Section (Primary Department) **Health Care Management – Utilization Management**		**SUBJECT (Document Title)** **Clinical Information for Utilization Review – LA**	
Effective Date June 8, 2015	**Date of Last Review** ~~July 6, 2021~~ July 18~~ne 9,~~ 2022	**Date of Last Revision** ~~July 6, 2021~~ July 18, 2022	**Dept. Approval Date** ~~July 6, 2021~~July 18, 2022
Department Approval/Signature :			

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

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

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.

Healthy Blue shall have written procedures listing the information required from a member or healthcare provider in order to make medical necessity determinations. Such procedures shall be given verbally to the member or provider when requested. The procedures shall outline the process to be followed in the event Healthy Blue determines the need for additional information not initially requested, and address the failure or inability of a provider or member to provide all the necessary information for review.

Members may submit, whether oral or in writing, a service authorization request for the provision of services. This process is included in the member handbook and incorporated in the grievance procedures.

DEFINITIONS:

** Denotes terms for which Healthy Blue must use the State-developed definition.*

Clinical Information – Information about a member's medical history or condition obtained directly or indirectly from a licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility. Clinical information includes, but is not limited to:

- Office and/or hospital records;
- A history of the presenting problem;
- Clinical exam(s);

- Results from diagnostic testing;
- Treatment plans and progress notes;
- Psychosocial history;
- Consultations with the treating practitioner(s);
- Evaluations from other health care practitioners and providers;
- Photographs (MRIs, X-rays, Ultrasounds, ECGs, EEGs, etc.);
- Laboratory results;
- Operative and pathological reports and results;
- Rehabilitation evaluations;
- Criteria related to request;
- Information regarding benefits for services and/or procedures;
- Information regarding the local delivery system;
- Member's characteristics and information;
- Information from responsible family member(s);
- Member's safety issues; and
- Diagnosis codes

Expedited/Urgent/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 life or health or ability to attain, maintain, or regain maximum function[DJ1], ~~the life, health, or safety of the member or the member's ability to regain maximum function,~~ based on a prudent layperson's judgment;
2) Could seriously jeopardize the life, health, or safety of others due to the member's psychological state;
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.

NOTE: Services requested as "Urgent" or "STAT" will be processed as non-urgent if the request does not meet Expedited/Urgent/STAT 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, it will be processed 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 qualified 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 qualified practitioner), the clinical information supplied is incomplete.

Medical Record – A single complete record kept at the site of the member's treatment(s), which documents medical or allied goods and services, including, but not limited to, outpatient and emergency medical health care services whether provided by Healthy Blue, its subcontractor, or any out-of-network providers. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR §456.111 and §456.211.

Minimum Necessary Clinical Information – At a minimum, the provider must provide the diagnosis at the time of the request for it to be considered a valid request.

Qualified Practitioner* – A physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law. Other health care practitioner includes any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician[DJ2] assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician. ~~An appropriately qualified practitioner who makes utilization management medical necessity denial decisions. Depending on the type of case, the qualified reviewer may be a physician, pharmacist, chiropractor, clinical psychologist, dentist, nurse practitioner, physical therapist, or other licensed and qualified practitioner type as appropriate.~~ Licensed health care professionals will include appropriately qualified practitioners in accordance with state laws. Only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease shall determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. The individuals who make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the Medical Director or other qualified and trained professionals.

Urgent Care* – Medical care provided for a condition that without timely treatment, could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily function, or cause the development of a chronic illness or need for a more complex treatment. Examples of conditions that require urgent care include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, and suspected

fracture. Urgent care requires timely face-to-face medical attention within twenty-four (24) hours of member notification of the existence of an urgent condition.

Utilization Management (UM) – Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. UM is inclusive of utilization review and service authorization.

Utilization Review (UR) – Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review.

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 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 UR and should generally be obtained through established channels.
3) The clinical associate requires the practitioner to supply the minimum necessary clinical information for certification to be considered. Practitioners are encouraged to supply numerically codified diagnoses or procedures, but are not required to do so for precertification.
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 security and privacy policies and retained in accordance with the retention schedule.

5) If there is "significant lack of agreement" between the Medical Director (or qualified practitioner) and the provider, additional information may be requested as part of the adverse determination and/or appeal processes. Attempts may also be made by the Medical Director (or qualified practitioner) to consult with the treating practitioner in instances of "significant lack of agreement."
6) Healthy Blue'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) Healthy Blue 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.
8) In accordance with 42 CFR §456.111 and §456.211, each member's record must include information needed to perform UR. This information must include, at least, the following:
    a) Identification of the enrollee;
    b) The name of the enrollee's physician;
    c) Physician's orders for requested service(s);
    d) Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;
    e) The plan of care required under 42 CFR §456.80 and §456.180;
    f) Initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133, §456.233 and §456.234;
    g) Date of operating room reservation, if applicable; and
    h) Justification of emergency admission, if applicable.
9) Healthy Blue ensures medical records:
    a) Are accurate and legible;
    b) Are safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all members evaluated or treated, and is accessible for review and audit;
    c) Are readily available for review and provide medical and other clinical data required for Quality and UM review;
    d) Include, minimally, the following:
        i) Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);
        ii) Primary language spoken by the member and any translation needs;
        iii) Services provided, date of service, service site, and name of service provider;
        iv) Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by Health Blue;
        v) Referrals including follow-up and outcome of referrals;

vi) Documentation of emergency and/or after-hours encounters and follow-up;
vii) Signed and dated consent forms (as applicable);
viii) Documentation of immunization status;
ix) Documentation of advance directives, as appropriate;
x) Documentation of each visit must include:
  (1) Date and begin and end times of service;
  (2) Chief complaint or purpose of the visit;
  (3) Diagnoses or medical impression;
  (4) Objective findings;
  (5) Patient assessment findings;
  (6) Studies ordered and results of those studies (e.g., laboratory, X-ray, EKG);
  (7) Medications prescribed;
  (8) Health education provided;
  (9) Name and credentials of the provider rendering services (e.g. MD, DO, OD) and the signature or initials of the provider; and
  (10) Initials of providers must be identified with correlating signatures.
xi) Documentation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements include but are not limited to:
  (1) Comprehensive health history;
  (2) Developmental history;
  (3) Unclothed physical exam;
  (4) Vision, hearing, and dental screening;
  (5) Appropriate immunizations;
  (6) Appropriate lab testing including mandatory lead screening; and
  (7) Health education and anticipatory guidance.

10) Healthy Blue is required to provide one (1) free copy of any part of a member's record upon the member's request.
11) All documentation and/or records maintained by Healthy Blue, its subcontractors, and its network providers related to covered services, charges, operations and agreements under the Contract shall be maintained for at least ten (10) calendar years after the last good, service or supply has been provided to an enrollee or an authorized agent of the state or federal government or any of its authorized agents unless those records are subject to review, audit, investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

Insufficient Clinical Information

Healthy Blue is responsible for eliciting pertinent medical record information from treating healthcare provider(s), as needed and/or as requested by the Louisiana Department of Health (LDH), for purposes of making medical necessity determinations. Healthy Blue takes appropriate action when a treating healthcare provider does not provide complete medical

history information within the requested timeframe. Healthy Blue is not required to pay for a particular item or service when the provider does not provide requested medical information for purposes of making medical necessity determinations, for that particular item or service. When the provider fails to provide medical record information, Healthy Blue may at its discretion, or as directed by LDH, impose financial penalties against the provider as appropriate.

It is the provider's responsibility to submit all clinical information necessary to justify both severity of illness and intensity of service. If the clinical submitted is inadequate, Healthy Blue may deny the request or request additional information. When submitting additional documentation, providers should only submit the pertinent clinical information needed to justify the request. Healthy Blue requests additional information, the turnaround time clock for decision does not start until all necessary clinical information to make the decision to approve or deny initial or continued inpatient stay is received. In cases where the provider or member will not release necessary information, Healthy Blue may deny authorization of requested services within two (2) business days.

NOTE: The State turnaround time clock for decision-making does not start until all necessary clinical information to make the decision is received. However, NCQA measures timeliness of notification to the member and practitioner from the date when the organization receives the request, even if the organization does not have all the information necessary to make a decision.

Timing of Standard Service Authorization Decisions
Healthy Blue's clinical associates and Medical Directors (or qualified practitioner) adhere to established State-specific and National Committee for Quality Assurance (NCQA) time standards when rendering UM medical necessity decisions. The clinical associate or Medical Director (or qualified 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 will apply. The standard, expedited, and post-service timeframes, including timing of notice, listed below are the more stringent State-specific standards.

1) ~~All Ninety-Five percent (95%) of~~ All cconcurrent review determinations are made within one (1) calendar day ~~and ninety-nine point 5 percent (99.5%) concurrent review determinations within two (2) business days~~ of obtaining the appropriate medical information that may be required.
2) Eighty percent (80%) of pre-service authorization determinations are made within two (2) business days of obtaining appropriate medical information that may be required regarding

a proposed procedure or service requiring a review determination, with the following exceptions:

a) All inpatient hospital pre-service authorizations are made within two (2) calendar days of obtaining appropriate medical information.

b) All Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) service authorizations are made within five (5) calendar days of obtaining appropriate medical information.

3) All standard service authorization determinations are made no later than fourteen (14) calendar days following receipt of the request for service.

4) The standard service authorization decision may be extended once by up to fourteen (14) additional calendar days if:

a) The member, or the provider, requests an extension; or

b) Healthy Blue justifies (to LDH upon request) a need for additional information and has made at least one (1) attempt to obtain the necessary information and how the extension is in the member's interest.

c) If the timeframe is extended other than at the member's request, Healthy Blue shall provide oral notice of the reason for the delay to the member by close of business on the day of the determination, and written notice of the reason for the delay within two (2) calendar days of the determination.

~~c)~~d) Healthy Blue notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

Timing of Expedited Service Authorization Decisions

1) In the event a provider indicates, or Healthy Blue determines, that the standard service authorization timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, an expedited authorization decision is made and notice provided as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

2) The seventy-two (72) hour time period may be extended once, up to fourteen (14) calendar days if the member requests the extension or Healthy Blue justifies to LDH a need for additional information and has made at least one (1) attempt to obtain the necessary information and how the extension is in the member's best interest.

3) Healthy Blue notifies the member or the member's authorized representative of its decision as expeditiously as the member's health condition requires, but no later than the expiration of the extension.

~~2)~~

Timing of Post-Service Authorization Decisions[SC3][RBM4]

1) Healthy Blue shall make retrospective review determinations within thirty (30) calendar days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred eighty (180) calendar days from the date of receipt of request for service authorization.
2) Healthy Blue shall not subsequently retract its authorization after services have been provided or reduce payment for an item or service furnished in reliance upon previous service authorization approval, unless the approval was based upon a material omission or misrepresentation about the enrollee's health condition made by the provider.
3) Healthy Blue shall not use a policy with an effective date subsequent to the original service authorization request date to rescind its prior authorization.

Timing of Notice

1) For service authorization approval for a non-emergency admission, procedure or service, the Healthy Blue shall notify the provider verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.
2) For service authorization approval for extended stay or additional services, Healthy Blue shall notify the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.
3) Healthy Blue shall notify the member or their authorized representative, in writing using language that is easily understood by the member, of decisions to deny a service authorization request, to authorize a service in an amount, duration, or scope that is less than requested, and/or any other action as defined in the Contract. The notice of action to members shall be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210, the Contract for member written materials, and any agreements that LDH may have entered into relative to the contents of member notices of denial or partial denial of services, regardless of whether such agreements are related to legal proceedings or out-of-court settlements.
4) Healthy Blue shall notify the requesting provider of a decision to deny an authorization or reauthorization request or to authorize or reauthorize a service in an amount, duration, or scope that is less than requested. Healthy Blue shall notify the notify the provider rendering the service, whether a health care professional or facility or both, verbally or as expeditiously as the member's health condition requires but not more than one (1) business day of making the initial determination and shall provide documented confirmation of such written notification to the provider within two (2) business days of making the initial certification.

5) Healthy Blue's service authorization system provides the authorization number and effective dates for authorization to participating providers and applicable non-participating providers. The service authorization system has capacity to electronically store and report the time and date all service authorization requests are received, decisions made by Healthy Blue regarding the service requests, clinical data to support the decision, and timeframes for notification of providers and enrollees of decisions.

REFERENCES:

- A02 Drug Use Evaluation
- A08 Pharmacy Prior Authorization
- CFR Title 42
- Clinical Criteria for Utilization Management Decisions – Core Process
- Concurrent Review (Telephonic and On-Site) – LA
- Current – Louisiana Emergency Contract 2020
- Health Care Management Denial – LA
- Informal Reconsideration – LA
- Louisiana State Contract
- NCQA Health Plan Standards and Guidelines
- Precertification of Requested Services – LA
- Retrospective Review – LA
- Utilization Management Clinicians Responsibilities (Health Plan/Region)
- ~~Current – Louisiana Emergency Contract 2020~~

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management – Utilization Management

Secondary Department(s):
Behavioral Health
National Customer Care Organization
Quality Management

EXCEPTIONS:

1) Healthy Blue shall not require service authorization for emergency services or post-stabilization services as described in the Contract whether provided by an in-network or out-of-network provider.
2) Healthy Blue shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.

3) Healthy Blue shall not require service authorization or referral for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening services.
4) Healthy Blue shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into the health plan, regardless of whether such services are provided by an in-network or out-of-network provider, however, prior authorization of services may be required beyond thirty (30) calendar days.
5) Healthy Blue is prohibited from denying prior authorization solely on the basis of the provider being an out-of-network provider for the first thirty (30) days of a newly enrolled member's linkage to the plan.
6) Healthy Blue shall not require a primary care physician (PCP) referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the plan for routine and preventive women's healthcare services and prenatal care.
7) Healthy Blue shall not require a PCP referral for in-network eye care and vision services.
8) Healthy Blue may require notification by the provider of obstetrical care at the time of the first visit of the pregnancy.
9) Healthy Blue may require notification by the provider of obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding forty-eight (48) hours after vaginal delivery. In this case, only the portion of the claim related to the inpatient stay beyond forty-eight (48) hours is denied.
10) Healthy Blue may require notification by the provider of obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. Healthy Blue is allowed to deny a portion of a claim for payment based solely on lack of notification by the provider of obstetrical admission exceeding ninety-six (96) hours after Caesarean section. In this case, only the portion of the claim related to the inpatient stay beyond ninety-six (96) hours is denied.
11) Healthy Blue may require notification by the provider of inpatient emergency admissions within one (1) business day of admission. Healthy Blue is allowed to deny a claim for payment based solely on lack of notification of inpatient emergency admission, if the provider does not notify of inpatient emergency admission within one (1) business day of admission.

~~**REFERENCES:**~~

- ~~A02 Drug Use Evaluation~~
- ~~A08 Pharmacy Prior Authorization~~
- ~~CFR Title 42~~
- ~~Clinical Criteria for Utilization Management Decisions – Core Process~~
- ~~Concurrent Review (Telephonic and On-Site) – LA~~
- ~~Health Care Management Denial – LA~~
- ~~Informal Reconsideration – LA~~

- ~~Louisiana State Contract~~
- ~~NCQA Health Plan Standards and Guidelines~~
- ~~Precertification of Requested Services – LA~~
- ~~Retrospective Review – LA~~
- ~~Utilization Management Clinicians Responsibilities (Health Plan/Region)~~

~~**RESPONSIBLE DEPARTMENTS:**~~

~~**Primary Department:**~~
~~Health Care Management – Utilization Management~~

~~**Secondary Department(s):**~~
~~Behavioral Health~~
~~National Customer Care Organization~~
~~Quality Management~~

REVISION HISTORY:

Review Date	Changes
06/08/2015	• Revised Corp version to be LA Health Plan Specific
09/01/2015	• Louisiana Bayou Health Contract Amendment 4 Behavioral Health Additions
02/18/2016	• Off Cycle / Early Annual review per upcoming NCQA audit • Update made under Insufficient Clinical Information • Reference section updated
03/03/2017	• For annual review • Definitions placed in alphabetical order • Policy updated to reflect current contract language
07/05/2017	• Off cycle edits • Removed Bayou from reference section • Procedure section updated with revised contract language
03/15/2018	• For annual review • Revision to incorporate Amendment 11 contract language
03/06/2019	• For annual review • No changes
07/14/2020	• Annual review; • Revised for new LA Emergency Contract • Edits to policy, definitions, procedure, exception, and reference sections • Primary department updated from HCM to HCM – UM

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management – Utilization Management	**Clinical Information for Utilization Review – LA**

Review Date	Changes
	• Behavioral Health and Quality Management added as Secondary departments • Policy title change from "Clinical Information for Utilization Management Reviews - Core Process – LA" to "Clinical Information for Utilization Review - LA" • "Appropriate Practitioner" definition replaced by the LDH-approved "Qualified Practitioner" definition • "Qualified practitioner" replaced "appropriate practitioner" throughout
03/02/2021	• Off-Cycle Review • Updated the procedure • Revised Procedure to mirror Contract Amendment 3 language and stricter TAT standards
07/06/2021	• Annual Review • Updated the "Effective Date" from 5/5/1996 to 06/08/2015 as the LA plan went live in 2012 & this also reflects the original policy creation date noted in the Revision History (this is a LA-specific policy created from a corporate policy version) • Added diagnosis codes to the "Clinical Information" definition for NCQA standards • Procedure updated to add a note regarding State TAT • Procedure updated to add language for NCQA standards
076/189/2022	• Annual Review • Updated definition for "Expedited/Urgent/STAT Request" and "Qualified Practitioner" • Updated procedure • Added reference and placed in alphabetical order