Aetna Medicaid Administrators LLC
Policy

Policy Name:	Utilization Management System Controls	Page:	1 of 14
Department:	Medical Management	Policy Number:	7000.19
Subsection:	Utilization Management	Effective Date:	05/01/2022
Applies to:	Medicaid Health Plans		

PURPOSE:

This policy defines the requirements and procedures for assuring compliance with utilization management (UM) System Controls process and accreditation standards to protect authorization request receipt dates, UM decision dates and decision notification dates from being altered, outside of prescribed protocols.

More stringent state requirements may supersede the requirements of this policy.

STATEMENT OF OBJECTIVE:

This policy will explain how all modifications to date and time stamps for authorization request receipt and decision notifications for both approvals and denials will be done in accordance with Centers for Medicare & Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA) requirements. Compliance monitoring and/or performance of audits is used to identify date modifications that do not meet the established policy and to take action when non-compliance is found.

SCOPE:

This policy applies to both precertification and concurrent review requests received and entered manually into the business application system by UM staff or via ICR/OCR (robotic mechanism) and the resulting decision notifications outcome (to approve or deny) from the medical necessity review process.

DEFINITIONS:

Authorization request (may be referred to as a case)	**For the purposes of this policy, a request for either prior authorization or concurrent authorization review and decision regarding coverage of services.**
Audit /Monitoring	**For the purposes of this policy: Specific method/process for assessing compliance with this policy and procedure on a routine basis by employing a system-generated report or event log of all date modifications that occurred since the previous audit. The process includes analyzing the outcome for corrective action when non-compliance is identified.**

Completed status	**An authorization request is considered completed when the review process for coverage, or medical necessity, has resulted in a decision for approval or denial and notification of that decision has been initiated. The final step in the process is to move that request and decision to a completed status in the business application system.**
Closed authorization	**For the purposes of this policy, a closed authorization request is one that has been voided or closed not in a completed status. Closure is permitted when the request was entered in error, when the requesting provider has withdrawn the request; when the entry is a duplicate of an existing authorization request or when a completed authorization contains errors that can only be corrected with a new authorization.**
Concurrent Review Request	**A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the health plan did not previously approve the earlier care. All inpatient concurrent requests are considered urgent. Concurrent reviews are typically associated with inpatient care, residential behavioral care, and intensive outpatient behavioral health care and ongoing ambulatory care.**
Correction date	**For the purposes of this policy: The date that an approved modification is made to correct the initially documented receipt or notification date.**
Date of notification (of UM decision)	**The date on the decision notice is the notification date when written (i.e. letter) notice of a UM decision/determination is sent. If electronic notification is used, the date when the notification was posted to the electronic system. (See Notification)**
Date of receipt (of the authorization request)	**The date when the organization receives the request [for service] from the member, member's authorized representative/ or practitioner, even if it is not received in the UM department and the organization does not have all the information necessary to make a decision. [NCQA]**

Denial, reduction, or discontinuation of requested services	**The non-authorization of care or service at the level requested based on either medical necessity or benefit coverage. Partial approvals and approvals that are less than the requested service in amount, duration or scope or decisions to discontinue authorization are also denials.**
Decision/determination	**For the purposes of this policy, a decision or determination is the outcome of a review for coverage of requested services or treatment, either to approve or deny, based on specific medical necessity criteria or other guidelines.**
ICR/OCR	**Intelligent character recognition (ICR)** **Optical Character Recognition (OCR)**
Medical Necessity Determination	**This term refers to a decision regarding coverage of services or supplies for diagnosing, evaluating, treating or preventing an injury, illness, condition or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Determination of medical necessity is based on specific criteria.**
Notice of Action (NOA)	**Written notification of decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, specific to the member's clinical condition, utilizing language that is easily understood by the member and practitioner/provider. The notification includes a reference to the criterion, rationale for the decision and member appeal rights**
Notification	**Written or electronic communication of a UM determination or decision to approve or deny a service request. (Verbal notification does not replace electronic or written notification of denial decisions and does not extend the timeframe for written notification.)**

Prior authorization request/Preservice request	**Prior assessment (by application of medical necessity or benefit eligibility) that proposed services (such as hospitalization) are appropriate for a particular member and will be covered by the health plan.**
Role Based Access Control (RBAC)	**Role Based Access Control (RBAC) is a company-wide process developed to ensure employees have access only to those systems necessary to perform their job. RBAC models are defined specifically for common groupings of jobs and system needs.**
System or utilization management business application system	**For the purposes of this policy: electronic business application platform in which service requests are received, tracked and responded to. This may encompass computer servers, hardware and physical records, files and data.**

System Controls

The UM business application system has the capacity to electronically store and report all service authorization requests, decisions made by the UM department regarding service requests, clinical data to support the decision/determination to approve or deny, and timeframes for written notification of decisions to practitioners/providers and members (when required). Business system documentation includes member demographics and information supporting clinical and benefit coverage determinations. All electronically stored data is housed within Aetna's business applications and are not outsourced to external vendors.

Access to the Aetna business application system is limited to appropriate staff through Role Based Access Control (RBAC). Access for staff is limited to the minimum necessary security to perform their job function. Each user is assigned a unique identification (user ID). The process for password-protecting electronic systems includes user requirements to utilize strong passwords, avoid writing down passwords and use of different passwords for different accounts. Aetna's company-wide procedures requires users to change passwords at minimum every ninety (90) days and when a password has been compromised. Changing or withdrawing passwords, includes alerting appropriate staff who oversee computer

security, to change passwords when appropriate and disable or remove passwords of employees who leave the organization.

Physical access to the operating environment that houses utilization management data, including, but not limited to, the organization's computer servers, hardware and physical records and files is limited in accordance with the Clean Desk Standard (CHIP-059596).

How Dates are Recorded

Authorization requests (a case) may enter the business application system manually (non-clinical UM staff data entry) or by ICR/OCR (artificial intelligence digitization) entry. Receipt dates are autogenerated when the case is opened in the business application system. The information may be manually revised during the *initial* data entry process to reflect a correct mail date, fax date, telephonic date or when initial information is incomplete and requires outreach to and/ or verification by the requesting provider. Receipt date, medical necessity determination and notification dates are defined consistent with NCQA UM 5: Timeliness of UM Decisions, or state mandates, whichever is more stringent.

The business application system locks all clinical and non-clinical free text note entries once they have been saved by the original author (UM staff). The following modifications are not permitted after the initial case entry and a new case must be created for the request:

- **to change or add unrelated CPT codes**
- **to add additional units of service**
- **to change an approved outpatient service template to an inpatient service template**
- **for a modification that requires medical necessity review.**

When a request determination is made, the case placed in completed status and the determination notification issued, system controls are in place to make sure date field entries are locked (e.g., initial date/time of receipt of request, date/time of decision, date/time of system entry notes, notification date) and prohibit all staff the ability to modify the field entries. Access to the denial database is password protected and restricted.

Written denial notification dates are auto generated and cannot be modified under any circumstances in the denial database or UM data entry business system. These notification

dates are time stamped, default to the current date/time when the notification is sent and locked with no capability to alter the date forward or backward.

Notification Date Modification Reporting and Analysis

Notification dates cannot be backdated or postdated and are processed in real time. As such, reporting and analysis related to notification date modifications is not required.

Modification of Receipt Dates

Once the case is locked the only permitted way to correct a receipt date that has been entered in error is to close the authorization request and create a new record of that case. Only a UM Manager or UM Supervisor may approve closure of an authorization request (case).

Circumstances when it is acceptable to close a case are as follows:

- **Incorrect member – Any case that is built under the wrong member should be closed.**
- **Duplicate cases –instances, such as a submission through a third party (example: Availity), that result in a duplicate case, should be closed.**
- **Provider requests closure:**
  - **outpatient – provider withdraws a request**
  - **inpatient – provider changes an inpatient request to observation level of care prior to a final determination being made.**
- **Newborn delivery – when a case is built and the open case is no longer required for claims processing, it can be closed.**
- **Authorizations built in error:**
  - **No auth required – staff should review prior authorization requirements before building a case. If a case is built where no prior authorization is required, the case may be closed, only if the final determination has not been made.**
  - **Secondary – Member eligibility must be evaluated prior to building a case. If a case is built where Medicaid is considered secondary, the case can be closed.**

- **Third party vendor –staff should determine if a case is to be sent to a third-party vendor, prior to a case being built. If a case is built but the request should have been sent to a vendor, the case can be closed. Examples of third-party vendors include, but are not limited to: delegated entities or vendors, such as eviCore and Avesis.**

- **If the request receipt date or decision notification date is incorrect.**

After the initial case entry only the following designated UM staff may perform allowable modifications when a receipt date requires correction:

- **Inbound/Outbound Queue Associate (IBQA - Prior Authorization Representative)**
- **Prior Authorization Nurses**
- **Concurrent Review Nurses**

Circumstances when it is acceptable to manually revise the receipt date are as follows:

- **Receipt date is different from the auto-generated business system case open date due to the request having been submitted on an earlier date to a department other than UM**
- **Transcription error noted by the Prior Authorization/Concurrent Review Nurses upon verification of Inbound/Outbound Queue Associate (IBQA-Prior Authorization Representative) entry**

If a receipt or notification date correction is required:
NOTE: Only a UM Manager or UM Supervisor can approve a receipt date modification/ correction.

If a determination has been made, notification initiated, and the request has been placed in completed status, the UM clinician must:

- **Notify a UM Manager/Supervisor of the need for the receipt date correction with details supporting the request**
- **Once the date correction is approved by a UM Manager/Supervisor, the request may be closed**
- **The request is then re-entered with the corrected information**
- **In the re-entered request, the first note is entitled "Correction" and includes an explanation of:**

- **receipt date modified,**
- **why the modification was needed,**
- **who approved the modification, by title (UM Manager/Supervisor) and name**
- **and the date and time the modification was completed.**

These closed/voided cases are tracked in the system as "closed" cases. A report is produced quarterly of all denied cases closed and re-entered. The system will track closed cases.

If a determination to approve or deny has not been made, the UM clinician must:

- **Notify a UM Manager/Supervisor of the need to correct the receipt date with details supporting the request**
- **Once the date correction is approved by a UM Manager/Supervisor the date may be corrected**
- **A note entitled "Correction" is entered and documents:**
  - **by title and name who approved the correction.**
  - **the reason for the correction**
  - **and the original source of the correct information or date (i.e. fax date or other system date stamp)**

As with all free text notes, the Correction note is date stamped and locked by the business system. The business system prevents any modification to the note.

Monitoring Compliance of System Controls

Denial System Control Monitoring

On a quarterly basis, compliance with the established policy and procedures is monitored through a comprehensive (all Medicaid health plans) report and analysis of authorization denials based on medical necessity. All requests will be reported in which a denied case has a date change before completion and in which a denied case is closed and re-entered after being placed in a completed status. The Medicaid Centralized Audit team will monitor for compliance and audit 100% of closed/re-entered cases to ensure that they align with current policies and procedures for receipt date modifications. Data analysis focuses on cases that do not meet criteria for date modifications. The goal for the analysis is 95% of

cases closed for date modification will meet criteria for permitted date modifications. Analysis report includes only cases that were closed for date modifications. Audit will include review of the authorization (case) file that replaced the closed case to verify date modifications were compliant with criteria.

Monitored elements will include:

- **Verification of actual initial date of receipt of the authorization request**
- **Verification of the actual date of the denial and appeal notification**
- **Time and date of the request to modify the receipt date**
- **Name and title of the individual authorizing the modification (only manager/supervisor)**
- **Documentation of the reason for the modification**
- **Analysis of all instances of date modifications that did not meet established policy and procedures**

Plan specific findings are presented to the UM director(s) and health plan UM leadership who then report the findings to the Plan QM/UM committee. Where non-compliance is identified, corrective action is initiated by the UM managers/supervisors.

Corrective actions initiated include:

- **Retraining of identified staff to policy requirements**
- **Retraining of identified staff to the approved procedure**
- **Quarterly monitoring to assess the effectiveness of implemented actions on all findings until full compliance is achieved for three consecutive quarters**

LEGAL/CONTRACT REFERENCE:

- **Center for Medicare and Medicaid (CMS)**
- **National Committee for Quality Assurance (NCQA)**
- **State contract requirements, where applicable.**
- **State and federal regulations**

FOCUS/DISPOSITION:

Responsibilities

The Medicaid Centralized Audit team will conduct quarterly denial file audits.

Health plan UM directors or their designees will initiate and monitor corrective measures until, compliance with the policy and procedure is met for three (3) consecutive quarterly audits.

OPERATING PROTOCOL:

Systems

- **Business application systems**

Measurement

Audit findings reported by health plan:

- **Number of fully and partially denied authorizations with system create dates earlier than the receipt dates**
- **Number of denied prior authorization and concurrent review requests in completed status that have been closed and re-entered**
- **Number of audited cases in compliance (threshold 95%)**
- **Number of audited cases not in compliance**
- **Trended status of corrective actions**

Reporting

- **QM/UM Committee (NQM)**
- **National Medicaid Accreditation Team**

INTER/INTRADEPENDENCIES:

Internal

- **Information Technology**
- **National Medicaid Accreditation Team**
- **Medicaid Centralized Audit Team**
- **Chief Medical Officer**

- **Plan Medical Director**
- **Medical Management**
- **Quality Management**
- **Grievances and Appeals**
- **Quality Management/Utilization Management Committee**

External

- **Regulatory bodies**

Aetna Medicaid Administrators LLC

Lisa M. VanSteelant, Vice President
Market Operations & Governance
Aetna Medicaid

Edith Calamia, D.O., MPH
Vice President, Chief Medical Officer
Aetna Medicaid

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Effective Date: 04/08/2024
Last Review Date: 04/08/2024
Last Revised Date: 04/08/2024

PURPOSE
This Amendment is written to meet regulatory and legislative requirements under Louisiana law/regulation that impact AMA 7000.19 Utilization Management System Controls policy. This amendment will be used in conjunction with AMA 7000.19 to comply with Louisiana requirements.

SCOPE

Applies to Department:	**o Care Management**	**o Precertification (including NME, SCPU, Specialty Medical Precert)**	**o NME Case Management**	**o Aetna Maternity Program**
	o SCPU Case Management	**o 24-Hour Nurse Line**	**o DM**	**o BH**
	o Medical Management – Concurrent Review	**o Medical Management – Prior Authorization**	**n Medical Management – Utilization Management**	**o Medical Management**

Product:	**o HMO**	**o EPO**	**o PPO**	**o MC/POS**	**o TC**	**o JV**
	n Medicaid					

These requirements apply when the Controlling State is Louisiana.

POLICY
OPERATING PROTOCOL:
Systems

Legislation	**Policy/Procedure Language Change:**

2023 Louisiana Medicaid Managed Care Organization, Attachment A, Model Contract, Section 2.18.9.1.7 **Prior Authorization – The system shall determine whether a Managed Care Organization (MCO) Covered Service required Prior Authorization and if so, whether the Contractor granted such authorization;**	**Prior Authorization – The system shall determine whether a health plan Covered Service required Prior Authorization and if so, whether the Contractor granted such authorization;**

Reporting

Legislation	Policy/Procedure Language Change:
2023 Louisiana Medicaid Managed Care Organization, Attachment A, Model Contract, Section 2.16.7.2 **LDH (Louisiana Department of Health) reserves the right to request additional reports as deemed necessary. LDH will notify the Contractor of additional required reports no less than sixty (60) Calendar Days prior to the due date of those reports.**	• **LDH reserves the right to request additional reports as deemed necessary. LDH will notify the Contractor of additional required reports no less than sixty (60) Calendar Days prior to the due date of those reports.**

PROCEDURE
N/A

REVIEW AND APPROVALS

Jess R. Hall **Chief Executive Officer**	**Date**
Antoinette K. Logarbo, MD **Chief Medical Officer**	**Date**

EXHIBIT(S): N/A