Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management	**Clinical Information for Utilization Management Reviews - Core Process**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
05/15/1996	02/28/2019	12/19/2019	12/19/2019
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Nevada	☐ Tennessee
☒ **Medicare/SNP**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☒ **MMP/Duals**	☐ Colorado	☒ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☐ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

To ensure receipt of relevant clinical information for timely Utilization Management (UM) decision-making and continuity of care and service through established contacts and defined processes with health care providers.

DEFINITIONS:

Appropriate Practitioner: A representative who makes utilization management decisions. Depending on the type of case, the reviewer may be a health plan Medical Director, or a physician, pharmacist, chiropractor, doctoral-level clinical psychologist, dentist or other licensed practitioner type as appropriate. Licensed health care professionals may include appropriately qualified practitioners in accordance with state laws.

Clinical information appropriate to each case includes, but is not limited to:

1) Office and/or hospital records
2) A history of the presenting problem
3) Clinical exam(s)
4) Results from diagnostic testing
5) Treatment plans and progress notes
6) Psychosocial history
7) Consultations with the treating practitioner(s)
8) Evaluations from other health care practitioners and providers
9) Photographs (MRIs, X-rays, Ultrasounds, ECGs, EEGs, etc.)
10) Laboratory results
11) Operative and pathological reports and results
12) Rehabilitation evaluations
13) Criteria related to request
14) Information regarding benefits for services and/or procedures
15) Information regarding the local delivery system
16) Member's characteristics and information

17) Information from responsible family member(s)
18) Member's safety issues

Expedited/Urgent Care/STAT Request: Any request for care or treatment with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances:

1) Could seriously jeopardize the life, health or safety of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
2) Could seriously jeopardize the life, health or safety of others due to the member's psychological state, or
3) In the case of a pregnant woman, could seriously jeopardize the life, health, or safety of the woman or fetus, or
4) 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. The practitioner must be allowed to act as the authorized representative of that member.

Practitioners request for services as "Urgent" or "STAT" will be processed as non-urgent if the request does not meet Urgent Care as defined above. If we receive requests marked urgent and determine in consultation with the provider that the request should be handled as non-urgent, we will process as non-urgent.

Insufficient Clinical Information: When a request for service(s) has been initiated; but the clinical associate or health plan Medical Director (or appropriate practitioner) is unable to render a fully informed medical necessity decision due to the provider not supplying the following:

1) Supporting clinical information, or
2) In the opinion of the clinical associate or health plan Medical Director (or appropriate practitioner), the clinical information supplied is incomplete.

Minimum Necessary Clinical Information: At a minimum, the provider must provide the diagnosis at the time of the request for pre-certification to be considered a valid request.

PROCEDURE:

The organization has a process for requesting clinical information from individuals identified by practitioners or their designees to ensure timely UM decision making and continuity of care and service for members, while avoiding unnecessary or excessive requests.

1) The health plan contacts appropriate individuals designated by the practitioner as a resource for the provision of routine clinical information. The clinical associate retains the right to contact the practitioner or their designee when a review may be unreasonably

delayed or the designated individual is unavailable or unable to supply the requested clinical information.

2) When conducting routine utilization reviews, the clinical associate generally requests only relevant clinical information to pre-certify the admission, procedure, treatment or length of stay and development of a discharge plan when appropriate. This includes identifying information about the member or the treating practitioner rendering care. It may also include clinical information, allowable by law or with permission, regarding diagnosis and treatment plan along with justification for the treatment plan. Second opinion information may be requested when applicable. This information should only be requested when relevant to the utilization review and should generally be obtained through established channels.
3) The clinical associate requires the practitioner to supply the minimum necessary clinical information for pre-certification to be considered. Practitioners are encouraged to supply numerically codified diagnoses or procedures, but are not required to do so for pre-certification.
4) The clinical associate may request copies of medical records for members if there is difficulty determining medical necessity, appropriateness of admission or length of stay in some instances. In those instances, only the necessary or pertinent clinical information is required. Medical records will be secured in accordance with the organization's security and privacy policies and will be retained in accordance with the corporate document retention schedule.
5) If there is "significant lack of agreement" between the health plan Medical Director (or appropriate practitioner) and the practitioner, additional information may be requested as part of the adverse determination and/or appeal processes. Attempts may also be made by the health plan Medical Director (or appropriate practitioner) to consult with the treating practitioner in instances of "significant lack of agreement."
6) The organization's policies and procedures are designed to share all clinical and demographic information on a particular case with appropriate internal departments to prevent duplication of requests.
7) The health plan does not require, as a condition of treatment approval or for any other reason, the observation of a psychotherapy session or the submission or review of a mental health therapist's process or progress notes. This does not preclude the health plan from requiring submission of a member's medical record.

Insufficient Clinical Information

The health plan's clinical associates and health plan Medical Directors (or appropriate practitioner) adhere to established National Committee for Quality Assurance (NCQA) time standards when rendering UM medical necessity decisions. The clinical associate or health plan Medical Director (or appropriate practitioner) retains the right to extend the time frames in certain circumstances such as lack of necessary clinical information. Note: where State or Federal time standards differ from NCQA, the more stringent time standard applies.

1) Urgent Pre-Service Requests – An initial decision is required, as expeditiously as the member's health condition requires and no later than seventy-two (72) hours or three (3) calendar days of receipt of the request. The time frame may be extended once up to fourteen (14) calendar days for the following reasons:
    a. The member requests the extension.
    b. For Medicaid, the health plan justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.
    c. For Medicare, the extension is justified and in the member's interest due to the need for additional clinical information from a non-contract provider.
    d. For Medicare, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the member's interest.

    The health plan may provide written, electronic, or oral notification of the decision to the member and the member's authorized representative no later than seventy-two (72) hours of receipt of the request. If oral notification was given, electronic or written denial notification must be provided no later than three (3) calendar days after the oral notification.

2) Urgent Concurrent Requests – An initial decision is required, as expeditiously as the member's health condition requires and no later than seventy-two (72) or three (3) calendar daysof receipt of the request. The time frame may be extended once up to fourteen (14) calendar days for the following reasons:
    a) The member requests the extension.
    b) For Medicaid, the health plan justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.
    c) For Medicare, the extension is justified and in the member's interest due to the need for additional clinical information from a non-contract provider.
    d) For Medicare, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the member's interest.

3) Non-Urgent Pre-Service Requests – An initial decision is required within fourteen (14) calendar days from the receipt of the request. The time frame may be extended once for up to fourteen (14) calendar days due to the following reasons:
    a) The member requests the extension.
    b) For Medicaid, the health plan justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.
    c) For Medicare, the extension is justified and in the member's interest due to the need for additional clinical information from a non-contract provider.
    d) For Medicare, the extension is justified due to extraordinary, exigent, or other non-routine circumstances and is in the member's interest.

    The health plan notifies the member or the practitioner, acting as the member's authorized representative, in writing of the reasons for the decision and inform the member of the

right to file an expedited appeal. The health plan must notify the member, as expeditiously as the member's health condition requires and not later than upon expiration of the extension.

Notification of the decision is made according to standard procedures and time standards.

4) Post-Service Requests (Retrospective) – An initial decision must be made within thirty (30) calendar days from the receipt of the request. The time frame may be extended once for up to fourteen (14) calendar days due to lack of necessary clinical information.
   a) The clinical associate notifies the member or the practitioner, acting as the member's authorized representative, within thirty (30) calendar days of the request of the specific clinical information needed to make the decision, the method of submission, and the time frame allowed for submission of the clinical information (at least forty-five (45) calendar days as per NCQA standards).
      i) The resulting decision must be made within fourteen (14) calendar days of either:
         (1) The date in which the requested clinical information is received (without regard to whether all of the requested clinical information is provided), or
         (2) At the end of the specified time frame to supply the clinical information, whichever comes first.
   b) Notification of the decision is made according to standard procedures and time standards.
5) Members or their authorized representative may voluntarily agree to extend the decision-making time frame for urgent pre-service, non-urgent pre-service and post-service decisions.

   In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), the organization may extend the non urgent preservice and post-service time frames once, for up to fourteen (14) calendar days. Within fourteen (14) calendar days of a preservice request or thirty (30) calendar days of a post-service request, the organization notifies the member (or the member's authorized representative) of the need for an extension, and the expected date of the decision.

   Members may also voluntarily agree to additional extensions of urgent pre-service, non-urgent pre-service and post-service decisions beyond the prescribed time frames previously described under the extensions for these categories.

6) The clinical associate ensures documentation (in the medical management system) of the medical necessity criteria elements that were not met according to the current criteria source and of the extensions granted. Note: Documentation of any extension must be evident or a decision must be rendered within the appropriate time frame.

7) All adverse determinations are rendered by the health plan Medical Director (or an appropriate practitioner as allowed by state law, contract, regulation, and accreditation requirements).
   a) If the health plan Medical Director (or appropriate practitioner) issues a denial due to lack of necessary clinical information and subsequently receives a phone call or the required clinical information prior to the issuance of the notice of action, the health plan Medical Director (or appropriate practitioner) who issued the initial denial may review the case with the new clinical information and over-turn the decision.
   b) If additional clinical information is received after the issuance of the notice of adverse determination, the practitioner would be notified to follow the reconsideration or appeal process per the notice of action.
      i) When the receipt of requested clinical information and over-turned decisions are not a result of the initial denial, the additional review does not fall under the scope of the National Committee for Quality Assurance (NCQA) appeal standards, but the case should be classified as a denial because the notice of action was issued.

REFERENCES:

42 CFR 438.210 Coverage and Authorization of Services
42 CFR §456.125; 42 CFR §438.210(b)(3); 42 CFR §438.210 (d)(2)(ii); CFR §438.404 (c)(5); 42 CFR §438.404 (c)(4) (i and ii); 42 CFR §456.111; 42 CFR §456.211
Kentucky Medicaid Management Care Contract § 21.1, 21.2, 21.3, 21.4
Kentucky Revised Statute 304.17A-607

Related Policies or Procedures
A02 Drug Use Evaluation
A08 Pharmacy Prior Authorization
CPP 101 Purpose and General Rules of the Privacy Policies CPP208 Safeguards
Clinical Information for Utilization Management Reviews – Core Process – LA
Health Care Management Denial - Core Process
Health Care Management Denial Core Process - KY

Prior Procedure Reference(s):
Insufficient Information for Clinical Review
Medical Information Received From Providers for Utilization Management Reviews - TN

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management

Secondary Department(s):

EXCEPTIONS:

The following states allow members to request prior authorization for services: Kentucky

Kentucky:
The health plan will provide the member written notice that meets the language and formatting requirements for member materials, of any adverse benefit determination with the timeframes for each type of adverse benefit determination pursuant to 42 CFR 438.210(d) and in compliance with 42 CFR 438.404 and other contract and regulatory provisions.

All Necessary Information is limited to the items listed in statute KRS 304.17A-607(1)(i):
- Results of any face-to-face clinical evaluation;
- Any second opinion that may be required; and
- Any other information determined by the department to be necessary to making a utilization review determination (current guidance 806 KAR 17:370 for attachments to a claim)

Non-Urgent Pre-Service Reviews: The health plan will make a determination and provide written notification to the member and provider as expeditiously as the member's health condition requires and no later than two (2) business days from receipt of request, with a possible extension of up to fourteen (14) additional days if the member or provider requests an extension, or if the health plan justifies, in writing, to the Department a need for additional information and how the extension is in the member's best interest. If an extension is taken by the health plan, written notice will be given to the member with the reason for the decision to extend the time frame and of the member's right to file a grievance if he or she disagrees with that decision; and carry out the determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Urgent Pre-Service Review: For cases in which a Provider indicates, or the health plan determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the health plan will make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than twenty-four (24) hours after obtaining all necessary information to make the utilization review decision per KRS 304.17A-607(1)(i). If all necessary information is not received, the health plan has up to 2 business days after receipt of the request for service to make the utilization review decision and provide notice per Kentucky Medicaid Managed Care Contract 21.3 (or 3 calendar days per NCQA, whichever is lesser).

The health plan will give notice on the date that the timeframes expire when service

authorization decisions not reached within the timeframes for either standard or expedited service authorizations.

Urgent Concurrent Review: The health plan will provide a utilization review decision and notification within 24 hours after obtaining all necessary information to make the utilization review decision.

Post-service Review: The health plan will make a determination and provide written notification within fourteen (14) calendar days of receipt of the request or, if the member or the provider requests an extension or the health plan justifies a need for additional information and how the extension is in the member's interest, may extend up to an additional fourteen (14) days.

Urgent health care services include all participating requests for hospitalization and outpatient surgery.

A failure to make a determination and provide written notice on a requested service within the required timeframes shall be deemed authorized.

A staff member that provides oral notification of a decision, documents the time and date notification occurred, and whom was notified.

If the denial is due to lack of clinical information and there is insufficient clinical information to reference a specific guideline or criterion (for a given condition, service request), the notification must state the inability to reference the most appropriate criteria, and must describe the information needed to render a decision in a manner specific enough for the member or member's authorized representative to understand what is needed.

A written notification in electronic format, including e-mail or facsimile, may suffice where the member or provider has agreed in advance in writing to receive such notices electronically.
The member and provider must be notified on all adverse determinations. The health plan will give notice on the date of the adverse benefit determination when the adverse benefit determination is a denial of payment.

In the event that a member or provider requests written confirmation of an approval, the health plan will provide written confirmation of its decision within three (3) working days of providing notification of a decision if the initial decision was not in writing. The written confirmation will be written in accordance with Member Rights and Responsibilities.

The Medical Director and Behavioral Health Director shall supervise the UM program and shall be accessible and available for consultation as needed. Decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a physician who is of the same specialty and subspecialty, when possible, as

the ordering provider, has appropriate clinical expertise in treating the Member's condition or disease and is consistent with state and federal regulations and state contracts

The Department shall provide a common Prior Authorization Form for all Contractors to utilize for a Provider to initiate its prior authorization process. The Contractor shall give the Provider the option to use the common form or the Contractor specific form. Kentucky health plan Medicaid's prior authorization process complies with the Kentucky Medicaid Managed Care Contract provisions. Kentucky health plan Medicaid's prior authorization process complies with the Kentucky Medicaid Managed Care Contract provisions.

REVISION HISTORY:

Review Date	Changes
11/01/13	• Off-cycle review to add Virginia as an applicable market. Add VA exception and move to MBU template.
01/01/14	• Added Kentucky health plan.
02/20/14	• Updates to MD exception.
04/02/14	• Annual/PPOC/MOC Review
10/01/14	• Off-cycle edits: VA exception
01/02/15	• Changes made to reflect LA 2015 contract language
03/06/15	• Updates made to reflect 2015 WA Apple Health Contract
07/15/15	• Annual review by PPOC and MOC. Remove LA as applicable market. Updates to references and exceptions sections.
12/03/15	• Off-cycle edit to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016. • Added Iowa exception language
03/10/16	• Administrative task. Transferred to Shared Services template. No content revisions made.
03/22/16	• Off-cycle edit to WA exception language
11/17/16	• Off-cycle edit to add KY exception language
12/01/16	• Off-cycle edits to add New York-Western as an applicable market and add NY-Western exception language.
01/03/17	• Annual review by PPOC and MOC • Added language under Urgent/Stat definition • Added language around post service timeframes • Revised References & Primary Departments • Revised IA, NJ, NY, TX, VA, WA exceptions
01/23/17	• Off-cycle edits to add IA contract reference and revise IA exception language

03/24/17	• Off-cycle edits to TX references and exception language for TX 19206 19207 UMCC and 1.3 STAR Kids contract amendment
05/30/17	• Off-cycle edit to add MMP as an applicable product
06/29/17	• Off-cycle edits to TX exception language
11/08/17	• Off-cycle edits to add IN as an applicable market, IN references and IN exception language.
02/02/18	• Annual review • Removed VA MMP as an applicable marked (termed) • Added "benefit" to "adverse determination" under #5 of Procedure section • Replaced references to Claims Payment System with Medical Management System in #6 - 8 of Insufficient Clinical Information Procedure section • Revised References section • Revised IA, TN & WA exception language
03/19/18	• Off-cycle edit to MD exception language
06/28/18	• Off-cycle edits • Revised Procedure, Definitions and References sections • Revised IN, KY, NJ, TX & WA exception language
08/10/18	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
01/25/19	• Off-cycle edit to add AR as an applicable market. No content edits.
02/28/19	• Annual review • Added DC as an applicable market; removed KS • Revised References section • Revised KY, MD, NJ, TN & VA exception language; removed MN exception language
03/07/19	• Off-cycle edit to TX exception language
04/02/19	• Off cycle review TX exception language updated
05/28/19	• Off cycle review • TX exception language updated
11/14/19	• Off Cycle Review • Updates made to TX exeption section and TX references to comply with UMCM, Senate Bill, TAC and TIC
12/19/19	• Off Cycle Edits • Added NC and SC as applicable markets • Update to procedure and references

	• Updates to FL, KY, VA, WA exception language