Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management - Utilization Management	**Pre-Certification of Requested Services - Core Process**

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
01/20/1996	07/05/2019	12/18/2019	12/18/2019

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:

This policy is also applicable to Medicare. Please see exceptions section for additional information.

To ensure that members are treated in the most appropriate, least restrictive, cost effective setting that is compatible with medical necessity, as determined by the severity of the illness and/or the intensity of the services needed to contribute to an improved health status relative to the specific condition.

The following services are subject to pre-certification:

1) Elective inpatient admission
2) Specialty procedures (the organization does not require pre-certification for specialty care emergency services for treatment of any immediately life-threatening medical condition.)
3) Non-emergent services rendered by an out-of-network practitioner or provider, with the exception of covered EPSDT services, covered family planning services and women's preventive health services, unless excluded by State or Federal requirements.

Please reference the appropriate resource help files on the HCM SharePoint Site for more specific authorization rules. (PLUTO, Code for Treatment Type Look-up)

DEFINITIONS:

Customer Care Representative (CCR)/Care Specialist: The Customer Care Representative/Care Specialist is responsible for responding to inquiries from members and practitioners to clarify benefits, providing member education and providing members health referrals. He or she documents pre-certification requests and arranges for services as identified by the Licensed UR Nurse and/or the Care Manager.

D-SNP: A Dual- Eligible Special Needs Plan for Medicare Advantage.

Expedited/Urgent Care/STAT Request: Any request for medical 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) Serious jeopardy to 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) Serious jeopardy to the life, health or safety of others based on a prudent layperson's judgment.
3) In the case of a pregnant woman, serious jeopardy to the life, health, or safety of the fetus, or
4) In the opinion of a practitioner with knowledge of a member's medical condition, subject the member to severe pain that cannot be adequately managed 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", "Expedited" or "STAT" are processed as non-urgent if the request does not meet Expedited/Urgent Care/STAT as defined above.

Licensed Professional for Behavioral Health: Behavioral health utilizes Licensed Professionals for Behavioral Health for day-to-day management of pre-certification activities. He or she manages member care ensuring essential, effective, appropriate and coordinated behavioral and physical health and social services.

Notification: Process by which a practitioner informs the organization that care either has or will be rendered; thereby, allowing the organization the opportunity to assess the member for Case or Disease Management services.

Nurse Coordinator: The Licensed UR Nurse (in National Customer Care - NCC) or other licensed professional for Behavioral Health (BH) is responsible for day-to-day management of pre-certification activities. He or she manages member care ensuring essential, effective, appropriate and coordinated behavioral and physical health and social services.

Practitioner: A licensed or certified professional who provides medical care or behavioral healthcare services.

Pre-certification: Process by which medical necessity criteria are applied to assure that proposed care is medically necessary and performed at the appropriate level of care.

PROCEDURE:

1) A non-clinician (CCR/Care Specialist in the NCC or UM Representative in HCM) receives a request for pre-certification via telephone, WebPortal or fax from a Primary Care Provider

(PCP), specialist or hospital.

2) The non-clinician (CCR/Care Specialist in the NCC or UM Representative in HCM) performs the following actions:
   a) Checks for Medicare/Medicaid sanctions, Medicare Opt Out Status on every request for an OON practitioner;
   b) Validates Medicaid/Medicare ID number on every request if indicated for OON practitioners;
   c) Verifies member eligibility, other health insurance (OHI) and benefits coverage;
   d) Creates the auth shell with appropriate documentation.
   e) The case may be routed to the Licensed UR Nurse or other licensed professional for Behavioral Health (BH), if indicated.

3) The Licensed UR Nurse or other licensed professional for BH performs the following actions:
   a) Obtains additional clinical information regarding the network affiliation of specialist, or the facility where the procedure is to be done;
   b) Determines the clinical appropriateness of the procedure based upon the appropriate medical necessity criteria, local delivery system and the individual member needs.
   c) Consults with the requesting practitioner based on the mode of communication the practitioner initiated the request, i.e., via telephonic or facsimile.
   d) If the above information meets the medical necessity criteria used by the organization, the Licensed UR Nurse or other licensed professional for BH updates the utilization management system, per documentation standards, and releases the reference number to the requesting (attending/treating) practitioner.
   e) If the information provided does not meet pre-certification due to the criteria below, the Licensed UR Nurse or other licensed professional for BH informs the requesting (attending/treating) practitioner that a decision is required by the health plan Medical Director, updates the utilization management system, per documentation standards, and forwards the pended case to the appropriate health plan for Medical Director review and determination.
      i) If meets a lower level of care, that care can offered. Authorization is approved if accepted. If not accepted, then pre-certification is sent to a peer for review,
      ii) Medical necessity is not established based on application of criteria against presenting clinical information,
      iii) Member may not be eligible for the proposed procedure, and/or it may not be a covered benefit,
      iv) The specialist or facility is out-of-network and the requesting (attending/treating) practitioner or member refuses re-direction to an in-network specialist or facility.

4) If a health condition is identified during the pre-certification process that is amenable to planning and coordination of services prior to admission (i.e., operative procedures, such as a total knee replacement), the Licensed UR Nurse or other licensed professional for BH documents the information so that the appropriate health plan can proactively coordinate services that enhance the availability of care needs during the post-hospitalization period.

5) Pre-certification requests that require different actions:
   a) Member not in system: Contact the Enrollment Area of Financial Operations to review the member's eligibility. Enrollment notifies the associate of the outcome. If the member is not enrolled with the organization, the requesting (attending/treating) practitioner is informed that the "member is not enrolled with the organization per the current enrollment information in the system." If the member is eligible, the Licensed UR Nurse or other licensed professional for BH completes the pre-certification process or administrative denial for no benefit or not eligible.
   b) Services are not covered: After review by the health plan Medical Director, the designated Health Care Management (HCM) associate at the health plan initiates the appropriate notification letter to inform the member and the requesting (attending/treating) practitioner. Refer to the Non-Covered and Cost Effective Alternative Services P&P.
   c) Benefits/Cap maximum met: After review by the health plan Medical Director, the designated HCM associate at the health plan initiates the appropriate notification letter to inform the member and requesting (attending/treating) practitioner.
   d) Services not clinically appropriate: After review by the health plan Medical Director and the requesting practitioner, whenever possible, if the services remain deemed not clinically appropriate, the health plan Medical Director denies the pre-certification, and the designated HCM associate initiates a coverage not medically necessary denial letter to the member and requesting (attending/treating) practitioner.
   e) Specialist/facility out-of-network: If there are specialists/facilities within GEO access and the member or provider refuses redirection to an in- network provider, then the request is sent for health plan Medical Director review. The health plan Medical Director reviews the pre-certification request and makes a decision to approve or disallow.
      - If the service is **approved**, the designated HCM associate completes the pre-certification. If the provider/facility accepts 100% of applicable Fee Schedule, then the authorization can be released. If the provider/facility does not accept 100% of applicable Fee Schedule, then the case must be routed to the appropriate department for a Single Case Agreement (SCA) – **Note**: the case can be released approved as medically necessary with the disclaimer that it is "Approved as medically necessary; however, pending rate negotiations, if services are rendered before rates are negotiated, the reimbursement will be at 100% of the applicable Fee Schedule".

- If the service is denied, the claims system is updated per standard denial process, and the designated HCM associate generates a denial letter for the requesting (attending/treating) practitioner and the member.

f) Services not available in-network: After review by the health plan Medical Director:
- If the outcome is that the specialist/facility is clinically appropriate and the provider/facility accepts 100% of applicable Fee Schedule, then the authorization can be released.
- If the outcome is that the specialist/facility is clinically appropriate and the provider/facility does not accept 100% of applicable Fee Schedule, then the case must be routed to the appropriate department for a Single Case Agreement. (SCA) – **Note**: the case can be released approved as medically necessary with the disclaimer that it is "Approved as medically necessary; however, pending rate negotiations, if services are rendered before rates are negotiated, the reimbursement will be at 100% of applicable Fee Schedule
- If the service is not clinically appropriate, the claims system is updated per standard denial process, and the health plan HCM associate initiates a denial letter to the requesting (attending/treating) practitioner and the member.

g) Other health insurance (OHI) discrepancy: The NCC or health plan associate obtains as much information about the OHI as offered by the requesting practitioner. If there is a discrepancy between the information on file in the claims payment system and the information provided with the pre-cert request; the associate notifies the Cost Containment Unit via email (ccuohi@amerigroupcorp.com) for review of member's OHI. The associate proceeds with processing the pre-certification request, regardless of the member's OHI, as long as the member is eligible with the organization.

h) One-time sick visit: The NCC associate determines the practitioner is in-network, documents the request as notification only and pre-certifies the one-time sick visit request.

i) Tonsillectomy with Adenoidectomy: The Licensed UR Nurse or health plan Medical Director determines the request meets medical necessity, pre-certifies the tonsillectomy to include the adenoidectomy. The adenoidectomy does not require medical necessity review.

j) Pre-certification Date Span: Pre-certification requests entered into the utilization management system are allowed extension of services up to six (6) months. If services are still required after the expiration of the precertification, the NCC or health plan associate enters a new precertification for services.

6) The NCC and health plan associate ensures the appropriate system is updated per documentation standards.

7) Pre-certification determinations are made according to the following National Committee for Quality Assurance (NCQA) time standards. Note where State or Federal times standards differ from NCQA; the more stringent time standard is applicable.
   a) Non-urgent pre-service decisions and notifications are made within fourteen (14) calendar days of receipt of the request; State and Federal specific timelines are listed under exceptions for the state.
   b) Precertification requests are required from the provider within 72 hours (at a minimum) before services are rendered. If it is requested after this time frame, the provider can be issued a failure to pre-cert denial.
   c) Urgent pre-service decisions and notifications are made within seventy-two (72) hours/three (3) calendar days of receipt of the request.
      i) The following criteria must be met to qualify for an urgent review: A member, or any physician (regardless of whether the physician is affiliated with the Health Plan), may request that the health plan expedite an organization determination when the member or his or her physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.
      ii) The following situations are examples of what do not meet criteria for an expedited/urgent/STAT request and are managed as non-urgent requests:
         (1) The date of service (DOS) is $\geq$ one (1) week from the request date
         (2) Any request for therapy (occupational, speech or physical therapy) > two (2) days from the request date.

8) There are certain circumstances under which the above standard timelines may be extended. Practitioners and members need to be notified when an extension is to be made. Unless the State or Federal mandates otherwise, standard extension timelines are detailed as follows:
   a) Pre-service urgent due to lack of necessary information: the organization may extend the time frame once for up to forty-eight (48) hours. Within twenty-four (24) hours of receipt of request, the organization must notify the member or authorized representative of what specific information is required to make the decision. The organization must specify the time period given to provide the information (at least forty-eight [48] hours). The decision must be made within forty-eight (48) hours of receiving information (even if the information is incomplete), or within forty-eight (48) hours of the specified time frame, whichever is earlier.
   b) Pre-service non-urgent due to lack of necessary clinical information/: the organization may extend the timeframe once for up to fourteen (14) calendar days. Within fourteen (14) calendar days of the request, the organization must notify the member or authorized representative what specific information is required to make the decision, unless the State or Federal mandates otherwise. The organization must specify the time period given to provide the information (at least forty-five [45]

calendar days). The fourteen (14)-day extension period within which a decision must be made begins on the date the information is received (even if the information is incomplete), or the end of the specific time period, if no response is received, whichever is earlier.

c) Pre-service non-urgent due to matters beyond the control of the organization (e.g. waiting for an evaluation by a specialist): the organization may extend the time frame once for up to fourteen (14) calendar days. Within fourteen (14) calendar days of the request, the organization must notify the member or authorized representative of the need for an extension and the expected date of the decision, unless the State or Federal mandates otherwise.

REFERENCES:

AR - Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Agreement, 01-02-19; For the Service Delivery Period March 1, 2019 through December 31, 2021
Federal Medicaid Managed Care Rule – 42 CFR 438.210(d); 42 CFR 440.230
Florida AHCA Contract # FP068
Florida Healthy Kids 2020-03 Medical Services and Coverage Contract
GA Families Contract §4.11.2
IA Health Link Contract 11.2.5.2
Healthy Indiana Plan, Sect. 9.3; Hoosier Care Connect, Sect. 7.3; Hoosier Healthwise, Sect. 6.3
Iowa Administrative Code 441-78.28(249), 441—79.8 (249A), 441—79.8 (1)
Iowa Medicaid Enterprise Policy Clarification # 000169
Kentucky Medicaid Managed Care Contract § 21.1, 21.2, 21.3, 21.4, 31.2
907 Kentucky Administrative Regulation (KAR) 1:479
Kentucky Revised Statute KRS 304.17A.600, 304.17A-005, 304.17A-603, 304.17A.607
MD - COMAR 10.09.71.04(A), COMAR 10.09. 71.04(C)
Minnesota Contract PMAP, MinnesotaCare, MSC+, and MSHO. January 2018.
MIPPA 2.A.b.6 (d)
MIPPA 2.A.b.6 (f)
NCQA Accreditation Standards and Guidelines
Nevada RFP 3260 3.13.3
New Jersey Managed Care Contract: 4.1.1.E, 4.6.4.B.1-4
NY MMC/FHPlus Model Contract Appendix F
Texas HHSC Uniform Managed Care Contract (UMCM), Uniform Managed Care Manual (UMCM) and Texas Medicaid Provider Procedures Manual
TX - 28 Tex.Admin.Code § 4201.301-304
VA – Commonwealth Coordinated Care Plus § 4.0 and § 6.0
VA - Virginia Medallion 4.0 and FAMIS Contracts, Section 8.2.N

Desktop Processes
Approval - Outpatient Authorization QRG
Approval - Post MDR Review Outpatient QRG
Expedited Requests – Outpatient QRG
De-Expedited - MA QRG
Denial - Outpatient Auth QRG
Denials DTP
HCM Precertification DTP
Pend to MD - Outpatient Authorizations QRG
Precertification of Unlisted Codes DTP
Single Case Agreement DTP

Prior Procedure Reference(s)
Prior Authorization of Requested Services

Related Policies and Procedures
A08 - Pharmacy Prior Authorization
Health Care Management Denial - Core Process
Health Care Management Denial Core Process – KY
Health Care Management Denial- TX
IN_UMXX_041 Pre-service Authorization of Services – IN
Non-Covered and Cost Effective Alternative Services
Out of Network Authorization Process
Pre-Certification of Outpatient Services - NY

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management - Utilization Management

Secondary Department(s):
Claims
Cost Containment Unit
Medicaid Enrollment and Billing
National Customer Care
Provider Services Organization

EXCEPTIONS:

Kentucky:

Health Care Service: means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed.

Medically Necessary or Medical Necessity: Covered Services which are medically necessary as defined under 907 KAR 3:130, meet national standards, if applicable, and provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

Medically Necessary Health Care Services: means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:
(a) In accordance with generally accepted standards of medical practice; and
(b) Clinically appropriate in terms of type, frequency, extent, and duration.

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)

Prospective review: means a utilization review that is conducted prior to the provision of health care services. Prospective review also includes any insurer's or agent's requirement that a covered person or provider notify the insurer or agent prior to providing a health care service, including but not limited to prior authorization, step therapy, preadmission review, pretreatment review, utilization, and case management.

Nurse Coordinator: The Licensed UR Nurse (in the National Customer Care - NCC or KY Health Plan) is responsible for day-to-day management of pre-certification activities. He or she manages member care ensuring essential, effective, appropriate and coordinated behavioral and physical health and social services.

The Department shall provide a common Prior Authorization Form for all Contractors to utilize for a provider to initiate the prior authorization process. The health plan gives the providers the common Prior Authorization Form to utilize. The health plan's prior authorization process complies with the provisions of the Kentucky Medicaid Managed Care Contract.
The health plan shall approve or deny a standard Prior Authorization request within two (2) business days. The timeframe for a standard authorization request may be extended up to fourteen (14) days if the Provider or Enrollee 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 Enrollee's best interest.

The health plan shall make Prior Authorization determinations in a timely and consistent manner so that Enrollees with comparable medical needs receive comparable and consistent levels, amounts, and duration of services as supported by the Enrollee's medical condition, records, and previous affirmative coverage decisions.
The health plan will not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the health plan or its designee for those services unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person, authorized person, or the provider.

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 Enrollee'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).

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 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 health plan must give notice by the date of the adverse benefit determination for the following:

1) In the death of a Member;
2) A signed written Member statement requesting service termination or giving information requiring termination or reduction of services (where he understands that this must be the result of supplying that information);
3) The Member's admission to an institution where he is ineligible for further services;
4) The Member's address is unknown and mail directed to him has no forwarding address;
5) The Member has been accepted for Medicaid services by another local jurisdiction;
6) The Member's physician prescribes the change in the level of medical care;
7) An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989;
8) The safety or health of individuals in the facility would be endangered, the Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Member's urgent medical needs, or a Member has not resided in the nursing facility for thirty (30) days.

The health plan must give notice on the date of the adverse benefit determination when the adverse benefit determination is a denial of payment.

The health plan will ensure direct access and may not restrict the choice of a qualified provider by a member for the following services within the health plan's provider network:

1) Primary care vision services, including the fitting of eye-glasses, provided by ophthalmologists, optometrists and opticians;
2) Primary care dental and oral surgery services and evaluations by orthodontists and prosthodontists;
3) Voluntary family planning in accordance with federal and state laws and judicial opinion;
4) Maternity care for Members under eighteen (18) years of age;
5) Immunizations to Members under twenty-one (21) years of age;
6) Sexually transmitted disease screening, evaluation and treatment;
7) Tuberculosis screening, evaluation and treatment;
8) Testing for Human Immunodeficiency Virus (HIV), HIV-related conditions, and other communicable diseases as defined by 902 KAR 2:020;
9) Chiropractic services;
10) For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, allow members to directly access a specialist as appropriate for the Member's condition and identified needs; and
11) Women's health specialists.

The health plan will ensure direct access and may not restrict a member's access to services in accordance with 42 CFR 438 and applicable state statutes and regulations.

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management - Utilization Management	**Pre-Certification of Requested Services - Core Process**

The health plan and its providers and subcontractors will not bill a member for Medically Necessary Covered Services with the exception of applicable co-pays or other cost sharing requirements provided under the Kentucky contract.

The Plan follows the requirements set forth in 907 KAR 1:479 Durable medical equipment covered benefits and reimbursement.

For up-to-date precertification requirements, providers are encouraged to utilize the list of services and codes for which preauthorization is required on the health plan's publically accessible website (https://mediproviders.anthem.com/ky/pages/precert.aspx). The Precertification Lookup Tool is available on the health plan's provider website. Precertification is also required for all services provided by nonparticipating providers.

The written precertification procedures are readily accessible on the health plan's website for providers at https://mediproviders.anthem.com/ky/pages/precert.aspx; a link to these procedures is provided to covered and authorized persons at https://mss.anthem.com/ky/care/referrals-preapprovals.html.

Precertification is not required for births or the inception of NICU services and shall not be required as a condition of payment. Continued hospital NICU stays require authorization.

REVISION HISTORY:

Review Date	Changes
01/01/14	• Added Kentucky health plan
04/01/14	• Added Wisconsin as applicable health plan and removed New Mexico. Added WI exception language.
04/17/14	• Added WA SNF language
07/28/14	• Added WA exception • NJ Contract Language Added
09/03/14	• Additional language added by NJ HP
10/05/14	• Off cycle edits to the VA exception
10/14/14	• Off cycle edits to the NY exception
01/15/15	• Annual Review. Exception language updated for WI, VA, TN, NJ, and MD. • Updated Primary department from HCMS to HCM
04/10/15	• Off Cycle Revisions to NV Exception
07/23/15	• Off Cycle Revisions to WA Exception
12/03/15	• Off-cycle edits to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016.

04/28/16	• Annual review by PPOC and MOC • Added definition of "practitioner" • Added clarifying language that requesting practitioner is attending/treating • Added 6bi under Procedures section – criteria for urgent review • Revised references section • Revised exception language for Medicare, TN D-SNP, KY, NY, VA, WA & WI • Added exception language for FL
10/27/16	• Annual review by PPOC and MOC • Added NY-Western as an applicable market • Process revisions; wordsmithing; references/DTPs added • Added IA exception language and revised TX, VA, WA exception language
12/01/16	• Off-cycle edits to add NY – Western and TX DCHP/Seton exception language.
12/29/16	• Off-cycle edits to TX contract reference and TX exception language
01/23/17	• Off-cycle edits to add IA contract reference and revise IA exception language
03/13/17	• Off-cycle edits to revise IA contract references and add 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
03/28/17	• Off cycle edits for WA Amendment #8
04/10/17	• Off-cycle edits to revise IA exception language
05/30/17	• Off-cycle edit to add MMP as an applicable product
06/26/17	• Off-cycle edits to TX exception language
09/07/17	• Off-cycle edits to IA exception language
12/29/17	• Annual review • Added IN as an applicable market • Revised definition of Customer Care Representative (CCR)/Care Specialist • Revised #1-2 of Procedure section • Revised References section • Revised exception language for IA, TN, TX, VA & WA; added exception language for IN
01/08/18	• Off-cycle edits to TX contract references and exception language
05/03/18	• Off-cycle edits to NV contract references and exception language

06/07/18	• FL Only - 2/1/18 - Reviewed prior to Utilization Management Committee vote to adopt in FL Simply/Amerigroup/Clear Health Alliance • Updated Plan name to reflect legal rebranding of Simply, Better and Amerigroup to Simply and separate branding for Clear Health Alliance as Simply Healthcare Plans, Inc. dba Clear Health Alliance • Edits to FL exception language • 2/16/18 - Adopted by FL Medicare Plan with no changes to policy language
07/26/18	• Early Annual review • Added definition of Licensed Professional for Behavioral Health; revised definition of Nurse Coordinator • Revised #1-5 of Procedures section • Revised References section • Revised IN, KY, MD, TX & WA exceptions
07/30/18	• Off-cycle edits to VA References and exception for VA 4.0 Medallion project
08/01/18	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
10/10/18	• Off cycle edits • Revisions to WA exceptions section per contract changes
01/25/19	• Off-cycle edits to add AR as an applicable market, add AR contract reference and exception language
02/07/19	• Off-cycle edit to NJ exception language
02/18/19	• Off-cycle edits to FL exception language update to reflect new FL Medicaid contract language; added Simply Florida Healthy Kids exception language; added Simply Medicare exception language • Added DC as an applicable market
4/08/19	• Off-cycle edits • TX exception language updated • FL exception language updated • Removed KS as applicable market
07/05/19	• Annual Review • Updated References • Updated GA, IN, KY, NV, TN, TX and WA exceptions
09/05/19	• Off-cycle Review • addition of federal statute language required as a follow-up action to the 2019 Florida Healthy Kids audit per post-audit report.

	• Off-cycle update to Florida Medicaid service level agreements language • Update to FL Reference • NV exception language updated
12/18/19	• Off-Cycle Review • Revised KY exception language