated NCQA verbiage for notification to include the word “written” per most recent NCQA Standards Updated retro decision and notification time from 14 Days to 30 days per most recent NCQA Standards Updated urgent concurrent decision and notification timeframe from 24 hours to 72 hours or 3 calendar days per most recent NCQA standards. Updated RFP references	08/24/18
Ad Hoc Review	Informal Reconsideration / Peer to Peer, Section 5.e. removed. Removed reference to CCL.229	09/25/18
Ad Hoc Review	Added statement referencing requirements from RFP Amendment 11 regarding Informal Reconsiderations	05/29/19
Ad Hoc Review	Added notation related to new process for provider release of criteria and applicable timeframes as per new House Bill 424- Act 330 requirement Added reference to LA.UM.02.13 Tracking Disclosure of Medical Necessity Criteria Added reference to HB 424/Act 330	08/26/19
Ad Hoc Review	Changed review nurse to UM clinical review Removed verbiage regarding informal reconsideration Removed the HBA 424 as this is in LA.UM.02.13 Added NCQA verbiage Added TAT Chart with emphasis on stringency Added CPST/PSR TAT Removed the documentation of documenting all clinical received	10/24/19
Ad Hoc Review	Added timeframe applicable to all determinations Added attempts to request additional information Added language regarding administrative denial due to lack of information Changed RFP to Emergency Contract Changed specific NCQA standards to general Current NCQA Health Plan Standards and Guidelines Changed Medical Director to Medical Advisor Defined Medical Advisor	08/25/20
Ad Hoc Review	Add Inpatient Service determination Updated Concurrent Review determination Added Amendment #3 Reference Updated attached TAT Chart	12/30/20
Ad Hoc Review	Added turnaround time for BH crisis services from Emergency contract Amendment 11 Removed medical information from Emergency contract amendment 11	03/28/22
Ad Hoc Review	Updated Section B and grammatical changes Changed MM to PHCO	11/15/22

	Reformatted to new policy template	
Ad Hoc Review	Changed member to enrollee Updated verbiage and contract references Reformatted to latest Policy Template	12/20/22
Annual	Updated policy statement and scope. Added several definitions from contract. Updated section “Standard / Non-urgent decisions” with amendment 2 language from Model Contract 2.12.6.1.1.3. Removed Enrollee from notification requirements. Removed 2 incorrect contract references. Made enrollee contact attempts uniform at least one attempt. Reorganized policy for clarity. Ensure that all contract requirements are in the policy and referenced. Removed attachments as not necessary.	11/2023
Annual Review	Grammatical and formatting edits. Updated references. Added definitions for "Calendar days" & "Time of Receipt". Added clarifying details for Timeliness of UM Decision Making and Notifications. Removed details from Post-service/Retrospective decisions and referenced policy that details the process. Removed maternity claims language from “Timeliness of Provider Notification to Plan” section.	8/5/2024

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.