Government Business Division
Policies and Procedures

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

Effective Date	**Date of Last Review**	**Date of Last Revision**	**Dept. Approval Date**
May 5, 1996	~~March 6, 2019~~July 14, 2020	~~March 15, 2018~~July 14, 2020	~~March 6, 2019~~July 14, 2020
Department Approval/Signature :			

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

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

POLICY:[SC1]

To ensure receipt of relevant clinical information for timely ~~U~~utilization ~~M~~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.*

~~**Appropriate Practitioner:** A representative who makes utilization management determination. Depending on the type of case, the reviewer may be a health plan Medical Director, a board-certified consultant, medical, behavioral health, pharmaceutical, dental, chiropractic or visitation practitioner as appropriate.~~

Section (Primary Department)	SUBJECT (Document Title)
Health Care Management – Utilization Management	Clinical Information for Utilization ~~Management~~ Review~~s~~ – ~~Core Process –~~ LA

Clinical ~~i~~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); and
- Member's safety issues.

Expedited/~~ Urgent CARE~~/ ~~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 the life, health, or safety of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment;~~others due to the member's psychological state, or~~
2) Could seriously jeopardize the life, health, or safety of others due to the member's psychological state;~~, or~~
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: ~~Practitioners request for s~~Services requested as "Urgent"~~,~~ or "STAT" will be processed as non-urgent if the request does not meet Expedited/Urgent/STAT~~Urgent Care~~ 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~~we~~ 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 ~~appropriate~~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 ~~appropriate~~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.

~~**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 24 hours of member notification of the existence of an urgent condition.~~

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

Qualified Practitioner* [WJL2]– 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.

~~**Service authorization** – includes, but is not limited to, prior authorization, concurrent authorization and post authorization~~

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 ~~pre-~~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 ~~utilization review~~UR and should generally be obtained through established channels.

3) The clinical associate requires the practitioner to supply the minimum necessary clinical information for ~~pre-~~certification to be considered. Practitioners are encouraged to supply numerically codified diagnoses or procedures, but are not required to do so for pre-certification.

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 ~~the organization's~~ security and privacy policies and ~~will be~~ retained in accordance with the ~~corporate document~~ retention schedule.

5) If there is "significant lack of agreement" between the ~~health plan~~ Medical Director (or ~~appropriate~~qualified practitioner) and the provider~~actitioner~~, additional information may be requested as part of the adverse determination and/or appeal processes. Attempts may also be made by the ~~health plan~~ Medical Director (or ~~appropriate~~qualified practitioner) to consult with the treating practitioner in instances of "significant lack of agreement."

6) Healthy Blue~~The organization~~'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

Justification of emergency admission, if applicable.

h)

~~1)~~

~~2) Healthy Blue shall perform prior authorization and concurrent utilization review for admissions to inpatient general hospitals, specialty psychiatric hospitals in Louisiana or out-of state, or state mental hospitals.~~

~~3)~~

~~4) Healthy Blue shall have written procedures to address the failure or inability of a provider or member to provide all the necessary information for review. In cases where the provider or member will not release necessary information, Healthy Blue may deny authorization of the requested service(s) within two (2) business days.~~

~~5)~~

~~6) Healthy Blue shall ensure that inpatient psychiatric hospital and concurrent utilization reviews are completed by an LMHP for each Medicaid beneficiary referred for psychiatric admissions to general hospitals. Healthy Blue shall comply with the requirements set forth in the Inpatient Psychiatric Services Rule [Louisiana Register, Vol. 21, No. 6, Page 575].~~

~~7)~~

~~8) In accordance with 42 CFR 453.111 and 456.211, Healthy Blue Utilization review (UR) plan must provide that each enrollee's record includes information needed for the Utilization Review committee to perform UR required under this section. This information must include, at least, the following:~~

~~9) Identification of the enrollee;~~

~~10) The name of the enrollee's physician~~

~~11) Date of admission, and dates of application for authorization of Medicaid benefits if application is made after admission;~~

~~12) The plan of care required under 42 CFR 456.80 and 456.180;~~

~~13) Initial and subsequent continued stay review dates described under 42 CFR 456.128, 456.133, 456.233 and 456.234;~~

~~14) Date of operating room reservation; if applicable; and~~

~~15) Justification of emergency admission, if applicable.~~

~~16)~~

~~17)~~1) ~~The clinical associate requires the practitioner to supply the minimum necessary clinical information for pre-certification to be considered. Practitioners are encouraged to supply numerically codified diagnoses or procedures, but are not required to do so for pre-certification.~~

~~18)~~1)

~~19)~~1) ~~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 the organization's security and privacy policies and will be retained in accordance with the corporate document retention schedule.~~

~~20)~~1)

~~21)~~1) ~~If there is "significant lack of agreement" between the health plan Medical Director (or appropriate practitioner) and the practitioner, additional information may be requested as part of the adverse determination and/or appeal processes. Attempts may also be made by the health plan Medical Director (or appropriate practitioner) to consult with the treating practitioner in instances of "significant lack of agreement."~~

~~22)~~1)

~~23)~~1) ~~The organization'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.~~

~~24)~~

25) ~~Concurrent utilization reviews are administrative in nature and should not be reported to LDH in encounter data. These reviews are not considered prior authorizations because inpatient reimbursement is not edited against the utilization review prior to payment. Also, there are instances where individuals personally presenting at the inpatient psychiatric hospital may be admitted by hospital staff. However, LDH does reserve the right to recoup~~

26) ~~reimbursement when concurrent utilization reviews fail to document medical necessity for the inpatient psychiatric treatment.~~

~~27)~~

28) ~~Concurrent utilization review includes:~~

29) ~~Provision of Emergency Inpatient Hospital Psychiatric Screen: A concurrent utilization review screening for inpatient services following the sudden onset of severe psychiatric symptoms, which could reasonably be expected to make the individual harmful to self or others if not immediately under psychiatric treatment. The individual is in crisis and not currently in a place of safety. If the individual presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent, as the person needs to be seen right away to determine appropriate treatment. The referral from Healthy Blue for an Emergency Inpatient Psychiatric Hospital Screen shall be made immediately. The screen to determine appropriate treatment shall be completed within one hour when requested by an emergency room for post-stabilization treatment or three hours after receipt of the request in other circumstances. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, the procedures specified below should be utilized.~~

30) ~~Provision of an Urgent Inpatient Hospital Psychiatric Screen:~~

~~31) A concurrent utilization review screening is initiated if the individual meets one criterion specified on the state approved screening form and is currently in a place of safety. If the member presents in a hospital, where they will not be hospitalized due to not having a psychiatric unit or trained psychiatric personnel, then the utilization screen would be emergent and follow the protocols and timeframes specified above. If the member presents at a hospital with a psychiatric unit or trained psychiatric personnel, and is admitted by the treating physician, then it will be classified as an urgent screen. The referral from Healthy Blue for an Urgent Inpatient Psychiatric Hospital Screen shall be made within 24 hours. The screen to determine appropriate treatment shall be completed within 24 hours of Healthy Blue's referral. If psychiatric residential treatment is recommended, in lieu of inpatient psychiatric hospitalization, due to concerns regarding the safety of a child/youth, the procedures specified above should be utilized.~~

~~32)~~

~~33) Upon completion of the Inpatient Psychiatric Hospital Concurrent Utilization Review, if the inpatient admission is approved, Healthy Blue shall notify the provider and individual requesting the screen of the results in writing within 48 hours. If denied, Healthy Blue shall notify the individual requesting the screen immediately, and within 48 hours provide written notification of the results to the provider and individual requesting the screen. The notification shall include whether or not an alternative community services plan is appropriate, the right of the member to appeal and the process to do so.~~

~~34)~~

9) Healthy Blue ensures medical records are:
   a) Accurate and legible;
   b) 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) 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.

~~The health plan's clinical associates and health plan Medical Directors (or appropriate practitioner) adhere to established the National Committee for Quality Assurance (NCQA) time standards when rendering UM medical necessity decisions. The clinical associate or health plan Medical Director (or appropriate 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.~~

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. When 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.

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 listed below are the more stringent State-specific standards.

1) 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 admission, procedure, or service requiring a review determination, with the exception of authorizations for CPST and PSR services for which the standard for determination is within five (5) calendar days of obtaining appropriate medical information. All standard service authorization determinations are made no later than fourteen (14) calendar days following receipt of the request for service.
   a) The standard service authorization decision may be extended up to fourteen (14) additional calendar days if the member, or the provider, requests an extension; or

b) Healthy Blue justifies to LDH a need for additional 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.

2) Ninety-five percent (95%) of concurrent review determinations are made within one (1) business day and ninety-nine point five percent (99.5%) of concurrent review determinations within two (2) business days of obtaining the appropriate medical information that may be required.

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 up to fourteen (14) calendar days if the member requests the extension or Healthy Blue justifies to LDH a need for additional information and how the extension is in the member's best interest.

Timing of Post-Service Authorization Decisions

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, 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.

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:

~~42 CFR 438.210, Coverage and Authorization of Services~~
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

~~CPP 101 Purpose and General Rules of the Privacy Policies CPP208 Safeguards~~
Health Care Management Denial ~~– Core Process –~~ LA
Informal Reconsideration – LA
Louisiana State Contract

Section (Primary Department)	**SUBJECT (Document Title)**
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~~LA Health Contract 8.5.1.2~~
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

~~**EXCEPTIONS:**~~

~~The plan cannot retract its authorization after services have been provided unless approval was based on a material omission or misrepresentation of a member's health by a provider.~~

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
02/18/2015	• 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	• ~~Off cycle~~Annual review;

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	• R~~r~~evised for new LA Emergency Contract • Edits to policy, definitions, procedure, exception, and reference sections • Primary department updated from HCM to HCM – UM • 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 • Updated template header to include CHIP in product list
~~7/14/2020~~	~~• "Appropriate Practitioner" definition replaced by the LDH-approved "Qualified Practitioner" definition~~ ~~• "Qualified practitioner" replaced "appropriate practitioner" throughout~~