POLICY AND PROCEDURE

POLICY NAME: Clinical Information and Documentation	**POLICY ID:** LA.UM.06
BUSINESS UNIT: Louisiana Healthcare Connections	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 09/01/2011	**PRODUCT(S):** Medicaid
REVIEWED/REVISED DATE: 10/12, 11/13, 01/14, 11/14, 8/15, 8/16, 8/17, 7/18, 6/19, 4/20, 2/21, 3/22, 12/~~01/~~22, 01/23, 11/~~20~~23, 8/~~16/20~~24, 06/~~12/20~~25, 04/~~08/20~~26	
REGULATOR MOST RECENT APPROVAL DATE(S): Please refer to system of record – Archer	

POLICY STATEMENT:

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

PURPOSE:

The purpose of this policy and procedure is to ensure that utilization management (UM) decisions are based on relevant clinical information, appropriately documented and securely maintained.

SCOPE:

This policy applies to employees of Louisiana Healthcare Connections in the UM Department. This includes officers, directors, consultants, and temporary workers (collectively, the "Plan").

DEFINITIONS: N/A

POLICY:

The Plan requires prior authorization for those procedures and services which have either a significant financial or quality of care impact that can be favorably influenced by the authorization.

For physical and behavioral ~~medical~~health services determined to require a referral, prior authorization, and/or certification, the Plan gathers clinical information and only the minimally necessary information required to make a decision is obtained. The information required is not overly burdensome for the enrollee, the practitioner/employee, or the health care facility employees. Clinical information received, as well as rationale for the medical necessity determination and/or leveling of care is documented and maintained in the clinical documentation system.

All medical record information used to make a decision, is attached to the enrollee's record in the clinical documentation system to allow for recreation of the decision-making processes of the enrollee case, utilizing the actual information that was reviewed.

Denial files contain clinical information appropriate to each case. The relevance of clinical information is considered in terms of the criteria used by the Plan to make its decision (i.e., the clinical information is related to the criteria stated in the denial notice as not met). If enough clinical information relevant to the criteria is not provided with the request, the Plan documents in the denial file its attempts to gather the clinical information needed to make a decision.

PROCEDURE:

Information for UM Decision Making

Each request for authorization requires collection of relevant information for consideration. Information from any reasonably reliable source that assists in the certification process ~~are~~ is accepted. Basic information needed to perform the review may include, as applicable, but is not limited to, the following information: (Model Contract 2.12.1.2.5)

- Identification of the enrollee (name, date of birth, enrollee identification, address, etc.) (Model Contract 2.12.1.2.5.1).
- Specific order or referral for services if requesting outpatient (OP) services.
- Office and hospital records.
- Enrollee's admitting/treating physician (Model Contract 2.12.1.2.5.2).
- Date of admission, and dates of application for and authorization of Louisiana Medicaid Program benefits if application is made after admission (Model Contract 2.12.1.2.5.3).
- Justification of emergency admission if applicable (Model Contract 2.12.1.2.5.7).
- A history of the presenting problem.

- Physical~~Clinical~~ or mental status exam.
- Diagnostic testing results.
- Treatment plans and progress notes per 42 CFR §456.80 and §456.180 (Model Contract 2.12.1.2.5.4).
- Initial and subsequent continued stay review dates described under 42 CFR. §456.128, §456.133, §456.233 and §456.234 (Model Contract 2.12.1.2.5.5).
- Enrollee psychosocial history or assessment/situation.
- Information on consultations with the treating practitioner.
- Evaluations from other healthcare practitioners and providers.
- Photographs
- Criteria related to the request (i.e., level of care utilization system (LOCUS), child and adolescent level of care utilization system (CALOCUS), or other level of care assessment).
- Physical or behavioral health screenings and results.
- Date of operating room reservation, if applicable (Model Contract 2.12.1.2.5.6).
- Operative and pathological reports.
- Rehabilitation evaluations.
- Printed copy of criteria related to the request.
- Information regarding benefits for service or procedure.
- Information regarding the local delivery system available to the enrollee that could include:
    - Availability of alternative levels of care (intensive outpatient (IOP), OP detoxification programs, residential) in the service area to support the enrollee after discharge from an acute hospitalization.
    - Benefit coverage for alternative levels of care (i.e., IOP, OP detoxification, or residential) where needed.
    - The ability of the treatment team to provide all recommended services within the estimated length of stay.

~~Enrollee characteristics and information.~~

    - Information from responsible family enrollees.
- Patient characteristics and information (i.e., age, medical, behavioral, and substance abuse co-morbidities, complications, etc.).
- Information from responsible family enrollees.
- Diagnosis codes

The Plan is responsible for eliciting pertinent health record information from the treating health care provider(s), as needed and/or as requested by the Louisiana Department of Health (LDH), for purposes of making service authorization determinations (Model Contract 2.12.3.6.1.1).

Only the section of the medical record necessary to certify medical necessity or appropriateness of the requested care or service is required. The process to be followed in the event the Plan determines the need for additional information not initially requested (Model Contract 2.12.3.6.2), ~~A~~is additional medical records are only requested when criteria have not been met or there is difficulty in making the UM determination ~~(Model Contract 2.12.3.6.2)~~.

To avoid duplicate requests for information on individual enrollees, clinical and demographic information is located in the clinical documentation system, in order to be accessed by all clinical and administrative employees with proper authority to view the information and that have a 'need to know'.

Documentation of Information

UM clinical reviewers request clinical information applicable to the case and document it and clinical criteria rationale used to make the decision in the clinical documentation system. The Plan takes appropriate action when a treating health care provider does not provide complete medical history information within the requested timeframe (Model Contract 2.12.3.6.1.2). If a determination cannot be made due to lack of necessary information, the UM clinical reviewers document their attempts to obtain the additional information. In cases where the provider or enrollee will not release necessary information, the Plan may deny authorization of the requested service(s). ~~(Model Contract 2.12.3.6.1.2).~~

Secure Medical Records

In alignment with applicable compliance and security policies, records containing confidential and proprietary information are securely maintained, controlled, and protected to prevent unauthorized access.

Medical records include but are not limited to, information created or received in any form including emails, paper documents, electronic documents, database, or application information and/or other electronic or photographic media received by the UM Department for utilization and care management (CM) processes.

Hard copy medical records mailed/faxed to the Plan for purposes of ~~utilization~~UM or CM~~care management~~ are scanned and attached to the applicable authorization, case, or referral file in the clinical documentation system within 48 hours of receipt.

REFERENCES:
Louisiana Medicaid MCO Model Contract:
2.12 Utilization Management
NCQA Health Plan Standards and Guidelines UM 6: Clinical Information
42 CFR §456 Utilization Control
42 CFR §456.80 Individual Written Plan of Care
42 CFR §456.128 Initial Continued Stay Review Date
42 CFR §456.133 Subsequent Continued Stay Review Dates
42 CFR §456.180 Individual Written Plan of Care
42 CFR §456.233 Initial Continued Stay Review Date
42 CFR §456.234 Subsequent Continues Stay Review Dates
42 CFR § 485.721 Condition of participation: Clinical records.
CC.UM.06 Clinical Information and Documentation

ATTACHMENTS: N/A

ROLES & RESPONSIBILITIES: N/A

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

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Ad Hoc Review	Language added to comply with Louisiana state contractual requirements	11/2013
Annual Review	Updated for NCQA 2013 Guidelines	01/2014
Ad Hoc Review	LA Procurement 2015 Policy Update, update references to reflect LA policies	11/2014
Annual Review	Updated NCQA date to current	08/24/15
Annual Review	Removed referral and definition	08/24/16
Annual Review	Updated what is needed within the clinical information and updating medical director asking for additional information.	08/24/17
Annual Review	No Revisions	07/24/18
Annual Review	Grammatical changes Changed Clinical Authorization System and Clinical Documentation System (CDS) to TruCare® Changed Medical Director to Medical Advisor Changed UM Staff to UM Clinical Reviewers (CRs) and UM designee to UM Clinical Reviewer (CR) Removed LA.UM.06.02 UM Documentation in TruCare® Notes from References Changed Product Type to Medicaid	06/24/19
Annual Review	Removed Corporate Authorization List section as removed from corporate policy Renumbering sections Changed providers will not to providers will be required to provide numerical diagnosis codes Changed RFP to Emergency Contract Added Secure Medical Records section	04/24/20
Annual Review	Format change Added required documentation from Emergency contract section 8.1.23	02/25/21

Annual Review	No changes	03/28/22
Ad Hoc Review	Changed MM to PHCO Changed member to enrollee Updated contract language and references Reformatted to new policy template	12/01/22
Annual Review	Replaced TruCare with clinical documentation system; updated Functional Area to Utilization Management; updated Reference Section Clarifying time on secure medical records item 3	01/13/23
Annual Review	Updated Policy statement and Scope, style guide changes, removed incorrect references, added information under local delivery system, replaced medical management with UM, updated regulatory reporting requirement,	11/2023
Annual Review	Grammatical and formatting edits. Updated references. Added additional language to the “Date of admission” bullet under the Procedure section to align with contract section Model Contract 2.12.1.2.5.3. Removed PA list sentence from Policy section because it is referenced in LA.UM.01.	8/16/2024
Annual Review	Under the Information for UM Decision Making section added a bullet for diagnosis codes. Removed the section Onsite Facility Reviews. Under the Documentation of Information section removed the 2 business days timeframe.	06/12/2025
Annual Review	Under the Policy section updated the information to include physical and behavioral health services & that the plan gathers clinical information required to make a decision. Under the Policy section added information about denial files & the clinical information it contains. Under the Information for UM Decision Making section updated clinical to physical status exam and removed enrollee characteristics and information. Updated contract citations to match contract language directly. Updated references.	04/08/2026

POLICY AND PROCEDURE APPROVAL

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