Section (Primary Department) **Utilization Management**		**SUBJECT (Document Title)** **Decision and Notification Timeframes - CA**	
Effective Date 05/01/2003	**Date of Last Review** 02/08/2024	**Date of Last Revision** 07/26/2023	**Dept. Approval Date** 02/08/2024
Department Approval/Signature:			

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

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

POLICY:

Anthem Medicaid (Anthem) ensures compliance with local, state, regulatory requirements and accreditation standards when making Utilization Management (UM) decisions and notifications. UM decisions are made as soon as possible, and take into account the medical urgency of the situation, and if applicable, are performed no later than the date the extension expires.

DEFINITIONS:

Clinical Information: Clinical information includes, but is not limited to**:**

- Office and hospital records.
- A history of the presenting problem.
- Physical exam results.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.

If Anthem receives any clinical information at all, even if only a diagnosis or procedure code or symptom, a case must be initiated, and it must be documented that additional clinical information has been requested.

Consideration: For operational purposes, The National Committee for Quality Assurance (NCQA) 72 hours equivalent to three (3) calendar days.

Continued Stay Review: Any review for an Initial inpatient admission or extension of a previously approved, ongoing course of treatment over a period of time or number of treatments. Continued Stay reviews are typically associated with inpatient care or ongoing ambulatory care.

Notice of Action: A letter of denial, deferral, or modification of prior authorization. Both members and providers will receive a written notice of action.

Post-service Decision: Any review for care or services that have already been received (e.g. retrospective review). A request for coverage of care that was provided by an out-of-network practitioner and for which the required PA (prior authorization) was not obtained is a post-service decision. If a request is received for coverage of an acute inpatient stay after the member's discharge, the request is considered post-service.

Pre-service Decision: Any case of service that must be approved, in whole or part, in advance of the member obtaining the medical care or services. Preauthorization (PA) and pre-certification are pre-service decisions.

Time of Receipt: When the request is made in accordance with its reasonable filing procedures, regardless of whether all the information necessary to make the decision is sent at the time of the request. For urgent requests, the time of receipt begins from the date the request was actually received, even if it was outside of normal business hours. For non-urgent requests received outside of normal business hours via fax, the time of receipt is the next business day.

Urgent Care: 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:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Urgent or Expedited Continued Stay Review: Any continued request that meets the definition of urgent. A request made while the member is in the process of receiving care to be an urgent continued stay request if the medical care requested meets the definition of urgent, even if the organization did not previously approve the earlier care. For example, if Anthem is

notified on day 2 that a member is in an inpatient facility and the member's practitioner requests authorization for additional days, the request is handled as an urgent continued stay request.

Urgent or Expedited Pre-service: Any pre-service request that meets the definition of urgent

PROCEDURE:

I. Pre-service Reviews for Authorization of Services (including therapeutic enteral formula and physician administered drugs)

A. Non-Urgent, Pre-Service Decisions:

The decision to approve, modify, or deny requested non-urgent pre-service requests, are made within five (5) business days from the receipt of the request, but no longer than 14 calendar days from the receipt of the request. The provider is notified within 24 hours of the decision. Written or electronic confirmations of deferrals, denials, modifications, reductions, suspensions, or terminations of covered services are sent to provider and member within two (2) business days of the decision.

If Anthem cannot make a decision to approve, modify, or deny the request for authorization within the timeframe above because Anthem is not in receipt of all of the information reasonably necessary and requested, or because the Anthem requires consultation by an expert reviewer, or because Anthem has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, and Anthem can provide justification upon request by the State for the need for additional information and how it is in the Member's interest, or Member or the Member's provider requests an extension (all occurring by the fifth (5) business day) the time limit will then be extended to 14 calendar days. The enrollee and provider will be notified in writing and given the anticipated date on which a decision may be rendered. The enrollee is also informed of the right to file a grievance if he or she disagrees with the decision to extend the timeframe.

Any decisions delayed beyond the above time limits is considered a denial and must be immediately processed as such.

B. Urgent or Expedited Pre-service Decisions:

The decision and notification to approve, modify, or deny requested urgent or expedited services are made as expeditiously as the member's health condition requires, and no later than 72 hours of receipt of the request, or no later than the date the extension expires. Written or electronic confirmation of denials, modifications, reductions, suspensions, or termination of covered services will be sent to the provider and member within 72 hours of the receipt of the request. Both provider and member are notified of how to initiate an expedited appeal at the time of notification.

If Anthem cannot make a decision to approve, modify, or deny the request for authorization within the timeframe above because Anthem is not in receipt of all of the information reasonably necessary and requested, or because the Anthem requires consultation by an expert reviewer, or because Anthem has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, and Anthem can provide justification upon request by the State for the need for additional information and how it is in the Member's interest, or Member or the Member's provider requests an extension (all occurring by the 72H) the time limit will then be extended to 14 calendar days. The enrollee and provider will be notified in writing and given the anticipated date on which a decision may be rendered. The enrollee is also informed of the right to file a grievance if he or she disagrees with the decision to extend the timeframe.

Any decisions delayed beyond the above time limits is considered a denial and must be immediately processed as such.

II. Continued Stay Review/Concurrent Review (inpatient and/or ongoing ambulatory services)

A. Continued Stay/Concurrent Review Decisions:

The decision to approve, modify or deny requested continued inpatient services is made within 72 (3 cal days) hours of the receipt of the request. If the decision is a denial or modification; two attempts will be made prior to the denial to contact the provider to discuss the plan of care and the provider and member are notified verbally, electronically, or in writing within 24 hours of the decision. The provider and member are notified of how to initiate an expedited appeal at the time of notification.

If Anthem cannot make a decision to approve, modify, or deny the request for authorization within the timeframe above because Anthem is not in receipt of all of the information reasonably necessary and requested, or because the Anthem requires consultation by an expert reviewer, or because Anthem has asked that an additional examination or test be performed upon the enrollee, provided the examination or test is reasonable and consistent with good medical practice, and Anthem can provide justification upon request by the State for the need for additional information and how it is in the Member's interest, or Member or the Member's provider requests an extension (all occurring by the 3rd calendar day) the time limit will then be extended to 14 calendar days. The enrollee and provider will be notified in writing and given the anticipated date on which a decision may be rendered. The enrollee is also informed of the right to file a grievance if he or she disagrees with the decision to extend the timeframe.

Any decisions delayed beyond the above time limits is considered a denial and must be immediately processed as such.

B. Non-Urgent, (Ongoing Ambulatory):

The decision to approve, defer, modify or deny requested continued ongoing ambulatory services is made within five (5) business days from the receipt of information reasonably necessary to render a decision. The provider is notified within 24 hours of the decision. Written or electronic confirmations of deferrals, denials, modifications, reductions, suspensions, or terminations of covered services are sent to provider and member within two (2) business days of the decision.

Anthem may extend the decision timeframe up to 14 calendar days if the member or provider requests the extension or if satisfactory evidence is provided that a delay in rendering the decision is in the member's best interest occurs by the fifth (5) business day. For an extension not requested by the member, Anthem shall provide written notice to the member of the reason for the delay and an estimated date of decision. A decision will be rendered by 14th calendar day regardless if the additional information requested is received.

For cases where the clinical information is not sufficient to determine medical necessity, the provider is contacted with a request for the clinical information reasonably necessary to determine medical necessity, provider to be consulted, and right to file a grievance to dispute the delay.

Any decisions delayed beyond the above time limits is considered a denial and must be immediately processed as such.

C. Hospice Care:

When the patient receives general care in an inpatient facility for pain control, or acute/chronic symptom management that cannot be managed in other settings (Example: chemotherapy/radiation for pain palliation by reducing tumor growth), the response time for Inpatient Hospice Care is 24 hours.

III. Post-service Review for Authorization of Services

A. The decision to approve, deny or modify post-service requests, are made within 30 calendar days of Post Service Clinical Claim Review Unit's (PSCCR) request. If the decision is a denial or modification, the member is notified in writing and the provider is also notified electronically or in writing within 30 calendar days of the receipt of the request.

IV. Communications

A. Written communications or Notice of Action (NOA) letters regarding decisions to the member and provider will identify the specific health care service denied, deferred, or modified and will include the following:

1. The action Anthem has taken or intends to take
2. A clear, concise explanation of reasons for the plan's decision
3. A description of the criteria or guidelines used
4. A citation of the specific regulations or plan authorization procedures supporting the action
5. Criteria or guidelines availability upon request
6. The name of the health care professional responsible for the decision
7. The phone number to contact the physician reviewer or ask questions
8. The member's right to file an appeal and the process for doing so
9. In the case of Medi-Cal members:
    a. The member's right to request a State Hearing
    b. An explanation on how to request a State Hearing.
    c. The member's right to represent himself/herself, or to be represented by legal counsel, friend or other spokesperson at the State Hearing
    d. Anthem's address and the State's toll-free telephone number for information on legal representation.
    e. The time limit for requesting a State Hearing.
    f. The circumstances under which a member may continue to receive benefits pending resolution of the Appeal.
    g. How to request that benefits be continued and the circumstances under which the member may be required to pay the cost of these services.

h. The circumstances under which an expedited resolution is available and how to request it.
i. The availability of the notice of action in alternative formats and translation services that considers the special needs of the enrollee, such as the hearing and visually impaired.

B. Communication to the provider regarding approved services will be given either:
1. Verbally
2. Fax Method
3. Written
4. Encrypted E-Mail

V. Additional information with regards to Denial, Deferral, or Modification of Prior Authorization Requests (Notice of Action):

A. Contractor shall ensure that at least ten (10) days of advanced notice is given to a Member when a Notice of Action results in a termination, suspension, or reduction of previously authorized covered services.

B. In cases of verified fraud by the recipient, Anthem may shorten the period of advance notice to five (5) days before the date of action.

C. Contractor shall not be required to provide advanced notice of a termination, suspension, reduction of services, or reduction of previously authorized covered services when the following conditions apply:
1. Death of a Member;
2. Member provides a written statement requesting service termination or giving information requiring termination or reduction of services;
3. Member admission into an institution that makes the Member ineligible for further services;
4. Member's address is unknown and mail directed to the Member has no forwarding address;
5. Member has been accepted for Medi-Cal services by another local jurisdiction;
6. Member's Primary Care Physician prescribes a change in the level of medical care;
7. An adverse determination made with regard to the preadmission screening requirements for nursing facility admissions on or after January 1, 1989 or;
8. Safety or health of individuals in a facility would be endangered,
9. Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Members

urgent medical needs, or Member has not resided in the nursing facility for a minimum of 30 days.

VI. Retention of Records:

Medical records will be maintained for a minimum of five (5) years from the end of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied.

REFERENCES:

- California Medicaid Policy #CA_UMXX_010 "Continued Stay Review/Care Coordination/Discharge Planning"
- California Medicaid Policy #CA_UMXX_013 "Non-Authorization of Medical Services"
- California Medicaid Policy #CA_UMXX_041 "Pre-service Authorization of Services"
- California Medicaid Policy #CA_UMXX_055 "Post-service Clinical Claims Review"
- DHCS Contract Exhibit A, Attachment III; 2.3.2Health and Safety Code §1367.01
- NCQA UM 5 Timeliness of UM Decisions
- NCQA UM 6 Clinical Information
- NCQA UM 7 Denial Notices
- Title22, CCR, § 53261
- Welfare and Institutions Code §14185

RESPONSIBLE DEPARTMENTS:

Primary Department:
Utilization Management (UM)

Secondary Department(s):
Grievance & Appeals (G&A)
Post Service Clinical Claims Review (PSCCR)

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
02/08/24	• Annual Review—no changes
07/26/23	• Off Cycle Review

Review Date	Changes
	• Added language to urgent and continued stay around deferrals under Procedure section • Updated References section • Added G&A as secondary department
03/30/23	• Off-Cycle Review • Updated Procedure section
01/25/23	• Annual Review • Updated Primary Department section from "Medical Management: Case Management (CM) & Utilization Management (UM)" to "Utilization Management (UM)" to match primary department in header
03/24/22	• Off-Cycle Review • Added extension verbiage for urgent requests • Placed references in alphabetical order
02/03/22	• Annual Review • Added verbiage per APL 21-011
07/30/21	• Off-Cycle Review • Updated References
11/11/20	• Annual Review, no changes
07/29/20	• Off-Cycle Review • Changed wording per DMHC in relation to providers and members receiving notifications on all types of cases as well as when the extension TAT would be applied • Updated policy, procedure, and definition: Notice of Action
10/30/19	• Annual Review, No changes • Updated to New Template
11/06/18	• Changed Retro TAT back to 30D per NCQA • Changed CSR TAT to 72H (3 calendar days) per NCQA
11/30/17	• Updated Post Service TAT to 14 calendar days from 30 calendar days per NCQA 2018 requirements • Updated References
12/30/16	• Annual Review • Changed wording under Non-Urgent PreService • Deleted extension section under Urgent/Expedited Preservice as we don't extend urgent preservice requests
01/08/16	• Updated wording under policy to reference H&S code • Updated References • Updated definition of clinical information from NCQA UM 6
01/28/15	• Deleted Healthy Families

Review Date	Changes
	• Changed Header to read Anthem Medicaid • Changed wording under time of receipt • Changed wording in the deferral paragraph to read up to 14 days • Deleted redundant paragraph under Non-Urgent Preservice Authorizations • Added 2 attempts to contact the provider under Concurrent Review Decisions
12/12/13	• Changed plan name from Anthem Blue Cross Medicaid to Anthem Medicaid (Anthem) throughout document per a Compliance directive.
12/17/12	• Changed reference from Anthem Blue Cross State Sponsored Business to Anthem Medicaid. • Corrected formatting and grammar • Added "Clinical Information" and "Notice of Action" to DEFINITIONS section • Aligned timeframes and notifications in policy to match CA regulations and CA contracts • Corrected information and re-titled the information under Section V to match contract language. • Changed reference from Care Management to Medical Management • Updated references • Added revision history to policy