UTILIZATION MANAGEMENT	ASPIRE HEALTH PLAN	**Effective Date** 01/01/2021	
		Policy # AHP ASO-OP002	
	TIMELINESS OF UM DECISIONS AND NOTIFICATION	**Review Date** 3/9/2022	**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 describe the processing and notification timeframe requirements for standard and urgent requests.

2.0 POLICY

2.1 The organization adheres to the time frames set for timeliness of UM decision making pursuant to the CA Health and Safety Code section 1367.01(h)(1) and (5) (Commercial).

2.2 Decisions to approve, modify, or deny health care services on the basis of medical necessity made by Aspire Health Plan (AHP) are made in a timely fashion appropriate for the nature of the member's condition.

2.3 AHP applies the following timeframes for **making the determination** as expeditiously as the member's health condition requires:

2.3.1 Urgent Pre-Service not to exceed 72 hours after receipt of the request.

2.3.2 Urgent Concurrent within 24 hours of receipt of the request.

2.3.2.1 Exceptions

2.3.2.1.1 If the request is not made at least 24 hours prior to the expiration date of prescribed period of time or number of treatments, and request is urgent, default to Urgent Pre-service category.

2.3.2.1.2 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.

2.3.3 Standing Referrals to Specialists/Specialty Care Centers not to exceed 3 business days of receipt of request.

2.3.4 Non-Urgent Pre-Service not to exceed 5 business days of receipt of request.

2.3.5 Post-Service within 30 calendar days of receipt of request.

2.3.6 Urgent or Exigent Circumstances Prescription Drugs (limited to prescription drugs that are injected in an office or outpatient setting) within 24 hours of receipt of request.

2.3.7 Non-Urgent Prescription Drugs (limited to prescription drugs that are injected in an office or outpatient setting) within 72 hours of receipt of request.

2.3.8 **Non-urgent pre-service** requests when **expert reviewer** is required:

2.3.8.1 Upon expiration of the 5 business days or as soon as the organization becomes aware that the 5 business day timeframe will not be met, whichever occurs first, written notification is given to the practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.

2.3.8.2 Decision must be made within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice.

2.3.9 **Urgent pre-service** requests requiring **additional information**:

2.3.9.1 Written notification is given to practitioner and member within 24 hours from receipt of requests of the need for specific information necessary to make the decision.

2.3.9.2 The organization provides 48 hours for submission of the requested information.

2.3.9.3 When additional information is received (complete or incomplete) decision must be made within 48 hours of receipt of information.

2.3.9.4 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.

2.3.10 **Post-service** requests requiring **additional information**:

2.3.10.1 Written notification is given to practitioner and member within 30 calendar days from receipt of requests of the need for specific information necessary to make the decision.

2.3.10.2 The organization provides 45 calendar days for submission of the requested information.

2.3.10.3 When additional information is received (complete or incomplete) decision must be made within 15 calendar days of receipt of information.

2.3.10.4 If the additional information requested is not received within the 45 calendar days, the decision must be made within an additional 15 calendar days.

2.3.11 **Post-service** requests when **expert reviewer** is required:

2.3.11.1 Upon expiration of the 30 calendar days or as soon as the organization becomes aware that the 30 calendar day timeframe will not be met, whichever occurs first, written notification is given to the practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.

2.3.11.2 Decision must be made within 15 calendar days from the date of the delay notice.

2.4 AHP applies the following timeframes for **providing notice of the determination** to the **provider** for approvals and denials:

2.4.1 Urgent Pre-Service communicated within 24 hours of the decision;

2.4.2 Urgent Concurrent communicated within 24 hours of receipt of request;

2.4.3 Standing Referrals to Specialists/Specialty Care Centers – Refer to appropriate service category (urgent, concurrent or non-urgent) for notification timeframes;

2.4.4 Non-Urgent Pre-Service within 24 hours of the decision;

2.4.5 Post Service within 30 calendar days of receipt of the request;

2.4.6 Urgent or Exigent Circumstances Prescription Drugs (limited to prescription drugs that are injected in an office or outpatient setting) within 24 hours of receipt of request.

2.4.7 Non-Urgent Prescription Drugs (limited to prescription drugs that are injected in an office or outpatient setting) within 24 hours of receipt of request.

2.5 AHP applies the following timeframes for **providing notice of the determination** to the **member** for approvals and denials:

2.5.1 Urgent Pre-Service

2.5.1.1 Within 72 hours of receipt of the request (for approval decisions).

2.5.2 Urgent Concurrent

2.5.2.1 Written notification no later than 2 business days after receipt of the request.

2.5.3 Standing Referrals to Specialists/Specialty Care Centers – Refer to appropriate service category (urgent, concurrent or non-urgent) for notification timeframes.

2.5.4 Non-Urgent Pre-Service within 2 business days of making the decision.

2.5.5 Non-Urgent Pre-Service (Extension needed for additional clinical information or consultation by Expert Reviewer) within 2 business days of the decision.

2.5.6 Post Service within 30 calendar days of receipt of the request.

2.5.7 Post Service (Extension Needed) within 15 calendar days of receipt of the information; within 15 calendar days after the timeframe given to supply the information is not met; or within 15 calendar days from the date of the delay notice when an Expert Reviewer is required.

2.5.8 Urgent or Exigent Circumstances Prescription Drugs (limited to prescription drugs that are injected in an office or outpatient setting) – Refer to appropriate service category (urgent or non-urgent) for notification timeframes.

2.5.9 Non-Urgent Prescription Drugs (limited to prescription drugs that are injected in an office or outpatient setting) – Refer to appropriate service category (urgent or non-urgent) for notification timeframes.

3.0 DEFINITIONS

3.1 Refer to the Definitions Manual

4.0 PROCEDURE

4.1 Authorization Request Receipt

4.1.1 Providers submit requests for authorization by mail, fax, telephone, or via the provider portal.

4.1.2 AHP will date and time stamp mailed requests upon arrival.

4.1.3 AHP will create an authorization in the source system if not already done so by online (provider portal) submission.

4.1.4 AHP will document all oral requests in writing in the case file.

4.1.5 AHP will verify member eligibility and benefits and document any exclusions or limitations in the authorization file.

4.2 Determine Urgent or Standard Review

4.2.1 AHP will automatically classify the request as an urgent request provided or supported by a physician, if the physician indicates, either orally or in writing, that applying the standard time for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function (the physician does not have to use these exact words).

4.2.2 For an urgent determination request made by a member, AHP will promptly decide whether to expedite the determination based on whether applying the standard time frame for making a determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

4.3 Denied Request for Urgent Review

4.3.1 If AHP medical director determines that an urgent/expedited request does not meet the definition of urgent services (e.g. Services furnished to an individual who requires services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition), the reviewer will:

4.3.1.1 Automatically transfer the request to the standard time frame.

4.3.1.2 Once the decision has been made to transfer the request to the standard time frame written notice will be sent to the provider and the member advising them of the decision.

4.3.1.3 Ensure the determination is made within the standard time frame (the 5 business day period starts when the request for an urgent determination is received).

4.4 Timeframes for Determination

4.4.1 AHP applies the timeframe documented in Section 2, as applicable.

4.5 Extending the Review Timeframe

4.5.1 If AHP Cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified above, because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan 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, then:

4.5.1.1 immediately upon the expiration of the timeframe specified above or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. Written notice sent to members and practitioners may include the following, as applicable:

4.5.1.1.1 Information was requested but not received

4.5.1.1.2 Consultation by an expert reviewer is required

4.5.1.1.3 Additional examinations or tests are required

4.5.1.1.4 Time frame for submitting the information

4.5.1.1.5 Expected date of decision

4.5.1.1.6 Type of expert reviewer required, if applicable

4.5.1.2 As noted above, the plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered.

4.5.1.3 Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified above, whichever applies.

4.6 Physician Review

4.6.1 Only a licensed physician (e.g. Aspire Chief Medical Officer or appropriate designee) who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity.

4.6.2 If AHP expects to issue a modified or denied medical necessity decision based on the initial review of the request, or has questions about the clinical aspects of the request:

4.6.2.1 The request will be reviewed by a California-licensed physician or other appropriate health care professional with sufficient medical and other expertise before the health plan issues the determination.

4.6.2.2 The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession.

4.6.2.3 The physician or other health care professional must consider whether the enrollee reasonably should have known that an emergency did not exist when making determinations regarding emergency services.

4.6.3 The UM denial includes reviewer's unique electronic signature or identifier on the denial letter or on the notation of denial in the file.

4.7 Timeframes for Notification

4.9.1 AHP applies the timeframes documented in 2.2 and 2.3, as applicable.

4.8 Notification Format (Denials)

4.8.1 The denial notification:

4.8.1.1 Includes a statement that members may be represented by anyone they choose, including an attorney

4.8.1.2 Provides contact information for the state Office of Health Insurance Consumer Assistance or ombudsperson, if applicable

4.8.1.3 States the time frame for filing an appeal

4.8.1.4 States the organization's time frame for deciding the appeal

4.8.1.5 States the procedure for filing an appeal, including where to direct the appeal and information to include in the appeal

4.8.2 The denial notification states the reason for the denial in terms specific to the member's condition or request and in language that is easy to understand, so the member and

practitioner understand why the organization denied the request and have enough information to file an appeal.

4.8.3 An appropriately written notification includes a complete explanation of the grounds for the denial, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.

4.8.4 For denials resulting from medical necessity review of out-of-network requests, the reason for the denial must explicitly address the reason for the request (e.g., if the request is related to accessibility issues, that may be impacted by the clinical urgency of the situation, the denial must address whether or not the requested service can be obtained within the organization's accessibility standards).

4.8.5 The denial notification references the specific criterion used to make the denial decision. The criterion used and referenced is specific to the member's condition or to the requested services.

4.8.6 The denial notification informs the member, and the practitioner acting as the member's authorized representative, that the criterion used to make the decision is available upon request.

4.8.7 AHP notifies treating practitioners about the opportunity to discuss a medical necessity denial in the denial notification, by a telephone call (including leaving a voicemail where the caller leave name, date and time of call, and return phone number), or via other materials sent to the treating practitioner to ensure awareness of the opportunity to discuss a specific denial with the reviewer (peer-to-peer discussion).

5.0 APPEALS

5.1 Expedited Appeals

5.1.1 AHP grants expedited appeal review for all requests concerning admissions, continued stay, or other health care services for members who have received emergency services but have not been discharged from the facility.

5.1.2 Expedited external review can occur concurrently with the internal appeal process for care that is urgent.

5.1.3 Decisions for expedited appeals and notifications go to the member within 72 hours of receipt of request.

5.2 Appeals for denials, reduction or termination of coverage for an ongoing course of treatment for which coverage that was previously approved allow continued coverage pending the outcome of an internal appeal of concurrent care decision until:

5.2.1 The end of the approved treatment period, OR

5.2.2 Determination of the appeal, subject to regulatory and contractual obligations.

6.0 TRAINING

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

7.0 REVIEW PERIOD

6.1 Annually

8.0 REGULATORY REQUIREMENTS AND REFERENCES

8.1 CA Health and Safety Code sections 1367.01(h)(1) and (2)

8.2 CA Health and Safety Code section 1367.01(h)(3)

8.3 CA Health and Safety Code sections 1367.01(e) and (g)

8.4 NCQA UM-4, UM-7

8.5 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.		
	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.

		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 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.*

9.0 POLICY VIOLATION

9.1 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.