# AmeriHealth Caritas Family of Companies
# Medicaid Policy and Procedure

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| **Supersedes:** | State-specific ACFC Health Plan versions of this policy | **Policy Number:** | UM.010 |
| **Subject:** | **Decision Response Time** | | |
| **Department(s):** | Utilization Management | **Current Effective Date:** | 07/2024 |
| | | **Last Review Date:** | 06/2024 |
| | | **Original Effective Date:** | 07/01/2022 |
| | | **Next Review Date:** | 07/2025 |

**Applicable Lines of Business:**

☒**100**: Keystone First
☒ **500/530/540/550**: AmeriHealth Caritas Pennsylvania
☒ **2100**: AmeriHealth Caritas Louisiana
☒ **2400**: Select Health of South Carolina
☒ **2600**: Blue Cross Complete
☒ **5400/5410**: AmeriHealth Caritas District Of Columbia
☒ **6400:** AmeriHealth Caritas Florida
☒ **7100**: AmeriHealth Caritas Delaware
☒ **7200:** Community HealthChoices (KFCHC, ACPCHC)
☒ **900**: AmeriHealth Caritas New Hampshire
☒ **1200:** AmeriHealth Caritas North Carolina
☒ **7700:** AmeriHealth Caritas Ohio

**Scope**
This policy applies to the following AmeriHealth Caritas Family of Companies (ACFC) business operations.

Member is defined as enrollee, participant,recipient or beneficiary.

As necessary to comply with local state regulations, the contents of this policy may be copied into a stand-alone document for a specific business operation.

**Purpose**
To ensure a consistent process for making and communicating utilization management determinations in accordance with applicable statutory, regulatory, contractual, and accreditation timeliness requirements.

**Policy**
ACFC will make and communicate utilization management determinations in accordance with applicable statutory, regulatory, contractual, and accreditation requirements and as outlined in the state specific attachments.

The Plan shall retain documents relating to PHI for 10 years in accordance with Policy 591.001 *Records Retention Policy & Schedule* unless otherwise required to retain such documentation for a longer period of time under applicable law or regulation.

All information with PHI is handled in accordance with Policy 168.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data* and related policies listed in the Related Procedures section, unless otherwise required by Law or regulation.

**Definitions**
N/A

**Procedure**

1. The Utilization Management (UM) Department will render and communicate determinations within the timeframes described in the State specific addenda.

2. The timeframe for an Urgent or Non-Urgent Prior Authorization determination may be extended for an addition fourteen (14) calendar days (or as outlined in state specific requirements and documented in the state specific addenda) if the Enrollee, Practitioner, Provider or Enrollee's authorized representative requests an extension, or if AmeriHealth justifies the need for additional information and that the extension is in the Enrollee's best interest.

    a. UM staff will notify the Practitioner/Provider and Enrollee in writing of the additional information needed to facilitate the decision and will include in the information to the enrollee that he/she has the right to file a grievance if he/she disagrees with the decision to extend the authorization determination timeframe.
    b. At the discretion of the UM staff person, or upon request by the Practitioner/Provider or Enrollee, a description of the necessary information and the process for submission will be communicated verbally and in writing.
    c. The final determination shall be carried out as expeditiously as the enrollee's health condition requires and no later than the date on which the extension expires.

3. ACFC shall send notification to the enrollee and provider at least 10 days in advance of the effective date for any terminated, suspended, or reduced services previously authorized, except as permitted under 42 CFR §431.213 and 431.214, or as applicable under state regulation.

4. The approval notification and the authorization number are provided to the requesting Practitioner/Provider by telephone, fax, or voice mail. Notification will include type of service approved, total number of units/days authorized and the authorization period.

5. Untimely Pre-Service Non-Urgent Authorization or Urgent/Expedited Prior Authorization constitute an Adverse Benefit Determination, except where specified under state regulation or contract, and ACFC treats these as appealable adverse actions (42 CFR §§ 438.404 and 438.210). An Adverse Benefit Determination is also issued if a determination or need for an extension is not communicated to the provider within the required timeframe.

6. In the event of a determination to deny, suspend, or reduce an admission, service, procedure, or extension of stay based on Medical Necessity, or to approve a service in an amount, duration, or scope that is less than requested:
    a. The requesting Practitioner/Provider is offered the ability to have the determination reconsidered through the Peer-to-Peer process (see Policy UM.105, *Peer to Peer Discussion*)

b. The Enrollee, requesting Practitioner/Provider and/or facility receive written notification in accordance with Policy UM.017, *Notification of Adverse Determination*.

**Related Policies**
See also - Policy 168.235 *HIPAA Privacy Definitions*
See also - Policy UM.001 *Glossary of Terms*
See also - Policy UM.017 *Notification of Adverse Benefit Determination*
See also - Policy UM.105 *Peer to Peer Discussion*
See also - Policy 168.200 *Authorization to Use or Disclose PHI*
See also - Policy 168.212 *Facsimile Machines and Transmission of Protected Health Information*
See also - Policy 168.213 *Safeguards to Avoid Unauthorized Use or Disclosure of Protected Health Information, Personally Identifiable Information, and/or Certain Sensitive Demographic Data*
See also - Policy 168.227 *Use and Disclosure of Protected Health Information without Member Consent or Authorization*
See also - Policy 591.001 *Records Retention Policy & Schedule*

**Source Documents & References**
MCO Standards for Accreditation - National Committee for Quality Assurance (NCQA), Utilization Management Standards

**Attachments**
A: State/Plan specific addenda <hyperling to addenda>

**Approved by**

**Vanessa Johnson**
**Vice President, Utilization Management Operations**
**Date: July 2, 2024**

**Lenaye Lawyer, MD**
**Vice President, Medical Affairs**
**Date: July 2, 2024**

| Revision Date | Revision |
|---|---|
| 7/2023 | Annual review: No changes to the policies scope or intent. |
| 06/2024 | Annual Review , minor changes to clarify additional information guideline |
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**AmeriHealth Caritas Family of Companies**

**Medicaid Policy Addendum**

**Territory:** Louisiana

**Addendum Number:** UM-A.010.LA

**Subject:** Decision Response Time

**Department(s):** Utilization Management

**Current Effective Date:** 11/12/2024

**Last Review Date:** 11/12/2024

**Original Effective Date:** 01/01/2023

**Next Review Date:** 11/2025

**Table 1: AmeriHealth Caritas Louisiana Decision and Notification Timeframe**

| Case Type | Decision | Initial Notification | Written Confirmation |
|---|---|---|---|
| Expedited Prior Authorization (Pre- Service) | As expeditiously as the member's health requires, no later than 72 hours from receipt of the request; or no later than 14 calendar days for requested extensions | As expeditiously as the member's health requires, no later than 72 hours from receipt of the request. Or no later than 14 calendar days for requested extensions. | Within the earlier of 2 business days from the decision or 72 hours of the request. Or no later than 14 calendar days for requested extensions |
| Non-Urgent Prior Authorization (Pre- Service) | 80% of requests:<br>Within 2 business days of receiving the necessary documentation; all inpatient hospital authorizations within 2 calendar days of obtaining appropriate medical documentation; or 14 calendar days (CD) from receipt of the request. Or no later than 28 CD for requested extensions information | As expeditiously as the member's health requires, no later than 1 business day of making the decision | Within the earlier of 2 business days from the decision or 14 calendar days of the request. Or no later than 28 CD for requested extensions |
| Community Psychiatric Supportive Treatment and Psychosocial Rehabilitation Services | All within 5 (five) calendar days of receiving appropriate documentation or 14 calendar days from receipt of the request | As expeditiously as the member's health requires, no later than 1 business day of making the decision | Within the earlier of 5 calendar days from the decision or 14 calendar days of the request |
| Behavioral Health Crisis Services | Determinations for any behavioral health crisis services that require prior authorization are to be made as expeditiously as the Enrollee's condition requires, but no later than one (1) calendar day after | As expeditiously as the member's health requires, no later than 1 business day of making the decision | All within 1 calendar day of obtaining the appropriate documentation |

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| | obtaining appropriate clinical documentation.<br><br>* ACLA shall perform Timely authorization, if required, for crisis services in order to minimize wait time before those services can commence and to assure the efficient operation of the crisis system of care. * | | |
| Urgent Concurrent Review | All within 1 calendar day of obtaining the appropriate medical information | All within 1 calendar day of making the decision | All within 2 business days of making the decision |
| Retrospective Review | 30 calendar days from receipt of the request but in no instance later than 180 days from the date of receipt of request for Service Authorization; retro-enrolled into the plan – no later than 365 days from date of service | Within 30 calendar days from receipt of the request but in no instance later than 180 days from the date of receipt of request for Service Authorization. | Within 30 calendar days from receipt of the request but in no instance later than 180 days from the date of receipt of request for Service Authorization |
| Psychiatric Residential Treatment Facility (PRTF) Admission | Within 48 hours of completion of the screen | 48 hours | 48 hours from receipt of request to provider and member |

*ACLA requires both Standard and Urgent (Pre-Service) Prior Authorization determinations be made within state mandated time frames from receipt of the request according to the LA Department of Health contract and federal regulations (42 CFR 438.404 and 438.210). In no instance will any determination on a Non-Urgent Prior Authorization request be made later than the mandated time frames by LDH.

**Reference/Resource:**
Louisiana Department of Health. Louisiana Medicaid Managed Care Organization Attachment A: Model Contract, Amendment 2. Section 2.12.6; 2.9.25.18.

**Approved By:**

Rodney Wise, MD.

Rodney Wise, M.D
Market Chief Medical Officer (CMO)
Date

Loretta Dumontet, MD

Loretta Dumontet, MD
Behavioral Health Medical Director
Date

**Revision Table**

| | | |
|---|---|---|
| 11/21/2022 | Contract Update | Base policy with plan addenda that specifies contractual requirements<br>Updated policy retention timeframe from 7 to 10 years<br><br>Added statement: "ACLA shall perform Timely authorization, if required, for crisis services in order to minimize wait time before those services can commence and to assure the efficient operation of the crisis system of care."<br><br>Urgent prior auth updated to expedited prior auth<br><br>Non-urgent prior authorization initial notification updated to within 1 business day of making the decision<br><br>CPST decision updated to within 5 calendar days of receiving **appropriate information**<br><br>Urgent concurrent initial notification updated to within 1 cd of making the decision; written notification - within 2BD of making the decision<br><br>Retrospective review- decision made 30 CD from receipt of the request but in no instance later than 180 days **from the date of receipt of request for service authorization**; initial and written notification- no later than 180 days from receipt of request for service auth. |
| 6/6/2023 | Contract Update | Transitioned policy from UM.010 Timeliness of UM Decision plan policy to corporate base policy UM.010 Decision Response Time with state specific addendum to meet plan requirement.<br><br>Update Behavioral Health Crisis Services decision timeframe to state: "All determinations for any behavioral health crisis services that require Prior Authorization are to be made as expeditiously as the Enrollee's condition requires, but no later than one (1) calendar day after obtaining appropriate clinical documentation." |
| 10/22/2024 | Annual Review | Removed ACFC Corporate Privacy policy; included in base. |