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<tr><td colspan="3">ADMINISTRATIVE POLICY AND PROCEDURE</td></tr>
<tr><td>Policy #:</td><td colspan="2">110.DC</td></tr>
<tr><td>Subject:</td><td colspan="2">Utilization Management Process</td></tr>
<tr><td>Section:</td><td colspan="2">Clinical Operations</td></tr>
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<tr><td>Responsible Parties:</td><td colspan="2">Manager Utilization Management</td></tr>
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District of Columbia Contract: Section C.5.28.15 and Subsection 1927 of the Act, C.5.30, C.5.30.9, C.5.30.10, 42 C.F.R. § 438.210(d), 42 C.F.R. § 438.404
EQRO Systems Performance Review:</td></tr>
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Purpose: **This policy describes the oversight mechanisms and processes designed to promote consistency in the Utilization Management (UM) process with the goal of ensuring that Enrollees receive appropriate, quality health services in a timely manner.**

Scope: **MedStar Family Choice District of Columbia (MFC-DC)**

Policy: **MFC-DC has a formal UM system designed to process pre-service, post-service and concurrent requests for authorization of services.**

Definitions:

Appeal:	A formal request to an organization by a practitioner, Enrollee or Enrollee’s representative for review of an adverse benefit determination.
Clinical Review:	Clinical information pertaining to the current inpatient days which is beyond the ‘Diagnoses’ documented on the face sheet. An example would be a review prepared by the Utilization Review nurse.
Concurrent Request:	A request for coverage of Inpatient or Outpatient services while an Enrollee is in the process of receiving the requested services, even if the organization did not previously approve the earlier care.
Notification of Admission:	Message from a hospital entity indicating that the Enrollee is admitted but does not include clinical review/information. An example of Notification of Admission would be a ‘Face Sheet’ or a telephone call.
Peer to Peer Review:	A communication between a practitioner and an MFC-DC Medical Director to provide additional information, clinical insight, or other information for pended or denied authorizations for inpatient services.
Manager of Utilization Management:	A Registered Nurse (RN) with a valid District of Columbia license who provides day-to-day supervision of assigned UM staff, participates/provides staff training, monitors for consistent application of UM criteria by UM staff for each level and type of UM decision, monitors documentation for adequacy, and is available to UM staff on-site, by telephone or virtually.
Medical Director:	A physician with a valid District of Columbia medical license (Medical Doctor or Doctor of Osteopathic Medicine) who provides day-to-day utilization decisions in accordance with policy/procedure and recognized criteria, participates in the development of medical criteria policy, monitors documentation for adequacy, and is available to UM staff for consultation and guidance on-site or by telephone.
Non-Urgent (Standard) Request:	A request for Inpatient or Outpatient services for which application of the time periods for making a decision does not jeopardize the life or health of the Enrollee or the Enrollee’s ability to regain maximum function and would not subject the Enrollee to severe pain.

Pre-Service Request:	A request for coverage of Elective Admissions or Outpatient services that the organization must approve in advance, in whole or in part, where there is no identified clinical urgency.
Post-Service Request:	A request for coverage of Inpatient or Outpatient services that have been received (e.g., retrospective review).
Redetermination:	Review of additional material, at the discretion of MFC-DC, when a concurrent denial is issued for insufficient or missing clinical information with option to reverse the decision to deny. This is a review of additional material and not a request for the denial to be reviewed.
Request for Authorization:	Notice of admission, including date of admission, facility, attending physician, and diagnoses accompanied by clinical review/information.
Urgent (Expedited) Request:	A request for Inpatient or Outpatient services where application of the time frame for making routine or non-life-threatening care determinations: i. Could seriously jeopardize the life, health or safety of the Enrollee or others, due to the Enrollee's psychological state, or ii. In the opinion of a practitioner with knowledge of the Enrollee's medical or behavioral condition, would subject the Enrollee to adverse health consequences without the care or treatment that is the subject of the request

Standards and Applicability:

A. For all determinations, MFC-DC:
   1. Bases UM determinations only on the appropriateness of care and services, individual Enrollee need, the availability of community resources and benefit coverage.
   2. Does not reward practitioners or other individuals for issuing denials of coverage or service.
   3. Does not provide financial incentives for UM decision-makers that encourage decisions that result in underutilization.

B. MFC-DC is compliant with the standards and regulations set forth by Department of Health Care Finance (DHCF), National Committee for Quality Assurance (NCQA), and Health Insurance Portability and Accountability Act (HIPAA).
   1. UM decisions are made within the defined timeframe requirements to accommodate the clinical urgency of the situation. When there are differences in timeframe requirements, MFC-DC will comply with the more stringent standard.

2. Appropriately qualified licensed health care professionals:
    a. Are involved in or make UM decisions.
    b. Assess the clinical information used to support UM decisions.
    c. Supervise all medical necessity decisions.

3. Appropriately licensed health professionals shall supervise staff who are not qualified health care professionals when there are explicit UM criteria and no clinical judgment used to approve services.

4. Any prior authorization decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a physician who has appropriate clinical expertise in treating the Enrollee's condition or disease.

5. Efforts are made to consistently obtain all necessary information including pertinent clinical information and to consult with the treating physician as appropriate. Clinical information includes, but is not limited to, office and hospital records, a history of the presenting problem, a clinical exam, diagnostic testing results, treatment plans and progress notes, patient psychosocial history, and information on consultations with the treating practitioner.

6. Only the minimum information necessary will be requested. If enough clinical information relevant to the criteria is not provided with the request, MFC-DC will document in the clinical software system its attempts to gather the clinical information needed to make a decision.

7. MFC-DC may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee.

8. Enrollee confidentiality is maintained.

C. Failure to follow filing procedures: If the Enrollee (or the Enrollee's authorized representative) does not follow MFC-DC's reasonable filing procedures for requesting services, MFC-DC will notify the practitioner (or the Enrollee's authorized representative) or Enrollee of the failure and informs them of the proper procedures to follow when requesting services.
    1. Urgent Pre-Service (Non-Pharmacy) and Concurrent: MFC-DC notifies the practitioner (Enrollee's authorized representative) or Enrollee within 24 hours (1 calendar day) of receiving the request for services. Notification may be verbal unless the practitioner or the Enrollee requests written notification.

    2. Non-Urgent Pre-Service (Non-Pharmacy) and Post-Service: MFC-DC notifies the practitioner or Enrollee within 5 calendar days of receiving the request for services.
        i. MFC-DC may not deny a Non-Urgent Pre-Service, Urgent Pre-service, Urgent Concurrent and Non-Urgent Pharmacy Pre-Service request that requires medical necessity review for failure to follow filing procedures. MFC-DC may deny a post-service request if the Enrollee (or the Enrollee's authorized

representative) does not follow MFC-DC's reasonable filing procedures but must provide the reason for the denial.

D. For any previously authorized service, written notice to the Enrollee must be provided at least 10 days prior to reducing, suspending, or terminating a covered service.

Procedure:

A. Inpatient Review (Urgent Concurrent) Procedures:
   1. All inpatient reviews will be conducted by an UM RN. The RN will identify requests for authorization reviews from the facility's CM/UM Department via their Open Authorizations widget or Request Received widget in the clinical software system. All concurrent reviews are performed telephonically or electronically.

   2. When performing a clinical review, the RN will self- introduce as an MFC-DC employee and provide their name and title when receiving, initiating, or returning telephone calls to Enrollees, authorized representatives, clinicians or facilities.

   3. The RN will concurrently gather information necessary to make a clinical determination from the hospital UM department. Facilities are permitted to fax clinical information which is automated to the clinical software system securely by the Information Systems (I.S.) team.

   4. Upon gathering the clinical information, the RN applies InterQual or American Society of Addiction Medicine (ASAM) criteria. If the case involves a delivery of a newborn, the RN or designee will approve two days for vaginal delivery and four days for C-section delivery for both the Maternity and Newborn authorizations, using State Mandated benefit criteria.

   5. Upon receipt of an initial request for authorization, MFC-DC will apply InterQual or ASAM criteria.

   6. Authorization determinations are to be based solely on the clinical information obtained at the time of the review determination. Throughout the initial and concurrent review process, the RN has access to the Medical Directors. If the clinical information provided to MFC-DC fails to meet the InterQual or ASAM criteria, the case is to be referred to a Medical Director. The Medical Director may utilize a board-certified consultant to assist in making a medical necessity determination.

   7. If InterQual or ASAM criteria is met for the admit day or approved by the Medical Director as medically necessary, beginning with day seven (7) through discharge, the RN reviewer can review the clinical for medical necessity and:
      a. If the RN determines that the day(s) are warranted as medically necessary for continued inpatient stay, and the day(s) does not meet InterQual or ASAM criteria, the RN has the authority to approve the day(s) and they do not have to make a

referral to a Medical Director for review. Clinical/ medical records will be uploaded into the clinical software system as per workflow.

b. The RN will enter a note in the clinical software system stating the day(s) are authorized per UM Process Policy Section A: Inpatient Review (Urgent Concurrent) Procedures as medically necessary inpatient day(s).

c. If InterQual or ASAM criteria is not met and the RN agrees that the day(s) in question are not medically necessary, care could be provided at a lower level, there is a delay in service/procedure, there is a delay in discharge planning or care available as an outpatient, the day(s) will be referred to a Medical Director for review.

8. MFC-DC will make a determination as expeditiously as the Enrollee's health condition requires and not later than seventy-two (72) hours of receipt of the request. MFC-DC will also notify the Provider of the decision to approve or deny within 72 hours of the receipt of request for authorization. If additional clinical is indicated, MFC-DC may elect to grant an extension for up to 14 calendar days. Extension requests are to be approved by DHCF.

9. All initial requests for authorization of inpatient days must be accompanied by clinical information. Notification of an admission without clinical information is not considered a request for authorization. Clinical information is defined as information pertaining to the current inpatient stay which is beyond the diagnoses documented on the face sheet. A face sheet, without clinical information, will be considered notification of an admission only and will not constitute a request for authorization. Facilities are notified of the request for authorization filing procedures.

10. Notification of admissions without clinical information will be uploaded to the Enrollee's chart for record keeping only.

11. Post initial review, MFC-DC will document on the Daily Communication Log, the next review due date. Clinical information not received three (3) days after the scheduled review date may be subject to denial. The RN will document the request for clinical information daily on the Daily Communication Log and enter a note in the clinical software system. If the requested clinical information is not received within the timeframe stated above, the request will be referred to a Medical Director to review for denial for lack of clinical information. MFC-DC will send a Daily Communication Log to individual hospitals with reported inpatient days. Communication logs will note, at minimum, the Enrollee's name, date of birth, admission date, approved and/or denied dates of service, level of care requested, next review due date, and the authorization number.

12. If the facility does not follow the proper procedure for request for authorization, MFC-DC staff are to inform the facility's representative of the specific UM requirements and procedures.

13. MFC-DC adheres to the following timeframes requirements in making non-behavioral healthcare and behavioral healthcare urgent concurrent review decisions:

Table 1: Authorization Determinations – Urgent Concurrent

Review Type	Timeline for UM Decision Making	Timeline for Notification	Notification Method	Who Must Be Notified

Urgent Concurrent	As expeditiously as the Enrollee's health condition requires and no later than 72 hours from receipt of the request ** For extensions, see Section D: Extension *All Requests for Authorization of inpatient days must be accompanied by clinical information. Notification of an Admission without clinical information is not considered a Request for Authorization.*	Within 24 hours of decision not to exceed 72 hours from the receipt of the request ** For extensions, see Section D: Extension	Electronic or written within 24 hours of decision not to exceed 72 hours from the receipt of the request Electronic or written (required for denials*) within 72 hours from receipt of the request for authorization.	Electronic/ written: - Facility - Requesting provider Electronic or written: Written (required for denials): - Facility - Requesting provider: Treating physician or clinician – primary care physician (PCP)

**Also includes authorization of a service in an amount, duration, or scope that is less than requested*

14. Documentation of all the aforementioned activities is made in the clinical software system, concurrently.

15. Any cases meeting criteria for case management or quality improvement will be referred to the appropriate department via the clinical software system.

16. Redetermination: A redetermination is not considered an appeal. If an Urgent Concurrent denial is issued for insufficient or missing clinical information and the facility or practitioner submits the clinical review or the missing information while the Enrollee remains an inpatient or up to three (3) business days after discharge, MFC-DC reserves the right to review the additional material and reverse the denied decision. MFC-DC staff will use the additional information submitted and apply the appropriate InterQual or ASAM criteria. If the additional information meets the InterQual or ASAM criteria, the nurse reviewer may approve the day(s). If the additional information does not meet the InterQual or ASAM Criteria, the nurse reviewer will refer the case to a Medical Director. The same reviewer or Medical Director may review and reverse the denied decision. If the same reviewer or Medical Director would not overturn the denial, the facility or practitioner would be notified that the denial stands and is referred to the content of the original denial letter for guidance on the appeal process.

17. Peer to Peer: A Peer to Peer is not considered an appeal. If a facility day(s) is pended or an Urgent Concurrent denial is issued, the facility or practitioner may request a Peer-to-Peer Review while the Enrollee remains an inpatient or up to three (3) business days after discharge. A Peer-to-Peer Review is a communication between a practitioner at the hospital and a MFC Medical Director. During a Peer to Peer, the facility-based practitioner may provide additional information, clinical insight, or other information to explain why the hospital day(s) should be approved. MFC-DC reserves the right to request documentation to support information supplied verbally and will incorporate this information into the clinical software system record. The same Medical Director involved in the case will participate in the Peer-to-Peer, when possible. This Medical Director may reverse the decision to deny and approve the day(s) if the information provided during the Peer-to-Peer warrants approval based on the Medical Director's clinical opinion. If the

Medical Director would not overturn the denial, the facility-based practitioner will be informed that the denial stands and is referred to the content of the original denial letter for guidance on the appeal process.

B. Pre-Service: Elective Admissions and Outpatient Authorizations (Urgent & Non-Urgent):

1. All outpatient reviews, pharmacy reviews, and elective prior authorization for admissions will be conducted by a Licensed Practical Nurse (LPN), RN or physician.

2. Outpatient prior authorization is required for the following:
    a. Service(s) noted in the Quick Authorization Guide, unless it specifies no authorization is required.
    b. Research/investigative.
    c. Out of Network (OON) procedures and services.
    d. Cosmetic procedures.
    e. Procedures related to Gender Dysphoria/Transgender Surgery.
    f. Pharmacy requests noted in the Prior Authorizations Table.
    g. Services that exceed benefit limits.

3. Outpatient prior authorizations/elective admission requests are accepted via a Prior Authorization Request Form, Uniform Consultation Referral form, or telephonically.

4. When performing a clinical review, the nurse will make self-introduction as an MFC-DC employee and provide their name and title when receiving, initiating, or returning telephone calls to Enrollees, Enrollee's authorized representatives, clinicians or facilities.

5. The nurse will gather minimally necessary information to make a clinical determination from individuals involved in treating the Enrollee such as the PCP, specialist, or treating clinician.

6. Upon gathering the clinical information and the request for authorization, the nurse applies InterQual or ASAM criteria or MFC-DC policies/protocols. MFC-DC protocols supersede InterQual and ASAM criteria. The availability of network providers is also considered.

7. Authorization determinations are to be based solely on the clinical information obtained at the time of the request for coverage. Throughout the review process, the nurse has access to a Medical Director.

8. If the clinical information provided to MFC-DC fails to meet the InterQual or ASAM criteria or MFC-DC policies/protocols, the service is not a covered benefit, or the request is for an OON provider/facility, the case is referred to a Medical Director.

9. If the practitioner/facility fails to provide sufficient information to facilitate making an authorization determination, the nurse will make at least one attempt to obtain clinical information. A denial occurs after failure to supply the requested clinical information.

10. For Standard Non-Urgent Pre-service Authorization, decisions must be made as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days from the initial request for service.

11. For Urgent Pre-service Authorization requests, MFC-DC shall make a prior authorization determination as expeditiously as the Enrollee's health condition requires and no later than 72 hours of receipt, if the provider indicates or the MCO determines following the standard timeframe could jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function.

12. For Pre-service Pharmaceutical requests,
    a. All covered outpatient pre-service pharmacy and concurrent pharmacy drug authorization requests will be acknowledged within twenty-four (24) hours of receipt.
    b. For all urgent concurrent, urgent preservice and non-urgent preservice decisions; MFC-DC will give electronic or written notifications of the decision to Enrollees and practitioners within twenty-four) (24) hours (one calendar day) of receipt of the prior authorization request.
    c. An extension of up to fourteen (14) days can occur if the Enrollee requests an extension or MFC-DC justifies to the DHCF a need for additional information and how the extension is in the Enrollee's interest. (See section D: Extension)
    d. A seventy-two (72) hour supply of a covered outpatient drug shall be dispensed in an emergency situation.
    e. If the service requested is denied, the practitioner may contact our Utilization Management Department to discuss the decision with the Medical Director who made the decision.

        i. *See Policy 212-DC, **Pharmacy Prior Authorization** policy for details of UM pharmacy management.
        ii. *See Policy 219-DC; **Opioid Prescription Parameters and Limitations** policy for details related to opioid prescription management.

13. If clinical information is received after the denial is rendered, the practitioner/facility will be notified to initiate a formal appeal process since a formal administrative adverse decision letter was sent.

14. If the facility does not follow the proper procedure for authorization, MFC-DC personnel are to verbally inform the facility representative of the specific UM requirements and procedures.

15. MFC-DC adheres to the following timeframe requirements in making elective admission, outpatient, and pharmacy authorizations for non-behavioral healthcare and behavioral healthcare decisions:

Table 2: Authorization Determinations - Elective Inpatient, Outpatient-Other/Outpatient-DME, Pharmacy-Other and Pharmacy-PBM

Review Type	Timeline for UM Decision Making	Timeline for Notification	Notification Method	Who Must Be Notified
Pre-Service Urgent Concurrent	As expeditiously as the Enrollee's health condition requires and no later than 72 hours from receipt of the request ** For extensions see Section D: Extension .	Within 24 hours of decision, not to exceed 72 hours from receipt of the request ** For extensions see Section D: Extension	verbally within 24 hours of decision not to exceed 72 hours from receipt of the request Electronic or written (required for denials*) within 72 hours of request for authorization.	Verbally: - Requesting Facility / Provider Electronic or written Written (required for denials): - Facility - Requesting provider (Treating physician or clinician – PCP) -Enrollee or Enrollee's Representative
Pre-Service (Urgent)	As expeditiously as the Enrollee's health condition requires and no later than 72 hours from receipt of the request ** For extensions, see Section D: Extension	Within 24 hours from the date of the determination, not to exceed 72 hours from receipt of the request ** For extensions, see Section D: Extension	Verbally within 24 hours of decision, not to exceed 72 hours from the receipt of the request Electronic or written (required for denials*) within 72 hours of request for authorization.	Verbally: - Requesting practitioner or provider Written (required for denials): - Requesting facility - Requesting physician or clinician - PCP -Enrollee or Enrollee's authorized representative -
Pre-Service (Non-Urgent)	As expeditiously as the Enrollee's health condition requires and no later than fourteen days (14) days of the receipt of the request **For extensions, see Section D: Extension	Within 24 hours from the date of the determination, not to exceed 14 calendar days from the receipt of initial request ** For extensions, see Section D: Extension	Verbally within 24 hours of decision not to exceed 14 calendar days from the receipt of request Electronic or written (required for denials*)	Verbally: - Requesting practitioner or provider Written (required for denials): - Requesting facility - Requesting physician or clinician - PCP -Enrollee or Enrollee's authorized representative

Pre-Service Pharmacy (Urgent Concurrent, Urgent, Non-Urgent) *See Policy 218; Pharmacy Process for details of UM pharmacy management	Within 24 hours from the receipt of a pharmacy request) MFC will approve, deny or request further information. If further information is requested: a decision is made within 24 hours of receiving the request regardless whether clinical information is received.	Within 24 hours from the receipt of the request	Electronic or written within 24 hours from receipt of the request Electronic or written (required for denials)	verbally: - Enrollee or Enrollee's authorized representative - Requesting practitioner Written (required for denials)**:** - Requesting facility - Requesting practitioner - PCP -Enrollee or Enrollee's authorized representative

**Also includes authorization of a service in an amount, duration, or scope that is less than requested.*

16. Documentation of all the aforementioned activities is made in the clinical software system, concurrently.

17. Any case meeting criteria for disease/case management or quality improvement will be referred via the clinical software system to the appropriate department.

18. If the Medical Director denies the service, the LPN, RN or designee will process the *Notice of Adverse Benefit Determination (Denial Notice)* letter in the clinical software system. The LPN or RN preparing the letter proofreads the document. The Manager of Utilization Management or designee may also proofread the letter for NCQA readability and compliance with standards.

C. Post-Service (Retrospective) Review Determinations: Post-service reviews occur when services have already been delivered and prior authorization did not occur. Participating treating physicians/clinicians and Enrollees have up to 180 calendar days after the last date of service to request a post-service review (this is not an appeal since there was never an initial review and no administrative claim denial was issued). MFC-DC will make post-service authorization decisions as expeditiously as the Enrollee's health requires and no later than fourteen (14) calendar days of receipt of the request for service with a possible extension of up to fourteen (14) calendar days as outlined in Section D: Extension.

1. Inpatient Post-Service:
    a. The UM RN may review inpatient post-service authorization requests.
    b. The UM RN will gather information necessary to make a clinical determination from the clinical information received or request additional from hospital personnel. Facilities are permitted to eFax, secure email or mail the clinical records.
    c. Upon gathering clinical information, the UM RN applies InterQual or ASAM criteria or MFC-DC policies/protocols.
    d. Authorization determinations are to be based on the clinical information obtained at the time of the review determination.
    e. If the clinical information provided to MFC-DC fails to meet the InterQual or ASAM criteria or MFC-DC policies/protocols, the case is to be referred to a

Medical Director and the Medical Director makes a decision. The Medical Director may utilize a board-certified consultant to assist in making a medical necessity determination. The requesting provider may be consulted, when appropriate.

f. In the event that the practitioner/facility fails to provide the clinical information to make an authorization determination, the UM RN may make at least one request for clinical information. A denial occurs after failure to supply clinical information within 14 calendar days. If clinical information is received after the denial is rendered, the practitioner/facility will be notified to initiate a formal appeal process since a formal adverse decision letter was sent.
g. If the facility does not follow the proper procedure for authorization, MFC-DC's staff are to give electronic or written notification to the facility representative of the specific UM requirements and procedures.

2. Outpatient Post-Service:
   a. The LPN or RN may review outpatient post-service authorization requests.
   b. The LPN or RN will gather information necessary to make a clinical determination from the clinical information received or request additional from individuals involved in treating the Enrollee such as the PCP, specialist, and treating clinician.
   c. Upon gathering the clinical information, the LPN or RN applies InterQual or ASAM criteria, clinical judgement, or MFC-DC policies/protocols. MFC-DC policies/protocols supersede InterQual and ASAM criteria.
   d. Authorization determinations are to be based on the clinical information obtained at the time of the review determination.
   e. If the clinical information provided to MFC-DC fails to meet the InterQual or ASAM criteria or MFC-DC policies/protocols, the case is to be referred to a Medical Director and the Medical Director makes a decision. The Medical Director may utilize a board-certified consultant to assist in making a medical necessity determination. The requesting provider may be consulted, when appropriate.
   f. In the event that the requesting entity fails to provide the clinical information to make an authorization determination, the LPN or RN will make at least one attempt to request clinical information. A denial occurs after failure to supply clinical information within 14 calendar days. If clinical information is received after the denial is rendered, the requesting entity will be notified of the need to initiate a formal appeal process since a formal adverse decision letter was sent.
   g. If the requesting entity does not follow the proper procedure for authorization, MFC-DC personnel are to give electronic or written notification to the entity representative of the specific UM requirements and procedures. Examples of a failure to follow reasonable filing procedures include, but are not limited to, failure to supply procedure CPT code(s) and/or ICD 10 diagnoses code(s). Notification may be verbal, unless the requesting entity or Enrollee requests written notification

3. MFC-DC adheres to the following timeframe requirements in making post-service review for non-behavioral healthcare and behavioral healthcare decisions:

Table 3: Post-Service Review Determinations

Review Type	Timeline for UM Decision Making	Timeline for Notification	Notification Method	Who Must Be Notified
Post-Service (Inpatient, Outpatient)	Within 14 calendar days of the receipt of the request.	Within 24 hours from the date of the determination, not to exceed 14 calendar days from the receipt of initial request ** For extensions, see Section D: Extension	Verbally within 24 hours of decision not to exceed 14 calendar days from the receipt of request Electronic or written (required for denials) Electronic or written (required for denials)	Verbally: - Requesting facility, practitioner or provider Written (required for denials)**:** - Requesting facility - Requesting physician or clinician - PCP -Enrollee or Enrollee's authorized representative

4. Documentation of all the aforementioned activities is made in the clinical software system.

5. Any case meeting criteria for disease/case management or quality improvement will be referred via the clinical software system.

6. If the Medical Director denies the service, the UM Nurse or designee will process the denial letter. The UM Nurse will proofread the letter. The Manager of Utilization Management or designee may also proofread the letter for NCQA readability and compliance with standards.

D. Extensions: Preservice, urgent concurrent and post service decisions may be extended up to 14 calendar days, if the following conditions are met:

1. The Enrollee, Enrollee's representative or the provider requests an extension; or
2. MFC-DC justifies to DHCF, upon request, a need for additional information and how the extension is in the Enrollee's interest; and
3. If MFC-DC successfully justifies extending the standard service authorization decision time frame, MFC-DC shall:
   a. Give the Enrollee written notice of the reason for the decision to extend the time frame.
   b. Inform the Enrollee of the right to file a grievance if he or she disagrees with the extension decision; and
   c. Issue and carry out the MCO's determination as expeditiously as the Enrollee's health condition requires but not later than the date the extension expires.

E. Enrollee Reimbursement:
1. MFC-DC will adhere to the most current DHCF Transmittal #20-03 *Reimbursement of Out-of-Pocket Expenditures for Managed Care Medicaid Beneficiaries* (embedded below) or Policy 218.DC for pharmacy specific reimbursement when applicable. When

the timeframe does not align for Policy 218.DC, the transmittal will apply. An Enrollee has six (6) months to request reimbursement from the date of service.

F. OON Facilities:
    1. Inpatient requests for authorization involving emergent/urgent admissions will be reviewed based on medical necessity.

    2. Inpatient requests for elective procedures will be redirected to an in-network facility unless the in-network facilities do not have the specialty to treat the case presented. If the request is a post-service review of an elective procedure, MFC-DC will deny unless the clinical supports emergent, urgent care or continuity of care.

G. OON Practitioners:
    1. Requests will be redirected to a network practitioner unless there is no clinical expertise available within the network for the presenting case or the case involves continuity of care.

    2. If the request is a post-service review for services provided by a non-participating practitioner, MFC-DC will deny unless the clinical supports emergent or urgent care or continuity of care.

H. Second Opinions:
    1. Upon request, MFC-DC will provide for a second opinion from a qualified health professional. If the qualified health professional is not available within our network, MFC-DC will make arrangements for the Enrollee to obtain a second opinion from an out-of-network provider at no cost to the Enrollee. See Policy 123.DC.

I. Enrollee Protected Health Information (PHI):
    1. Enrollee PHI is to be kept confidential in accordance with applicable laws.

    2. The use and disclosure of PHI is to be limited to the minimum amount necessary to accomplish the purpose of the intended disclosure.

    3. PHI is to be used solely for the purpose of UM, including case management, discharge planning and quality management.

    4. PHI is to be shared only with entities and/or individuals who have authority to receive the information and who need access to the information in order to conduct UM and other related processes.

    5. MFC-DC shall make reasonable efforts to limit the use and disclosure of PHI to the minimum amount necessary to accomplish the purpose of the use or disclosure.

Summary of Changes:	**07/23:**
	• Regulatory Reference: Updated NCQA to 2023. Added 42 C.F.R. § 438.210(d)
	• Procedure:
	    o Added ASAM where applicable in reference to the criteria used throughout the document.
	    o C.1: Added
	    o C.2: Updated Outpatient Post-Service process to align with C.1-Inpatient Post-Service
	    o C.6: Updated processing the denial letter
	    o Grammatical and formatting changes throughout the document
	• Removed embedded Transmittal
	07/22:
	• Updated responsible parties.
	• Updated regulatory references to reflect NCQA 2022.
	• Changed Enrollee to enrollee (throughout document).
	• Updated Inpatient Review Urgent Concurrent #12.
	• Clinical not received 24 hours after the scheduled review date may be subject to denial. The RN will document the request for clinical daily in a note in the electronic authorization. If the requested clinical is not received within the timeframe stated above, the case will be sent to the Medical Director to review for denial for lack of clinical.
	• Preservice Pharmacy determinations updated to not to exceed 24 hours.
	• Table 3, Preservice pharmacy request – determinations to be made expeditiously within 24 hours of receipt of request (decision making and timeliness).
	09/21:
	• Updated Standards and Applicability section, Subsection B, #6, p5 to read: "MFC-DC may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the enrollee".
	07/21:
	• Updated regulatory references to reflect NCQA 2021.
	10/20:
	• New policy.