POLICY AND PROCEDURE

DEPARTMENT: Utilization Management	**DOCUMENT NAME**: Timeliness of UM Decisions and Notifications
PAGE: 1 of 14	**REPLACES DOCUMENT:** CC.MEDM.UM.05
APPROVED DATE: 3/21/02	**RETIRED:**
EFFECTIVE DATE: 3/21/02	**REVIEWED/REVISED:** 03/15; 08/15; 02/16; 05/2017; 12/27/2017; 1/30/2018; 2/22/2018
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER: IL.UM.05**

SCOPE: Corporate and Plan Medical Management Departments

PURPOSE:
To ensure utilization management (UM) decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care.

POLICY:
Centene Corporation and its subsidiary health plans have timelines in place for providers to notify the plan of a service request and for the health plan to make UM decisions and notifications to the member and provider. Timeframes apply to all UM decisions, *whether the request is based on benefits or medical necessity and whether they are approvals or denials*. Review by an appropriate practitioner (as outlined in the UM.04 - *Appropriate UM Professionals* policy) is not required for requests for medical services specifically excluded from the member's benefit plan, or exceed the limitations or restrictions outlined in the benefit plan.
All timeframes are based on the requirements of the accreditation body (NCQA or URAC) where State or contract requirements are either silent or less stringent.

PROCEDURE:
A. <u>Timeliness of Provider Notification to Plan</u>

- For all pre-scheduled services requiring prior authorization, providers must notify the plan within **fourteen (14) business days,** (or per contract requirements), prior to the requested service date.
- Prior authorization is *not required* for emergent or urgent care services.
- Post-stabilization services *do not require* authorization. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required.
- Facilities are required to notify the plan of all inpatient admissions within **one (1) business day** following the admission.

- Requests for prior authorization involving genetic testing or outpatient testing for drugs of abuse will be accepted up to five (5) business days after specimen collection. (See *CP.MP.89 – Genetic Testing* and *CP.MP.50 Outpatient Testing for Drugs of Abuse*.)

B. Timeliness of UM Decision Making and Notifications – All time-frames are maximum time-frames; UM decisions should be made as expeditiously as the member's health condition requires.

1. **Non-urgent, Pre-service Decisions** (standard service prior authorization):
   a. Determinations for non-urgent, pre-service prior authorization requests are made within **four (4) days** of receipt of the request.
   b. Time of receipt is when the request is made to the plan according to the plan's filing procedures, regardless of whether the plan has all the information necessary to make the decision *and whether the plan is open for business on the date the request is received.* The date/time of receipt is documented for all requests.
   c. If the plan is unable to make a decision due to matters beyond its control, it may extend the decision time-frame once, for up to an additional **four (4) days.**
      - Within four (4) days of the original request, the member or member's authorized representative is notified of the extension, the specific information that is needed, and the expected date the determination will be made.
   d. If a determination cannot be made due to lack of necessary information, the UM designee makes at least two (2) documented attempts to obtain the additional information within the original four (4) day timeframe.
      - If there is no response or continued lack of necessary information, a determination is made based on the available information.

    - Reasonable attempts are made in all cases to obtain complete clinical information. 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 (e.g. lab values, current nursing notes, etc.).
  - The member (or member's representative) and/or the requesting practitioner is notified of the denial within four (4) days of the original request.
  - The appeal process may be initiated at this time if desired.
  - The medical director and/or case manager documents all relevant information related to the clinical decision in the clinical documentation system.

e. If the request for authorization is *approved*, the case manager or designee notifies the requesting provider of the approval by telephone, fax, or email within **one (1) business day** after the decision is made, not to exceed the original four (4) day determination period.
  - When notifying by telephone, the medical director and/or case manager documents the date and time of the notification as well as who was notified of the decision, in the clinical documentation system.
  - Members may also be notified of authorization approvals as mandated by state contract requirement or business needs.
  - When verbally notifying a provider of an approval, staff will give the authorization number, authorization dates, and number of units and must recite the "disclaimer".
  - Following is the "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."

f. If the determination results in a *denial*, reduction or termination of coverage, the medical director or designee notifies the provider orally within **one (1) business day** after the decision is made.
   - A written or electronic notice of the decision, including reason, right to a peer-to-peer discussion, right to appeal and the appeal process, is issued to the treating practitioner, PCP, facility and member within three (3) calendar days of the verbal notification, not to exceed the original four (4) day determination period.
     - **Note**: Notification is sent to the member's PCP if the treating practitioner cannot be identified, or per state contract guidelines.

2. **Urgent Pre-service Decisions** (Expedited Prior Authorization):
   a. Determinations for urgent pre-service care are issued within **48 hours** of receiving the request for service.
   b. Time of receipt is when the request is made to the plan according to the plan's filing procedures, regardless of whether the plan has all the information necessary to make the decision. The date/time of receipt is documented for all requests.
   c. If additional information is necessary prior to issuing a determination, a one-time extension of up to 48 hours may be implemented.
      - Within 24 hours of receipt of the request, the plan notifies the member (or the member's authorized representative) and/or requesting provider of the need for an extension and the specific information necessary to make the decision. A specified time frame for submission of the additional information, of at least 48 hours, must be given.
      - The plan makes a decision within 48 hrs of receiving the additional information (even if the information is incomplete) or within 48 hrs of the end of the specified period given to supply

the additional information (even if no response is received), whichever is earlier.

- The plan may deny the request if all necessary information is not provided within this time-frame. The appeal process may be initiated at this time if desired.
    - Reasonable attempts are made in all cases to obtain complete clinical information. Administrative denials for lack of clinical information <u>are not issued</u> 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 (e.g. lab values, current nursing notes, etc.).

d. The medical director and/or case manager documents all relevant information related to the clinical decision in the clinical documentation system.

e. If the request is *approved*, the case manager or designee notifies the requesting provider of the decision by telephone, fax, or email within **one (1) business day** after the decision is made, not to exceed the original 48 hour determination period or subsequent extension.

- When notifying by telephone, the case manager documents the date and time of the notification in the clinical documentation system, as well as who was notified of the decision.
- Members may also be notified of authorization approvals, as mandated by state contract requirement or business needs.
- When verbally notifying a provider of an approval, staff will give the authorization number, authorization dates, number of units and must recite the "disclaimer".
- Following is the "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.*"

f. If the determination results in a *denial*, reduction or termination of an urgent pre-service request, the medical director or designee will notify the provider orally within **one (1) business day** of the determination not to exceed the original 48 hour determination period or subsequent extension.
   - A written or electronic notice of the decision is issued within three (3) calendar days after the oral notification, to the treating practitioner, PCP, facility, and member (or as dictated by state requirements), including reason, right to a peer-to-peer discussion, right to appeal and the appeal process.
     - **Note**: Notification is sent to the member's PCP if the treating physician cannot be identified, or per state contract guidelines.

3. **Urgent Concurrent** (Expedited Continued Stay):
   a. An urgent concurrent review is a request for services made while the member is in the process of receiving the care; typically associated with inpatient care or ongoing ambulatory care. Determinations for urgent concurrent continued stay review are issued within **24 hours** of receipt of the request for services.
   b. Time of receipt is when the request is made to the plan according to the plan's filing procedures, regardless of whether the plan has all the information necessary to make the decision. The date/time of receipt is documented for all requests. For concurrent care, the date/time of the ongoing review is documented.
   c. If the request to extend a course of ongoing ambulatory treatment beyond the period of time or number of treatments previously approved does not meet the definition of "urgent care", the request may be handled as a new request and be handled under the applicable time frame (i.e. pre-service or post-service request).
      - The plan considers the content of the request when determining if an outpatient concurrent request meets the definition of "urgent care", and determines whether applying non-urgent

time frames could lead to adverse health consequences for the member and/or cause an unnecessary disruption in care.

d. The plan may extend the timeframe for making urgent concurrent decisions in the following situations:
   - If the request to extend urgent concurrent care is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the plan may treat it as an urgent pre-service decision and make the decision within 48 hours.
   - If the request to approve additional days for urgent concurrent review is related to care *not previously approved by the plan* and the plan documents that it made at least one attempt and was unable to obtain needed clinical information within the initial 24 hours after the request for coverage of additional days, the plan has up to 48 hours to make the decision. The extension of up to 48 hours applies to the initial review only, not subsequent concurrent reviews.
     - o Reasonable attempts are made in all cases to obtain complete clinical information. Administrative denials for lack of clinical information <u>are not issued</u> 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 (e.g. lab values, current nursing notes, etc.).

e. The medical director and/or case manager documents all relevant information related to the clinical decision in the clinical documentation system.

f. If ongoing care is *approved*, the case manager or designee notifies the requesting provider of the decision by telephone, fax, or email within **24 hours** of the request.
   - When notifying by telephone, the case manager documents the date and time of the notification, along with who was notified of the decision, in the clinical documentation system.

- Members may also be notified of authorization approvals, as mandated by state contract requirement or business needs.
- When verbally notifying a provider of an approval, staff will give the authorization number, authorization dates, number of units and must recite the “disclaimer”.
- Following is the “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.”*

g. If the determination results in *denial*, reduction or termination of coverage, the medical director or designee notifies the provider orally within **24 hours** of the request.
- A written or electronic notification is issued within **three (3) calendar days** of the oral notification, to the treating practitioner, PCP, facility and member (or as dictated by state requirements), including reason, right to appeal and the appeal process.
    - **Note**: Notification is sent to the member’s PCP if the treating physician cannot be identified, or per state contract guidelines.

4. **Post-Service Decisions** (Retrospective Review):

a. The plan makes retrospective review decisions for services as outlined in *UM.05.01-Retrospective Review for Services Requiring Authorization* policy. Medical necessity post-service decisions and subsequent written member and provider notification occur no later than **30 calendar days** from receipt of the request.

b. If a determination cannot be made due to lack of necessary information, the case manager or designee makes at least two documented attempts to obtain the additional information within the original 30 calendar day timeframe. If there is no response or continued lack of necessary information, the member (or member’s representative), requesting provider and attending practitioner are notified of the denial decision in writing within 30 calendar days of

the original post-service request. The appeal process may be initiated at this time if desired.

- Reasonable attempts are made in all cases to obtain complete clinical information. Administrative denials for lack of clinical information <u>are not issued</u> 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 (e.g. lab values, current nursing notes, etc.).

5. **Notice of Action for Previously Approved Services**
   a. When a service request for ongoing treatment(s) for a previously approved service request is received, the plan reviews medical necessity criteria for the continuation and extent of these ongoing services (e.g. Rehab Therapy Services).
   b. If the determination results in a termination, suspension, or reduction of a previously approved treatment request, the medical director or designee notifies the member and provider in accordance with the notification standards as stated herein, and issue a written or electronic notification notice at least ten (10) calendar days before the intended action.

REFERENCES / ASSOCIATED PROCESSES:

UM.05.01 - Retrospective Review for Services Requiring Authorization
UM.07 – Adverse Determination (Denial) Letters
UM.08 – Appeal of UM Decisions
UM.15 – Oversight of Delegated Utilization Management
CC.MP.50 – Outpatient Testing for Drugs of Abuse
CC.MP.89 – Genetic Testing
Current NCQA Health Plan Standards and Guidelines
Code of Federal Regulations – 42CFR 438.210 (d)(1), 438.404

POLICY AND PROCEDURE

DEPARTMENT: Utilization Management	DOCUMENT NAME: Timeliness of UM Decisions and Notifications
PAGE: 10 of 14	**REPLACES DOCUMENT:** CC.MEDM.UM.05
APPROVED DATE: 3/21/02	**RETIRED:**
EFFECTIVE DATE: 3/21/02	**REVIEWED/REVISED:** 03/15; 08/15; 02/16; 05/2017; 12/27/2017; 1/30/2018; 2/22/2018
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER: IL.UM.05**

HFS MCO Contract 2018-24-001

ATTACHMENTS: N/A

DEFINITIONS:

24 hours: NCQA considers 24 hours to be equivalent to 1 calendar day

48 hours: NCQA considers 48 hours to be equivalent to 2 calendar days

Concurrent Review Decision: any review for an extension of previously approved ongoing course of treatment over a period of time or number of treatments. If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the plan does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service or post-service).

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part.

Medical Necessity: Covered services that are prescribed based on generally accepted medical practices in light of conditions at the time of treatment. Medically Necessary services are: appropriate and consistent with the diagnosis of the treating provider and the omission of such could adversely affect the member's medical condition; compatible with the standards of acceptable medical practice in the community; provided in a safe, appropriate, cost-effective setting given the nature of the diagnosis and severity of the symptoms; not provided solely for the convenience of the member, the physician, or the facility providing the care; those for which there are no other effective and more conservative or substantially less costly treatment, service or setting available.

Medical Necessity Determinations: A decision on services that are, or that could be considered, covered benefits.

Post-Stabilization Services: Covered services related to an Emergency Medical Condition, provided after a Member is stabilized, in order to maintain

the stabilized condition, or to improve or resolve the member's condition.

Post-service Decision: any review of care or services that have already been received (e.g., retrospective review).

Pre-service Decision: any case or service that the plan must approve, in part or in whole, in advance of a member obtaining medical care or services. Pre-authorization and pre-certification are pre-service decisions.

Prior Authorization: Authorization granted in advance of the rendering of a service after appropriate medical review. When related to an inpatient admission, this process may also be referred to as pre-certification.

Retrospective Review: the initial review for medical necessity of services delivered to a member, but for which authorization and/or timely plan notification was not obtained.

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 hrs.

Urgent Care: any request for care or treatment with respect to which the application of the time periods for making nonurgent care determinations:

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

A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the plan did not previously approve the earlier care.

REVISION LOG	**DATE**
Updated reference of NCQA for current year; Updated "1.e", "2.e" and "3.f" with appropriate approval and disclaimer info to give providers for verbal notification; Updated Product type from All to Medicaid (HIM/Medicare have own policies).	05/21/14

Removed revision history prior to 2010; Updated NCQA for 2015; Updated approver titles; Added "business" days to describe first bullet under "A.", "five (5) business days"; Added "or per contract requirements" under first bullet under "A."; Added "calendar" to "5.b.", "(10) calendar days"; Added "calendar" to description for "B.2.a.", "B.2.c.", "B.2.e.", "B.2.f.", "B.3.a, d, f and g." Added second bullet to "B.3.g."; Removed "Organization determination" from Definitions as it applies only to Medicare.	09/16/14
Removed revision history prior to 2012; Added "Requests for prior authorization involving genetic testing or outpatient testing for drugs of abuse will be accepted up to five (5) business days after specimen collection. (See *CP.MP.89 – Genetic Testing* and *CP.MP.50 Outpatient Testing for Drugs of Abuse*." under "A."; Added CP.MP.89 and CP.MP.50 to reference section; Updated approver titles.	03/12/15
Added "Timeframes apply to all UM decisions, *whether the request is based on benefits or medical necessity*. Review by an appropriate practitioner (as outlined in the CC.UM.04 *Appropriate UM Professionals* policy) is not required for requests for medical services that are specifically excluded from the member's benefit plan, or exceed the limitations or restrictions outlined in the benefit plan." under "Policy" section; Removed "of receipt of request" from "B.1.c"; Added "the specific information that is needed" under bullet under "B.1.c"; Added "Reasonable attempts are made in all cases to obtain complete clinical information. For requests based on medical necessity, a diagnosis alone is considered sufficient clinical information to make a decision. 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." under "B.1.d", "2.c", and "3.d"; Added "Members may also be notified of authorization approvals as mandated by state contract requirement or business needs" under "2.e"; Added "Note: Notification is sent to the member's PCP if the treating physician cannot be identified, or per state contract guidelines." under "B.1.f" and "B.2.f"; Added "The extension of up to 72 hours	3/31/15

applies to the initial review only, not subsequent concurrent reviews." under "3.d"; Updated approver titles.	
Annual review; changed the term "physician" to "practitioner" throughout; added clarifying detail under "Policy": "and whether they are approvals or denials"; removed from bullet B1c "Notification must be in writing and include the reason for the delay and members right to expedited grievance if they disagree with the extension"-notification does not have to be in writing per NCQA. Member grievance rights are more inclusive than stated. Incorporated NCQA definitions for 24 hrs. and 72 hrs. in definition section.	08/2015

Removed revision history prior to 2013, added clarifying language for timeframes in policy statement: "All timeframes are based on the requirements of the accreditation body (NCQA or URAC) where State or contract requirements are either silent or less stringent" and removed the language "(or based on the more stringent of plan, state or NCQA guidelines)" in multiple areas as this is outlined within the policy statement; removed "Timeliness of Behavioral Health UM Decision Making and Notifications: As included in the plan's benefit package, behavioral health services, including UM decisions regarding behavioral health and substance abuse services, may be subcontracted to a behavioral health provider (i.e. Cenpatico). (See *UM.15 – Oversight of Delegated Utilization Management*.)" as delegation does not impact timeliness of non-behavioral health decision making; updated approver titles	03/2016
Annual review; No substantive changes	05/2017
Revised timeframes to adhere to new contract requirements and added correct disclaimer	12/27/2017
Revised pre-scheduled services requiring prior authorization, providers must notify the plan within fourteen (14) business days. Was 5 business day as per Centene Corporates recommendation.	01/30/2018
Revised verbal fax notification time frame from 72 hour to 48 hours to mirror HFS Contract	02/22/2018

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Director Accreditation: Approval on File
Director, Medical Management: Approval on File