Government Business Division
Policies and Procedures

Section (Primary Department) **Health Care Management – Utilization Management**		**SUBJECT (Document Title)** **Pre-Ccertification of Requested Services – LA**	
Effective Date January 20, 1996	**Date of Last Review** ~~August 8, 2018~~July 14, 2020	**Date of Last Revision** ~~September 13, 2018~~July 14, 2020	**Dept. Approval Date** ~~September 13, 2018~~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	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☐ California	☐ Iowa	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Kentucky	☐ New York – Empire	☐ Virginia
	☐ District of Columbia	☒ Louisiana	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Maryland	☐ North Carolina	☐ Wisconsin
	☐ Georgia	☐ Minnesota	☐ South Carolina	☐ West Virginia

POLICY:

To ~~as~~ensure that members are treated in the most appropriate, least restrictive, and most cost-effective setting that is compatible with medical necessity as determined by the severity of ~~the~~ illness and/or the intensity of ~~the~~ services needed to contribute to an improved health status relative to the specific condition.

The following services are subject to pre-certification (reference appropriate resource help files for specific authorization rules):

1) Elective inpatient admissions;
2) Specialty procedures (pre-certification is not required for specialty ~~care~~ emergency services or treatment of any immediately life-threatening medical condition); and
3) Non-emergent services rendered by an out-of-network practitioner or provider (with the exception of covered Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, ~~covered~~ family planning services, and women's preventive health services,~~;~~ unless excluded by State or Federal requirements).

~~Please reference the appropriate resource help files for more specific authorization rules (PLUTO, Code for Treatment Type Look up).~~

~~Healthy Blue allows m~~Members ~~to~~ may submit an authorization request for the provision of services~~requests for services, orally~~ verbally or in writing~~,~~ as directed in the ~~M~~member ~~H~~handbook. Pre-certification procedures are outlined in the ~~M~~member and ~~P~~provider ~~H~~handbooks and published online ~~Healthy Blue's website~~. ~~The~~Procedures and information required from a member or health-care provider in order to make medical necessity determinations are~~is~~ given verbally when requested. ~~In cases where the member or provider will not release necessary information, the pre-certification request may be denied within two (2) business days.~~

Healthy Blue is responsible for eliciting pertinent medical 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 medical necessity determinations. Healthy Blue shall take appropriate action when a treating health care provider does not cooperate with providing complete medical history information within the requested timeframe. In cases where the member or provider will not release necessary information, athe pre-certification request may be denied within two (2) business days.

Providers who do not provide requested medical information for the purposes of making medical necessity determinations, for a particular item or service, areshall not be entitled to payment for the provision of such item or service, and financial penalties may be imposed against the provider at the plan's discretion or directive by LDH.

Healthy Blue provides covered services in accordance with LDH's definition of medically necessary services, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and the Contract [42 C.F.R. §438.210(a)(5)(i)]. Healthy Blue covers medically necessary services that address:

1) The prevention, diagnosis and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability;
2) The ability for a member to achieve age-appropriate growth and development; and
3) The ability for a member to attain, maintain, or regain functional capacity.

In accordance with 42 CFR §456.111 and §456.211, each enrollee's record must include, at least, the following information for utilization review:

1) Identification of the enrollee;
2) The name of the enrollee's physician;
3) Date of admission, and dates of application for and authorization of Medicaid benefits if application is made after admission;
4) The plan of care required under 42 CFR §456.80 and §456.180;
5) Initial and subsequent continued stay review dates described under 42 CFR §456.128, §456.133, §456.233 and §456.234;
6) Date of operating room reservation, if applicable; and
7) Justification of emergency admission, if applicable.

Utilization review is performed by staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines. This includes UM staff specifically assigned to specialized behavioral health services and permanent supportive housing. Staff is available 24 hours per day, 7 days per week for prior authorization requests. Healthy Blue's secure online web-based portal allows providers and state agencies (DCFS, LDOE, LDH, and OJJ) to submit and receive responses to referrals and prior authorizations for services on a 24/7 basis.

LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) is used when making determinations. Healthy Blue determinations are consistent with the State's definition, and made by qualified and trained practitioners in accordance with

~~state and federal regulations. Qualifications of staff who determine medical necessity are identified and documented.~~

~~Only licensed clinical professionals with appropriate clinical expertise in the treatment of a member's condition or disease can determine pre-certification denials or authorize a service in an amount, duration, or scope that is less than requested. Staff making these determinations are required to attest that no adverse determination will be made regarding any medical procedure or service outside of the scope of such individual's expertise; and must have no history of disciplinary action or sanctions. Individuals or entities that conduct UM activities are not provided compensation incentives to deny, limit, or discontinue medically necessary covered services to any member.~~

Covered ~~S~~sservices shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service (FFS) Medicaid, as set forth in 42 CFR §440.230, and for enrollees under the age of twenty-one (21), as set forth in 42 CFR Part 441, Subpart B [42 CFR §438.210(a)(2)]. Healthy Blue ensures that covered services are sufficient in an amount, duration, and scope to reasonably ~~be expected to~~ achieve the purpose for which the services are furnished. ~~and that are no less than the amount, duration or scope for the same services furnished to eligibles under the Medicaid State Plan.~~ Healthy Blue may not arbitrarily deny or reduce the amount, duration, or scope of required services solely because of diagnosis, type of illness, or condition of the member [42 CFR §438.210(a)(3)].

In accordance with 42 CFR §438.210(a)(4), ~~A~~appropriate limits may be placed on a service that are on the basis of criteria applied under the State Plan, such as medical necessity; ~~or best practices; or~~ and for the purposes of utilization control, provided that: ~~(with the exception of EPSDT services), provided t~~

1) The services furnished can reasonably be expected to achieve their purpose; ~~in accordance with 42 CFR §438.210. Established mechanisms reduce inappropriate and duplicative use of health care services. Fraud, waste, and abuse is reported to LDH in accordance with 42 CFR §455.1(a)(1).~~
2) The services support members with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and
3) Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20.

Service authorization policies and procedures ~~shall be~~are consistent with 42 CFR §438.210, 42 CFR §441 Subpart D, ~~s~~State laws and regulations, Medicaid State Plan and waivers, and the court-ordered requirements of Chisholm v. Gee and Wells v. Gee for initial and continuing authorization of services (refer to *Prior Authorization Liaison (PAL) Policy – LA* for

precertification guidance regarding Chisholm v. Gee). UM Program policies and procedures shall meet all NCQA standards and include medical management criteria and practice guidelines that:

1) Are adopted in consultation with contracting health care professionals;
2) Are objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
3) Are considerate of the needs of the members; and
4) Are reviewed annually and updated periodically as appropriate.

Healthy Blue must identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to:

1) The vendor must be identified if the criteria was purchased;
2) The association or society must be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;
3) The guideline source must be identified if the criteria are based on national best practice guidelines; and
4) The Healthy Blue Medical Director or other qualified and trained professional who made the medical necessity determination must be identified if the criteria are based on their medical training, qualifications, and experience.

Medical management criteria and practice guidelines are posted to Healthy Blue's website. Upon request by an enrollee, their representative, or LDH, Healthy Blue must provide the specific criteria and practice guidelines, free of charge, utilized to make a decision and may not refuse to provide such information on the grounds that it is proprietary. Decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.

Service authorization systems shall have the capacity to provide the authorization number and effective dates to participating and applicable non-participating providers, electronically store and report the time and date all service authorization requests are received, decisions made regarding the service requests, clinical data to support decisions, and time frames for notification of providers and members of decisions.

Healthy Blue shall make eighty percent (80%) of standard service authorization determinations 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 Community Psychiatric Supportive Treatment (CPST) and Psychosocial Rehabilitation (PSR) services for which the standard for determination is within five (5) calendar days of obtaining appropriate medical information. All standard service authorization determinations shall be made no later than fourteen (14) calendar days following receipt of the request for service.

~~The standard service authorization decision may be extended up to fourteen (14) additional calendar days if the member, or the provider, requests the extension; or Healthy Blue justifies (to LDH upon request) a need for additional information and how the extension is in the member's interest.~~

~~In the event a provider indicates, or Healthy Blue determines the standard service authorization timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, Healthy Blue shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service. The seventy-two (72) hour time period may be extended up to fourteen (14) calendar days if the member or Healthy Blue justifies to LDH a need for additional information and how the extension is in the member's best interest.~~

~~Healthy Blue shall make retrospective review determinations within thirty (30) days of obtaining the results of any appropriate medical information that may be required, but in no instance later than one hundred, eighty (180) days from the date of service.~~

~~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 member's health condition made by the provider.~~

~~For service authorization approval for a non-emergency admission, procedure or service, Healthy Blue shall notify the provider verbally, or as expeditiously as the member's health condition requires, but no more than one (1) business day of making the initial determination, and will provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification. For service authorization approval for extended stay or additional services, the provider rendering the service, whether a health care professional or facility or both, and the member receiving the service, shall be notified verbally[kls1][WJL2] or as expeditiously as the member's health condition requires, but no more than one (1) business day of making the initial determination and will provide documented confirmation of such notification to the provider within two (2) business days of making the initial certification.~~

~~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 state contract. The notice of action to members will be consistent with requirements in 42 CFR §438.404 and 42 CFR §438.210, the state 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.~~

~~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. The provider rendering the service, whether a health care professional or facility or both, shall be notified 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.~~[kls3][WJL4]

~~As~~[kls5][WJL6] ~~part of the appeal procedures, Healthy Blue allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The member or a provider acting on behalf of the member is provided an opportunity to request an informal reconsideration of an adverse determination by the physician or clinical peer making the adverse determination. The informal reconsideration should occur within one (1) working day of the receipt of the request and be conducted between the provider rendering the service and the Healthy Blue physician authorized to make adverse determinations or a clinical peer designated by the medical director if the physician who made the adverse determination cannot be available within one (1) working day. The informal reconsideration will in no way extend the thirty (30) day required timeframe for a Notice of Appeal Resolution.~~

~~Exceptions to requirements:~~

- ~~Healthy Blue shall not require service authorizations for emergency services or post-stabilization services, including those for specialized behavioral health, whether provided by an in-network or out-of-network provider.~~
- ~~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 payment based solely on lack of notification of inpatient emergency admission, if the provider does not notify Healthy Blue of inpatient emergency admission within one (1) business day of admission.~~
- ~~Healthy Blue shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the service can be provided through an in-network or out-of-network provider at a lower level of care.~~
- ~~Healthy Blue shall not require hospital service authorization for non-emergency inpatient admissions for normal newborn deliveries.~~
- ~~Healthy Blue may require notification by the provider of Obstetrical admissions exceeding forty-eight (48) hours after vaginal delivery. A portion of a claim payment is allowed to be denied 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 allowed to be denied.

- Healthy Blue may require notification by the provider of Obstetrical admissions exceeding ninety-six (96) hours after Caesarean section. A portion of a claim payment is allowed to be denied 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 allowed to be denied.
- Healthy Blue may require notification by the provider of Obstetrical care at the time of the first visit of the pregnancy.
- Healthy Blue shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the MCO for routine and preventive women's healthcare services and prenatal care.
- Prior authorization shall not be required for covered family planning services, including long-activing reversible contraceptives and treatment of STIs.
- Healthy Blue shall not require a PCP referral for in-network eye care and vision services.
- Healthy Blue shall not require service authorization or referral for EPSDT screening services.
- Prior authorization of non-emergency ambulance services is prohibited.
- Healthy Blue shall not require service authorization for the continuation of medically necessary covered services of a new member transitioning into Healthy Blue, 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.
- Healthy Blue is prohibited from denying prior authorization solely on the basis of the provider being an out of network provider for the first 30 days of a newly enrolled member's linkage to the plan.
- Healthy Blue must honor any prior authorization for durable medical equipment, prosthetics, orthotics, and certain supplies services issued while the member was enrolled in another MCO or the Medicaid fee-for-service program for a period of ninety (90) calendar days after the member's enrollment in the MCO.

DEFINITIONS:

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

Customer Care Representative (CCR)/Care Specialist/Medical Management Specialist – Non-clinician responsible for responding to inquiries from members and practitioners to clarify benefits, providing member education and members health referrals. He/she documents pre-

~~certification requests and arranges for services as identified by the Licensed UR and/or the Care Manager.~~

Expedited/Urgent/STAT Request – Any request for medical 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 ~~S~~seriously jeopardize~~y to~~ the life, health, or safety of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment;~~ or~~
2) Could ~~S~~seriously jeopardize~~y to~~ 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~~y to~~ the life, health, or safety of the woman or fetus; or
4) In the opinion of a practitioner with knowledge of a member's medical or behavioral health condition, ~~the member would be~~ subject the member to adverse health consequences~~severe pain that cannot be adequately managed~~ 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: ~~Requests for s~~Services designated 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.

Licensed Utilization Reviewer (UR) – The ~~L~~licensed UR is responsible for day-to-day management of pre-certification activities. He or ~~/~~she manages member care ensuring essential, effective, and appropriate services, and coordinating~~ed~~ behavioral health,~~and~~ physical health, and social services.

Medical Management Specialist (MMS)/Case Specialist/Customer Care Representative – Non-clinician responsible for responding to inquiries from members and providers to clarify benefits, offer member education, and provide health referrals. MMS document precertification requests and arrange for services as identified by a licensed clinician.

Medically Necessary Services* – Those health care services that are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care. In order to be considered medically necessary, services must be: (1) d

~~1) D~~eemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have

resulted or will result in a handicap, physical deformity or malfunction; and (2) those for which no equally effective, more conservative, and less costly course of treatment is available or suitable for the beneficiary.

2) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Any such services must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the beneficiaryrecipient requires at that specific point in time. Although a service may be deemed medically necessary, it doesn't mean the service will be covered under the Medicaid Program. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid Director, in consultation with the Medicaid Medical Director, may consider authorizing services at his discretion on a case-by-case basis.

Notification – Process by which a practitioner informs the organization of care that either has or will be rendered; thereby, allowing the organization the opportunity to assess the member for Case or Disease Management services.

Practitioner – a licensed or certified professional who provides medical care or behavioral healthcare services.

Pre-Ccertification – The process of determining medical necessity for specific services before they are rendered.plan's decision that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Medical necessity review is prospective or conducted prior to the member's utilization of service or course of treatment in a hospital or other facility. Sometimes called prior authorization, prior approval, or preauthorization.

Qualified Practitioner* [WJL7]– 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.

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management – Utilization Management	**Pre-Ccertification of Requested Services – LA**

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 – 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:

1) The A non-clinician MMS (may also be a non-clinician National Customer Care (NCC) associate, or other UM representative(CCR/Care Specialist in the NCC or Medical Management Specialist/UM Representative in HCM) receives a request for pre-certification via telephone, or fax, or web portal from a provider.

2) The MMSnon-clinician performs the following actions:
   a) Checks for sanctions on every out-of-network (OON) provider requesting servicesrequest for an OON provider. At a minimum the following shall be utilized to screen OON and/or non-participating providers:
      i) Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE);
      ii) The System of Award Management (SAM);
      iii) Louisiana Adverse Actions List Search; and
      iv) Other applicable sites as may be determined by LDH.
      a) ;
      .Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
      0. LINK: Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE)
      . Louisiana Adverse Actions List Search;
      0. LINK: Louisiana Adverse Actions List Search
      . The System of Award Management (SAM);
      0. LINK: System of Award Management (SAM)
      h)
   i)b) Validates the Medicaid ID number on every request if indicated for OON providersactitioners;
   j)c) Verifies member eligibility, other health insurance (OHI), and benefits coverage; and
   d) Creates the authorization shell with appropriate documentation in the UMutilization management system;.
   e) Ensures appropriate systems are completed and updated per documentation standards; and

k)f) Routes the request to the appropriate and qualified licensed UR for review and processing if needed.

l) The case may be routed to the Licensed UR Nurse if indicated.

3) The Licensed UR performs the following actions:
   a) Obtains additional information as needed, includregarding the network affiliation of the specialist, or the facility where the service or procedure is to be performeddone;
   b) Confirms timeliness of the request. Precertification requests are required to be submitted a minimum of seventy-two (72) hours before services are rendered. Requests made less than this timeframe may result in an administrative denial;
   b)c) Determines the clinical appropriateness of the service based upon the appropriate medical necessity criteria, local delivery system, and the individual member's needs;
   c)d) Consults with the requesting provider when applicableactitioner based on the mode of communication the practitioner initiated the request, (i.e., viaby telephoneic or facsimile);
   d)e) If the above information meets medical necessity criteria, the Licensed URU updates the utilization managementUM system per documentation standards, and releases the reference number to the requesting/servicing (attending/treating) provider if the submitted clinical information and requested services are medical necessary;.
   e)f) If the information provided does not meet pre-certification due to a criterion below, Rthe Licensed UR outes the request to the informs the requesting/servicing provider that a decision is required by the health plan Medical Director (or qualified practitioner) for review and determination, if the clinical information provided does not meet precertification due to any of the criteria listed below: updates the utilization management system per documentation standards, and forwards the pended case to the appropriate Medical Director for review and determination.
      i.i) Medical necessity is not established based on application of criteria against presenting clinical information, and/or services are not clinically appropriate;
      ii) The Mmember ismay not be eligible for the proposed procedure, and/or it ismay not be a covered benefit or service; or
      ii.iii) The member's benefit cap or maximum limitation has been met; or
      iv) The specialist or facility is OONout-of-network and the requesting provideractitioner or member refuses re-direction to an in-network providerspecialist or facility.
   iii.g) If the clinical information provided does not meet precertification at the requested level of service, an appropriate, alternative service or level of care may be offered. If accepted by the provider, precertification of the alternative level of care is approved. If the alternative service is not accepted, the request is referred for review and determination by the Medical Director (or qualified practitioner).

h) If a health condition is identified during the pre-certification process that is amenable to planning and coordination of services prior to admission (i.e., operative procedures, ~~such as a total knee replacement~~), the ~~L~~licensed UR documents the information so that appropriate services can proactively be coordinated to~~that~~ enhance the availability of care ~~needs~~ during the post-hospitalization period ~~are proactively coordinated~~.

~~4)~~i) The licensed UR is responsible for ensuring all appropriate systems are completed and updated per documentation standards.

~~5)~~4) The following ~~P~~pre-certification requests ~~that~~ require different or additional actions:

a) **Member not in the system:** Contact the Enrollment Area of Financial Operations to review the member's eligibility. Enrollment notifies the associate of the outcome. If the member is not enrolled with Healthy Blue~~the organization~~, the requesting/servicing provider~~actitioner~~ is informed that the "member is not enrolled with the organization per the current enrollment information in the system." If the member is in the system (regardless of eligibility)~~e~~, the ~~L~~licensed UR completes the pre-certification process.

~~b) Services are not covered: After review by the Medical Director, the designated Healthcare Management (HCM) associate initiates the appropriate notification letter to inform the member and the requesting/servicing practitioner. Please refer to the Non-Covered and Cost Effective Alternative Services – LA P&P.~~

~~c) Benefits/cap maximum met: After review by the Medical Director, the designated HCM associate initiates the appropriate notification letter to inform the member and requesting/servicing practitioner.~~

~~d) Services not clinically appropriate: After review by the Medical Director, and the requesting practitioner whenever possible, if the services remain deemed not clinically appropriate, the Medical Director denies the pre-certification and the designated HCM associate initiates a coverage not medically necessary denial letter to the member and requesting/servicing practitioner.~~

~~e)~~b) **OON ~~S~~specialist/facility ~~out-of-network~~:** If there is a specialist/facility within geo-access, and the member or provider refuses redirection to an in-network provider, the request requires review and determination by the Medical Director (or qualified practitioner). ~~The Medical Director reviews all OON pre-certification requests and makes the decision to approve or disallow.~~ Upon request by the OON provider (or when applicable), approvals are routed to the health plan single case agreement (SCA) specialist for rate negotiation and completion of an SCA. If the OON provider accepts the Medicaid fee-for-service (FFS) or standard OON rate, there is no need for an SCA.

~~i. If the OON service is approved, the designated HCM associate completes the pre-certification. If the OON provider does not accept the applicable Fee Schedule rate per contract standards, the case is routed for a Single Case Agreement (SCA).~~

i) ~~The authorization~~ OON approvals pending an SCA can be released ~~approved as medically necessary~~ with the disclaimer that it is "Approved as medically necessary; however, pending rate negotiations. If services are rendered before

rates are negotiated, the reimbursement will be applicable to the Fee Schedule and contract standards."

1.ii) Refer to *Out-of-Area, Out-of-Network Care – LA* and *Out-of-Network Authorization Process* for additional details regarding OON processes.

ii. If the OON service is not approved, the designated HCM associate initiates a denial letter for the member and requesting/servicing practitioner. Designated HCM staff attempts to redirect care to an in-network specialist or facility.

f)c) **Other health insurance (OHI) discrepancy:** The NCC or health plan associate obtains as much information about the OHI as offered by the provider or member requesting practitioner. If there is a discrepancy between the information on file in the claims payment system and the information provided with the pre-certification request,; the associate notifies the Cost Containment Unit via email (ccuohi@amerigroupcorp.com) for review of the member's OHI. The associate proceeds with processing the pre-certification request regardless of the member's OHI as long as the member is eligible with the organization.

g) **One-time sick visit:** The NCC associate determines if the practitioner is in-network, documents the request as notification only, and pre-certifies the one-time sick visit request.

h)d) Tonsillectomy with Adenoidectomy: The Licensed UR or health plan Medical Director determines the request meets medical necessity, pre-certifies the tonsillectomy to include the adenoidectomy. The adenoidectomy does not require medical necessity review.

e) **Pre-certification Date Span:** Pre-certification requests entered into the utilization managementUM system are allowed extension of services up to six (6) monthsone (1) calendar year. If services are still required after the expiration of the authorizationprecertification, the NCC or health plan associate enters a new precertification for services upon receipt of a new request.

i)

6) NCC and health plan associates ensure appropriate systems are updated per documentation standards.

5) Pre-certification determinations are made according to **State contractual time standards**.
NOTE: Where State or Federal time standards differ from National Committee for Quality Assurance (NCQA), the more stringent time standard applies. NCQA timelines are listed in #6 belowabove in section seven (7).

Eighty percent (80%) of standard service authorization determinations areshall be 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 Community Psychiatric Support and Treatment (CPST) and Psychosocial Rehabilitation (PSR) services for which the

standard for determination is within five (5) calendar days of obtaining appropriate medical information.

a) All standard service authorization determinations are made no later than fourteen (14) calendar days following receipt of the request for service.
   i) The authorization decision may be extended up to fourteen (14) additional calendar days if the member, or the provider, requests the extension; or Healthy Blue justifies the need for additional information and how the extension is in the member's interest.

b) In the event the provider indicates, or the Healthy Blue determines, that the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, an eExpedited service authorization determinations is are made as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request.
   i) 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 a need for additional information and how the extension is in the member's best interest.

c) Retrospective review determinations are made 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 service.
   i) 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 member's health condition made by the provider.
   ii) Healthy Blue shall not use a policy with an effective date subsequent to the original service authorization request date to rescind its prior authorization.

d) For service authorization approval for a non-emergency admission, procedure or service, Healthy Blue notifies 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 provide written notification to the provider within two (2) business days of making the determination.

e) For service authorization approval for extended stay or additional services, Healthy Blue 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 written notification to the provider within two (2) business days of making the determination.

f) Healthy Blue notifies 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. Written notification is provided to the member and

the provider rendering the service, whether a health care professional or facility or both, within two (2) business days of making the determination.

g) As part of appeal procedures, the informal reconsideration process allows the member (or provider/agent on behalf of a member) a reasonable opportunity to present evidence, and allegations of fact or law, in person and in writing. Providers or agents acting on behalf of a member regarding a precertification denial require the member's written consent (refer to *Informal Reconsideration – LA*).

7)6) Pre-certification determinations are made according to National Committee for Quality Assurance (**NCQA**) **time standards**. **NOTE:** Where State or Federal time standards differ from NCQA, the more stringent time standard applies. State timelines are listed below in section nine (9).

a) Non-urgent pre-service decisions and notifications are made within fourteen (14) calendar days of receipt of the request;

b) Urgent pre-service decisions and notifications are made within seventy-two (72) hours/three (3) calendar days of receipt of the request.

i.i) The following criteria must be met to qualify for an urgent review: A member, or any physician (regardless of whether the physician is affiliated with the Healthy Blue Plan), may request that the health plan expedite a determination when the member or his/her physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy.

8) A date of service is less than fourteen calendar days from the request date, does not solely justify or The following situation does not meet criteria for an expedited/urgent/STAT review. request and is managed as a non-urgent request: the date of service (DOS) is less than fourteen (14) calendar days from the request date.

ii)

a) There are certain circumstances under which the above standard NCQA timelines maycan be extended. Practitioners and members are notified when an extension is made. Unless State or Federal standards mandate otherwise, NCQA extension timelines are as follows:

c)

i) The urgent pre-service timeframe may be extended due to lack of necessary information, once, for forty-eight (48) hours, under the following conditions:

- Within twenty-four (24) hours of receipt of the urgent preservice request, the member or authorized representative is notified of what specific information is required to make the decision.
- The member or representative is given at least forty-eight (48) hours to provide the information.

- The extension period, within which a decision must be made, begins when the additional information is received (even if all requested information is not provided), or at the end of the forty-eight (48) hours given when no response is received.

b)ii) Non-urgent pre-service requests that lack necessary information (this includes situations beyond the plan's control –(e.g., waiting for an evaluation by a specialist) may be extended, once, up to fourteen (14) calendar days, under the following conditions:

i.• Within fourteen (14) calendar days of the request, the member or authorized representative is notified of what specific information is required to make the decision.

ii.• The member or authorized representative is given at least forty-five (45) calendar days to provide the information.

iii.• The extension period, within which a decision must be made, begins when the additional information is received (even if all requested information is incomplete or not provided), or at the end of the forty-five (45) calendar days given when no response is received.

c)a) The urgent pre-service timeframe may be extended due to lack of necessary information, once, for forty-eight (48) hours, under the following conditions:

i. Within twenty-four (24) hours of receipt of the urgent preservice request, the member or authorized representative is notified of what specific information is required to make the decision.

ii.i. The member or representative is given at least forty-eight (48) hours to provide the information.

iii.i. The extension period, within which a decision must be made, begins when the additional information is received (even if all requested information is not provided), or at the end of the forty eight (48) hours given when no response is received.

9) Pre-certification determinations are made according to State time standards. **Note:** Where State or Federal time standards differ from NCQA, the more stringent time standard applies. NCQA timelines are listed above in section seven (7).

a) Eighty percent (80%) of standard service authorization determinations shall be made within two (2) business days of obtaining appropriate medical information, 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.

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

i.The decision may be extended up to fourteen (14) additional calendar days if the member, or the provider, requests the extension; or Healthy Blue justifies the need for additional information and how the extension is in the member's interest.

~~c) Expedited service authorization determinations are made no later than seventy-two (72) hours after receipt of the request.~~

~~i.The seventy-two (72) hour time period may be extended up to fourteen (14) calendar days if the member or Healthy Blue justifies a need for additional information and how the extension is in the member's best interest.~~

~~d) Retrospective review determinations are made within thirty (30) calendar days of obtaining any appropriate medical information, but in no instance later than one hundred, eighty (180) days from the date of service.~~

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 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.

Refer to *Non-Covered and Cost-Effective Alternative Services – LA* for additional information

regarding excluded, non-covered, and in lieu of services.

REFERENCES:

A08 – Pharmacy Prior Authorization
Associates Performing Utilization Reviews Core Process – LA
CFR Title 42
Clinical Criteria for Utilization Management Decisions – Core Process
Clinical Information for Utilization management Reviews – Core Process – LA
Continuity of Care – LA
Durable Medical Equipment – LA
Health Care Management Denial – LA
Informal Reconsideration – LA

Federal Medicaid Managed Care Rule – 42 CFR 438.210(d); 42 CFR 440.230
Louisiana State Contract
Medical Transportation – LA

NCQA Accreditation Standards and Guidelines
Non-Covered and Cost-Effective Alternative Services – LA
Out-of-Area, Out-of-Network Care – LA
Out of Network Authorization Process
Pediatric Day Health Care and Personal Care Services – LA
Prior Authorization Liaison (PAL) Policy – LA
Second Opinion
Specialty Referral
Standing Referral – LA
Staff Availability
Use of Board Certified Consultants (Medical/Behavioral Health) – Core Process
Utilization Management Clinicians Responsibilities (Health Plan/Region)
Utilization Management Support Staff
Office of Inspector General U. S. Department of Health and Human Services Exclusions Database.
United States General Services Administration System for Award Management
State of Louisiana Department of Health Louisiana State Adverse Actions List Search

RESPONSIBLE DEPARTMENTS:

Primary Department: Health Care Management – Utilization Management

Section (Primary Department)	**SUBJECT (Document Title)**
Health Care Management – Utilization Management	**Pre-Ccertification of Requested Services – LA**

Secondary Department(s): Behavioral Health, ~~—~~Enrollment Services,
National Customer Care Organization,
Provider Services ~~Organization~~

~~**EXCEPTIONS:**~~

~~Please refer to Contract section 8.5.4.1.2.1 and 42 CFR 438.404 that requires notice to members when decisions are not made within the specified time frames.~~

REVISION HISTORY:

Review Date	Changes
06/02/2015	• Louisiana specific removed from Corporate policy
09/03/2015	• Louisiana Bayou Health Contract Amendment 4 Behavioral Health changes review
07/05/2016	• For annual review • Definitions placed in alphabetical order
08/10/2017	• For annual review • References placed in alphabetical order • Secondary department placed in alphabetical order • Claims removed as a secondary department
02/12/2018	• Off cycle review • Revised to incorporate Amendment 11 contact changes
08/08/2018	• Annual review • Definitions section updated • Includes Amendment 12 and 13 changes • Cost Containment department removed as secondary
09/13/2018	• Off cycle review • Edits to procedure section with current contract language • Reference section updated • Exceptions section updated
~~10/24/2019~~07/14/2020	• Annual Review • Placed on updated template • Updated Policy, definitions, procedure, exceptions, and references ~~Updated Definitions~~ ~~Updated Procedure~~ ~~Updated Exceptions~~ ~~Updated References~~ • Updated Secondary Departments to include Behavioral

	Health • "Appropriate Practitioner" definition replaced by the LDH-approved "Qualified Practitioner" definition • "Qualified practitioner" replaced "appropriate practitioner" throughout
~~7/14/2020~~	~~• "Appropriate Practitioner" definition replaced by the LDH-approved "Qualified Practitioner" definition~~ ~~• "Qualified practitioner" replaced "appropriate practitioner" throughout~~