FILING NOTICE: Revisions to this policy require filing with the CA Department of Managed Healthcare. Notify the Compliance Department of any edits made to this policy.

UTILIZATION MANAGEMENT			
	ASPIRE HEALTH PLAN	**Effective Date** 01/01/2021	
		Policy # AHP ASO-OP001	
	ACCESS TO UM STAFF AND COMMUNICATION SERVICES	**Review Date** 6/16/2022	**Applicable to:** ☐ Medicare Advantage ☑ Commercial ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title	Eva Balint, MD – Chief Medical Officer	

1.0 PURPOSE

1.1 The purpose of this policy is to ensure that all Commercial HMO members and providers:

1.1.1 Have access to Utilization Management (UM) staff to discuss UM issues or address questions related to the UM process.

1.1.2 Receive communications specific to the approval, modification or denial of health care services in a timely manner, which include all applicable regulatory elements.

2.0 POLICY

2.1 UM staff will be available from 0800 to 1700 on normal business days (Monday through Friday) for inbound calls regarding UM issues. UM staff will respond to post-stabilization requests within thirty (30) minutes.

2.2 UM staff will be available to monitor incoming voicemail and fax communications when an office closure extends more than 48 consecutive hours (i.e. an observed holiday falls on a Monday).

2.3 Communication of UM decisions must be made in the following time frame:

2.3.1 Non-urgent Pre-Service Request:

2.3.1.1 Provider: Within 24 hours of the decision (approvals and denials)

2.3.1.2 Member: Within 2 business days of the decision (approvals and denials)

2.3.2 Urgent Pre-Service Request:

2.3.2.1 Provider: Within 24 hours of the decision, not to exceed 72 hours after receipt of request (approvals and denials)

2.3.2.2 Member: Within 72 hours of the request (approvals)

2.3.2.3 Provider an Member: If oral notification is provided within 72 hours of receipt of request, written or electronic notification must be given not later than 3 calendar days after oral notification (denials)

2.3.3 Post-Service Request:

2.3.3.1 Provider: Within 30 days of receipt of request (approval and denials)

2.3.3.2 Member: Within 30 days of receipt of request (approval and denials)

2.3.4 Non-Urgent Prescription Drug Request Communication to the Provider: Within 72 hours of the request (approvals and denials).

2.3.5 Urgent Prescription Drug Request or Exigent Circumstances Communication to the Provider: Within 24 hours of receipt of the request (approvals and denials).

2.4 Concurrent review decisions, pertaining to care that is underway, shall be communicated to the member's treating provider within 24 hours.

2.4.1 Care shall not be discontinued until the member's treating provider has been notified of the Plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

DEFINITIONS

3.1 Refer to the Definitions Manual

3.0 PROCEDURE

3.1 UM staff will be available from 0800 to 1700 on normal business days for inbound calls regarding UM issues.

3.2 AHP uses telephone, email, and facsimile for communications after-hours, after normal business hours, voicemail is available to receive and record questions regarding UM issues. The voicemail message also directs providers and members to call the on-call nurse if the issue is pertaining to an urgent authorization request that cannot wait until normal business hours. Members requiring urgent and emergent medical care are directed to the nearest emergency room or to call 911.

3.3 Communications received after normal business hours are returned on the next business day and communications received after midnight Monday–Friday are responded to on the same business day. Documentation of these calls are recorded in the member record.

3.4 Outbound communication regarding UM inquiries are conducted via telephone calls, fax and letters during normal business hours; when initiating or returning calls regarding UM issues, staff identifies themselves by name, title and organization.

3.5 TDD (telecommunications device for the deaf) or TTY (telephone typewriter, or teletypewriter) are electronic devices for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. AHP provides a separate toll free phone number for receiving TDD/TTY messages and also uses the State/711 Relay Services.

3.6 AHP provides access to discuss denials and approvals with non-behavioral healthcare reviewers. Callers may also ask questions regarding the UM process, including all inquiries about decisions beyond confirmation of approval or denial. Initial calls regarding questions related to the UM process are received by administrative staff within the UM department and are triaged accordingly. Should the question be clinical in nature, the call is forwarded to nursing staff or the medical director, as appropriate. Documentation of the communication is recorded in the member record by the (non-behavioral health care staff (nurse or medical director) receiving the call with their name, the date and time of the call, and who they spoke with. The same requirements of documentation hold true when outbound calls are made and/or a voicemail message is left.

3.7 AHP provides members and practitioners with direct access to UM staff for specific cases and in order to provide, information, status, direction and clarification about UM decisions.

3.8 Communications regarding decisions to approve requests prior to, retrospectively, or concurrent with the provision of health care services to members shall specify the specific health care service approved.

3.8.1 Be communicated to member and provider in writing via facsimile or mail.

3.9 Communications regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services shall:

3.9.1 Be communicated to member in writing, and to providers via facsimile;

3.9.2 Include a description of the criteria or guidelines used, including a clear and concise explanation of the clinical reasons for the decisions regarding medical necessity. Anthem HMO: Language must be at the Flesch-Kincaid 8th grade reading level (8.0-8.9).

3.9.3 Include the specific reasons for the denial in easily understandable language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand;

3.9.4 Include a reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based and is specific to the member's condition or to the requested services;

3.9.5 Include a statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar, criterion on which the denial decision was based, upon request by phone, facsimile, and/or mail;

3.9.6 Include instruction to call member services in order to request a copy of the actual benefit provision, guidelines, protocol, or other similar criterion, and member services will document the request in the member record;

3.9.7 Include a statement that the member can obtain explanation or detail of diagnosis or treatment codes from practitioner or provider;

3.9.8 Include a description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal;

3.9.9 Include an explanation of the appeal process, including members' rights to representation and appeal time frames;

3.9.10 Include a description of the expedited appeal process for urgent preservice or urgent concurrent services;

3.9.11 Include notification that expedited external review can occur concurrently with the internal appeals process for urgent care;

3.9.12 Include a statement regarding the right to bring civil action when all required reviews of the request, including appeal process have been completed and there is still disagreement with the outcome;

3.9.13 Include the following additional consumer resources:

3.9.13.1 Availability of a health insurance consumer assistance or ombudsman;

3.9.13.2 Health plan contact information to assist individuals with the internal claims and appeals and external review process;

3.9.13.3 Notice of language assistance translation service;

3.9.13.4 A statement on the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language.

3.10 Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall also include:

3.10.1 The name and telephone number of the health care professional responsible for the denial, delay, or modification.

3.10.1.1 The telephone number provided shall be a direct number or an extension to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification.

3.11 Member may request a Sensitive Service Confidential Communication (SSCC) concerning communication related to any sensitive services. Confidentiality must be protected regardless of method of requested communication; this may include information sent to an alternative location.

3.12 For all members who request language services, the organization must provide the information in the requested language through bilingual staff or an interpreter, to help members with their UM issues. Language assistance services are provided free-of-charge. AHP staff document this in member's record. This does not apply to after-hours calls.

4.0 TRAINING

4.1 Training for employees will occur within 90 days of hire, and upon updates to the policy.

5.0 REVIEW PERIOD

6.1 Annually.

6.0 REGULATORY REQUIREMENTS AND REFERENCES

6.1 29 CFR 2590.715

6.2 29 CFR 2590.715-2719(b)(2)(ii)(E)(I): 45 CFR 14 7 .136 (b)(2)(ii)(E)(I))

6.3 CA Health and Safety Code section 1367.01(i)

6.4 CA Civil Code 56.107

6.5 CA Health and Safety Code 1367.01(11)(4))

6.6 CA Health and Safety Code sections 1367.01(h)(3) and (4)

6.7 ICE_UM_TAT_Commercial_Standards_070116

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 72 hours after receipt of the request.**	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. **Note:** If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Pre-Service - Extension Needed • Additional clinical information required	**Additional clinical information required:** Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information. **Note:** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after receipt of information.	*Additional information received or incomplete* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials). Member: Within 48 hours after receipt of information (for approval decisions). Document date and time of oral notifications.	*Additional information received or incomplete* Within 48 hours after receipt of information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
	Additional information not received: If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. **Note:** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after the deadline for extension has ended.	*Additional information not received* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials). Member: Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions). Document date and time of oral notifications.	*Additional information not received* Within 48 hours after the timeframe given to the practitioner & member to supply the information. **Note:** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. **Exceptions:** • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to *Urgent Pre-service* category. • If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to *Non –urgent Pre-service* category.	Within 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request. **Note:** If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Standing Referrals to Specialists / Specialty Care Centers **-** All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. **NOTE:** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.
Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
Non-urgent Pre-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	**Additional clinical information required:** Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	Require consultation by an Expert Reviewer: Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	*Require consultation by an Expert Reviewer:* Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 2 business days of making the decision.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Post-Service - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request (for approvals). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
Post-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	**Additional clinical information required:** Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	*Additional information received or incomplete* Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	*Additional information received or incomplete* Within 15 calendar days of receipt of information.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	*Additional information not received* Practitioner: Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). Member: Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	*Additional information not received* Within 15 calendar days after the timeframe given to the practitioner & member to supply the information.
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Within 15 calendar days from the date of the delay notice.	*Require consultation by an Expert Reviewer:* Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 15 calendar days from the date of the delay notice.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity) 2. Non-Urgent (e.g., post-service pend or denial notifications)	<u>*LAP Services Not Delegated:*</u> All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request 2. Request forwarded within two (2) business days of member's request		<u>*LAP Services Delegated/Health Plan:*</u> All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.
Prescription Drugs CA Health & Safety Code section 1367.241 (CA SB 282; 2015-2016) ****Exigent circumstances**" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function **OR** when an insured is undergoing a current course of treatment using a non-formulary drug.*	▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	<u>Practitioner:</u> ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*	<u>Practitioner:</u> ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***NOTE:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*

7.0 POLICY VIOLATION

Any AHP associate or contractor who fails to abide by this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for further details.