



Utilization Management Policy & Procedure:  
**Treatment Authorization Process and Timeline Standards**  
**Requirement: UM 002**

Effective: Revised/Reviewed: August 2009, May 2011, January 2012, February 2013, August 2013, January 2014, October 2014, February 2015, August 2015, February 2016, May 2016, Nov 2016, February 2017, November 2017, February 2018, November 2018, February 2019, February 2020

## **TREATMENT AUTHORIZATION REQUEST: AUTHORIZATION PROCESS AND TIMELINE STANDARDS**

### **Purpose**

To provide a consistent process for reviewing Treatment Authorization Requests (TAR) which refer to requests for service.

### **Scope**

The review of requests for service applies to all requests received by the Utilization Management (UM) department. The UM staff works within their scope of practice, in conjunction with the Medical Director and with the oversight of the UM Committee to review requests appropriately. Appropriately licensed health professionals supervise all review decisions. VCHCP expects delegated entities to have similar standardized programs and processes and routinely audit delegated entities for compliance.

### **Definitions**

**Pre-service decision:** Any case or service that the Plan must approve, in whole or in part, in advance of the member obtaining medical care or services. Preauthorization and precertification are pre-service decisions.

**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 (OON) practitioner and for which the required prior authorization was not obtained is a post service decision. Although the Plan requires prior authorization of OON care, post service decisions include any requests for coverage of care or services that a member has already received.

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

**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 reasonable person's standard, 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.

Note: For urgent care decisions, a health care practitioner with knowledge of the member's medical condition may act as the member's authorized representative.

## **Policy**

VCHCP has a process for reviewing and authorizing, modifying or denying Treatment Authorization Requests (TARs) for services.

Determinations, when based on medical necessity, reflect appropriate application of VCHCP's approved medical policy and practice guideline criteria. Determinations may also be based on eligibility and benefit coverage. All reviews consider individual needs and an assessment of the local delivery system.

An RN or licensed physician may review and sign a denial based on benefit coverage. A licensed physician reviews and signs every denial that is based on medical necessity.

Determinations on behavioral health treatment authorization requests are delegated to OptumHealth Behavioral Solutions of California (OHBS-CA). Such delegation accepts that a licensed psychiatrist renders all denial decisions related to medical necessity determinations. A licensed psychologist may render denial decisions for outpatient services provided by non-physician practitioners.

Information, and relevant clinical decisions and rationale are clearly documented and appropriately available for review by members.

The member has a right to representation at any time during the referral process. The appointment of an authorized representative must be in writing. Members can obtain an Authorized Representative form by calling Member Services or visiting the VCHCP business office in person. The following persons may be submitted and considered as an authorized representative:

- A friend, relative or legal representative
- A parent of a child under 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of relevant information.

- A court- appointed guardian, except the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of relevant information.
- A court-appointed conservator

## Procedure

1. Referral requests and requests for authorization of services or medications are sent by providers to the VCHCP UM Department by mail, fax, and telephone or via electronic referral. After hours' requests for urgent or emergent pre service and concurrent services are to be received by telephone only. This procedural information is made available to all practitioners in the Provider's Manual and will be available on the provider website.
  - For medication requests, please refer to Pharmacy Policies: Prior Authorization of Medication Program Policy Procedure & Pain Management for Terminally Ill Patients.
2. The date and time of the receipt of request is automatically stamped by the system whether or not all necessary information is available at that time.
3. Member eligibility and benefits are checked.
4. If the request is for other than Emergency or Urgent Services, Step #4 is skipped and staff is directed to proceed to Step #5.

Requests to the Plan for authorization to provide Emergency or Urgent service are addressed according to the following:

a. Authorization for emergency care or service is not required before the care can be provided. In accordance with current law and the reasonable person definition, members presenting to an emergency room facility will be triaged by the emergency room staff. A "reasonable person" is considered to be a person who is without medical training and who draws on his/her practical experience when making decisions regarding whether emergency medical treatment is needed. A reasonable person is considered to have acted reasonably if other similarly situated reasonable person would have believed that emergency medical treatment was necessary.

However, if such a request for authorization of emergency care is received, it is processed immediately, and responses to such requests are made no later than four (4) hours from their receipt, or by the end of the business day, (4:30p.m. PST), whichever is sooner.

If members access a non-contracted Emergency Room and based on medical evaluation the member is admitted for stabilization of an emergent medical condition, the facility shall notify the Plan or Health Network of the admission within twenty-four (24) hours. Upon notification, clinical review will occur to determine whether the member has progressed to the post stabilization phase. If clinically appropriate, a safe transfer to a contracted facility will be initiated. Transfer will be executed following coordination between concurrent review, facility case manager and with concurrence of attending and accepting provider.

b. Urgent requests received during regular work hours are processed as soon as possible and not more than 72 hours from the plan's receipt of the information reasonably necessary and requested by the plan to make the determination.

c. Requests for emergency and urgent services are presented to the regular UR reviewer for that day, or the Medical Director or designee of the Plan, in order to comply with the above standards of response time.

d. Requests for emergency and urgent services, made after regular work hours, and on weekends and holidays, are referred to the Medical Director or Acting Medical Director or Administrator of the Day ("AOD"), one of whom is on call, at all times, and available to respond to such emergency requests.

5. The request is checked for complete information such as:
- a. Member Name
  - b. Member's Benefit Plan.
  - c. Other Insurance
  - d. Member ID #
  - e. Requesting Provider
  - f. Referral Provider
  - g. Services that are required as a result of an accident are specified as such and the location of the accident is noted such as work, home, auto, other
  - h. Diagnosis (ICD-10 Code), Procedure (CPT Code)
  - i. Clinical History/Findings which justify the requested procedure
  - j. Attempted treatment, other consults

- k. Hospital records, if indicated
  - l. Diagnostic testing if indicated or applicable
  - m. Operative and pathological reports when applicable
  - n. Medications
  - o. Requested care, procedure, or test (CPT and/or HCPCS code)
  - p. Description of service (inpatient, outpatient, office)
  - q. Estimated length of stay (for inpatient requests)
6. If information is incomplete, the request is held and the necessary data is obtained from the treating physician. If a request is routine, the provider is informed by fax of the need for additional data. If a request is urgent or emergent, the UR nurse informs the provider by fax and/or by telephone, of the need for such information. See Extending Time Frames/Pending Requests below for details.
7. Documentation supporting medical necessity is gathered from appropriate sources, including but not limited to patient medical records, both submitted information and additional information available in the electronic health record, conversations with appropriate physicians and office staff, pharmacy and claims data as well as previous UM decisions. Documentation of information collected is thorough but not overly burdensome for any of the parties.
8. Non-coded or miscoded services are corrected by or in conjunction with the requesting entity.
9. The request is submitted to the licensed personnel responsible for completing the authorization process.
10. The licensed personnel checks the information and coding for accuracy. Any necessary corrections are made by or in conjunction with the requesting entity.
11. Plan practice guidelines, Plan policies and procedures, and other accepted criteria are applied by qualified personnel in making authorization determinations. This process includes the application of the guidelines and criteria based on the needs of individual patients and characteristics of the local delivery system. See Medical Policy Development and Application of Medical Criteria document for details.
12. Benefit coverage is determined through Evidence of Coverage (EOC) information and eligibility verification.
13. Appropriateness of care and service issues are directed to qualified health professionals who are involved in the utilization management decision-making process.

14. Complex cases are referred to the Medical Director. Board-certified physicians from appropriate specialty areas also assist in making determinations of medical appropriateness.
15. Case management and concurrent review cases are submitted to the appropriate staff for follow-up.
16. Only licensed physicians make determinations for the denial of requests based on medical appropriateness and/or necessity.
17. Approved requests include an authorization number for the specific services authorized.
18. All authorization requests are followed by notification of the determination to the providers and members. See Notification section below.
19. UM staff involved in utilization related decisions is aware of the need for special concern about the risks of under-utilization. Issues of potential under-and over-utilization are submitted to the Utilization Management Committee for follow-up. The Utilization Management Committee may refer the situation(s) to the Quality Assurance Committee as appropriate.
20. All necessary emergency services are arranged for or facilitated, including appropriate authorization related to the coverage of costs, and according to the following:
  - a. Emergency services, which are necessary to screen and stabilize members, do not require prior authorization in cases where a reasonable person, that is, a person without medical training, using his or her practical experience when making a decision regarding the need to seek emergency medical treatment, acting reasonably, would have believed that an emergency medical condition existed.
  - b. Emergency services are covered if an authorized representative of the Plan, such as an employee or contractor, including but not limited to, an advice nurse, a customer service representative, a network physician or a VCHCP Medical Director, authorized the provision of emergency services.
  - c. For the purpose of retrospective claim review, reimbursement for emergency care may be denied only if, upon retrospective medical review by a Plan UR Physician and/or Plan Medical Director, it is determined that the emergency services and care were never performed or the screening examination revealed that the member did not require emergency care beyond the Basic Screening Exam and stabilization. Post service denials take into consideration the presenting symptoms as well as discharge diagnoses. Emergency room claims may be denied based on lack of information from the member or practitioner. The member and practitioner are sent a written request for the information

required and is afforded at least 45 calendar days to provide the requested information. Emergency room care is also not covered for services related to jail or other custody clearance or for drug testing. However, the plan will always hold the member harmless and not financially liable and also will always reimburse the facility/provider for a Basic Screening Examination.

d. The approval of emergency services is tracked by the Plan, to assure that the above standards are achieved. Any “Emergency Service” which is denied after being provided is reviewed by a UM Physician or the Medical Director of the Plan. Regular reports of such reviews and of the actions taken afterwards, are provided to the UM Committee of the Plan.

### **Timeline Standards**

VCHCP will honor all regulatory and any contracted accreditation agency standards for the amount of time allowed to process referral/authorization requests. VCHCP makes utilization decisions in a timely manner and accommodates the urgency of individual situations (refer to Utilization Management Timelines Standards below, for details). Examples of such timeliness include:

**Prospective or pre-service review** decisions are those decisions which are made by the Plan prior to the time that the Plan member is hospitalized and/or receiving specific care which must be authorized.

1. The Plan does not require prior authorization for emergency services.
2. Urgent referral for which all necessary information has been received at the time of initial request:
  - a. A decision is made within 72 hours of the Plan’s receipt of information that is reasonably necessary to make this determination.
  - b. The practitioner may be notified orally and/or electronically or in writing of the decision within 24 hours of the decision.
  - c. The member is notified in writing within 2 business days from the decision.
3. Urgent referral for which additional clinical information is required (extension needed).



- a. Both member and practitioner are notified within 72 hours of receipt of request that additional specific information is needed and provided five (5) business days from the date of the pend letter for submission of the requested information.
  - i. If additional information is received, complete or not, a decision must be made within 72 hours of receipt of the additional information. The practitioner is notified of the decision within 24 hours of the decision. The member is notified within 2 business days of the decision.
  - ii. If no additional information is received within the five (5) business days from the date of the pend letter given to the practitioner and member to supply the information, a decision must be made with the information that is available, on that 5<sup>th</sup> business day. The practitioner is notified of the decision within 24 hours of the decision. The member is notified of the decision within 2 business days of the decision.
4. Non-urgent referral for which all information necessary to make a decision is received:
  - a. A decision is made within five (5) business days of the Plan's receipt of information that is reasonably necessary to make this determination.
  - b. The practitioner may be notified orally and/or electronically or in writing within 24 hours of the decision.
  - c. The member is notified in writing within two (2) business days of the decision.
5. Non-urgent referral for which additional information is required or consultation by an Expert Reviewer is needed (extension needed).
  - a. Member and practitioner are notified within 5 business days of the receipt of the request of the need for additional specific information.
  - b. A minimum of 45 calendar days is provided for submission of the requested additional information.
    - c. If additional information is received, complete or not, a decision must be made within five (5) business days of receipt of the additional information.
      - i. The practitioner may be notified orally and/or electronically or in writing of the determination within 24 hours of the decision
      - ii. The member is notified of the determination in writing within 2 business days of making the decision.



**Concurrent review** decisions are those decisions which are made by the Plan during the time the Plan member is hospitalized and/or receiving ongoing/ambulatory services.

The following shall apply in regard to such decisions:

1. Urgent Concurrent review requests involve initial request for urgent care.
  - a. A decision must be made within 24 hours of the Plan's receipt of information that is reasonably necessary to make this determination, inclusive of weekends and holidays.
    - i. The practitioner may be notified orally and/or electronically or in writing within 24 hours of the decision.
    - ii. The member is notified within 2 business days of the decision.
  - b. A request that meets the definition of urgent will be processed as such, even if the earlier care was not previously authorized by the Plan.
2. Non urgent concurrent - extension of a course of treatment beyond the period of time or the number of treatments previously authorized:
  - a. A decision must be made within 72 hours of the Plan's receipt of information that is reasonably necessary to make this determination, inclusive of weekends and holidays.
    - i. The practitioner may be notified orally and/or electronically or in writing within 24 hours of the decision.
    - ii. The member is notified within 2 business days of the decision.
3. **Retrospective or post service review** decisions are those decisions which are made by the Plan after the time the Plan member is hospitalized and/or receiving specific care which must be authorized.
  - a. A decision regarding Medical Necessity is made within 30 calendar days of receipt of information that is reasonably necessary to make a determination.
  - b. The practitioner and member are notified in writing within 30 calendar days of receipt of information that is reasonably necessary to make a determination.

For discussion of the review of Appeals and Expedited Appeals, please refer to the Utilization Management Policy for Appeals document.

### **Authorization Period**

The period of time that authorizations are valid is determined by the UM department and approved by the UM Committee, in conformance with any contracted accreditation agency

requirements. This time period varies depending upon the type of request and UM template used in creating the record in the medical management/documentation system known as QNXT. This time frame could vary from 1 calendar day to 90 calendar days from the date of approval. Even when a service is pre-approved, providers are cautioned and encouraged to always check the member's eligibility before providing the particular service.

#### Extending Time Frames/Pended Requests:

Referral/authorization requests may be placed in a pended status until necessary additional clinical information or benefit clarification is obtained for the Medical Director or physician designee to make an appropriate determination.

Documentation of pended requests shall include the following:

1. Reason for pending the request
2. Efforts taken to obtain the necessary information
3. Judgment and name of the medically trained person making the decision

#### For Urgent Pre-service Decisions:

If the Plan is unable to make a decision due to a lack of necessary information, it may extend the decision time frame once, for up to 5 business days. Within 72 hours of the receipt of the request, the Plan will notify the member's authorized representative of what specific information is necessary to make the decision and of the 5 business days' time frame in which to provide the requested information. The 5-business day extension period, within which a decision will be made, begins on the date of the pend letter requesting additional information. If the information requested is not received, the request may be denied. For approvals and denials, the practitioner may be notified orally and/or electronically or in writing within 24 hours after the decision is made. For approvals and denials, the member is notified in writing within 2 business days of the decision.

#### For Non-Urgent Pre-Service Decisions:

The Plan may extend the decision-making time frame once if it is unable to make a decision due to matters beyond its control or the lack of necessary information. The Plan must notify the member or the member's authorized representative of the specific information required within 5 business days of receipt of request and also notifies the member or the member's authorized representative that they are allowed at least 45 calendar days to provide the requested information. Once the specific information is received, complete or not, the decision to approve

or deny must be made within a timely manner for the member's condition but not to exceed 5 business days of receipt of the information. If the requested information is not received within 45 calendar days, the decision to approve or deny must be made with the information available not to exceed an additional 5 business days. The practitioner may be notified orally and/or electronically or in writing within 24 hours of the decision and the member is notified within 2 business days of the decision.

#### For Post Service Decisions:

The Plan may extend the decision making time frame once if it is unable to make a decision due to matters beyond its control or the lack of necessary information. The Plan must notify the member or the member's authorized representative of the specific information required within 30 calendar days of receipt of request and also notifies the member or the member's authorized representative that they are allowed at least 45 calendar days to provide the requested information. Once the specific information is received, complete or not, the decision to approve or deny must be made with the information available within 15 calendar days of receipt of the information. If the requested information is not received within 45 calendar days, the decision to approve or deny must be made with the information available not to exceed an additional 15 business days. The practitioner and the member are notified in writing within 15 calendar days of the decision.

#### Extension by members:

Members may voluntarily agree to extend the decision making time frame for urgent concurrent care. Members may also voluntarily agree to extend the time frame for urgent and non-urgent pre-service and post service decisions for reasons other than a lack of necessary information or matters beyond the Plan's control. They may also voluntarily agree to additional extensions of urgent and non-urgent pre-service and post service decisions beyond the previously mentioned extensions. Extensions by members can be accomplished by calling or writing the Utilization Review Department and the received information will be documented in QNXT.

#### Notifications

1. Notification of the determination for all authorization requests are sent to the practitioners and members according to the required time frames.
2. Denial notifications for Urgent Care requests are sent to practitioners and members.

3. Denial notifications for concurrent or post service requests are sent to the practitioners and members.
4. Notifications to practitioners may be oral and/or electronic or written.
5. Notifications to members are to be written.
6. The determination notification identifies the physician or staff reviewer and the process available to the treating physician(s) to discuss by telephone those denials that are based on medical appropriateness. Physician peer to peer is completed within 1-2 business days. Plan physician reviewers document the peer to peer discussion in the medical management clinical notes section. Timeliness of peer to peer completion will be reported in the Utilization Management Committee.
7. Written communication to a Physician or other health care provider of a denial, delay, or modification of a request include the direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them.
8. Modifications or Denials for requested services include a clear statement on the notification letter, in easy to understand language, explaining the reason for the action, how the reason for the denial pertains to the member's particular case and suggestions for alternative treatment plans (when appropriate). The information also includes the specific utilization review criteria, guideline or protocol or the benefit provision used in making the determination and the procedure for how to obtain the full criteria, guideline, and protocol or benefit provision if desired.
9. Notification of a denied request, for all types of authorization requests which include non-urgent pre-service, urgent pre-service, urgent concurrent review and post service, includes information about initiating an expedited appeal, if appropriate. See expedited appeal process in the UM policy for Appeals document for details.
10. Notification letter of a denied or modified request includes the information on the member's right to participate in the appeal and grievance process of the Plan, including a description of the Plan's appeal and grievance process, Plan's address and telephone numbers.

Through the UM denial/modification notification letter, the member is provided the Department of Managed Healthcare's telephone number, the Department's TDD line, and the Department's internet address. The UM denial/modification notification letter includes the Independent Medical Review (IMR) information obtained through the Department of Managed Health Care (DMHC) which includes the department's toll-free telephone number and the department's internet web site to access complaint forms, IMR application forms and instructions online. The letter provides information regarding the right of a member to request an Independent Medical



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Review (IMR) in cases where the member believes that health care services have been improperly denied, modified or delayed.

11. When the Plan denies services deemed experimental and the member is identified as having a terminal illness, notification of the denial includes information regarding the process for requesting a conference as a part of the appeal procedure. 12. The Plan's denial and modified letters includes information regarding the members' right to participate in the grievance process of the Plan, the Plan's telephone number, the Department's telephone number, the Department's TDD Line, and the Department's Internet address.

**Utilization Management Timeline Standards**

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic / Written)	Member Notification of All Decisions (Written Only)
<b>Urgent Pre-Service</b> All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition <b>not to exceed 72 hours after receipt of the request.</b>	<u>Practitioner:</u> Within 24 hours of the decision.  Document date and time of oral notifications.	<u>Member:</u> Within 2 business days of decision.
<b>Urgent Pre-Service Extension Needed</b>  Additional clinical information required	<b>Additional clinical information required:</b> Notify member and practitioner within 72 hours of receipt of request & provide 5 business days for submission of requested information.  <u>Additional information received or incomplete:</u>  If additional information is received, complete or not, decision must be made within 72 hours of receipt of information.	  <u>Additional information received or incomplete</u>  <u>Practitioner:</u> Within 24 hours of the decision.  Document date and time of oral notifications.	  <u>Additional information received or incomplete</u>  <u>Member:</u> Within 2 business days of the decision.



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	<u>Additional information not received:</u>  If no additional information is received within the 5 business days given to the practitioner and member to supply the information, decision must be made with the information that is available by the end of that 5 <sup>th</sup> business day.	<u>Additional information not received</u>  <u>Practitioner:</u> Within 24 hours of the decision.  Document date and time of oral notifications.	<u>Additional information not received</u>  <u>Member:</u> Within 2 business days of the decision.
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Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic / Written)	Member Notification of All Decisions (Written Only)
<b>Urgent Concurrent</b> - (i.e., inpatient, ongoing/ambulatory services)	Within 24 hours of receipt of information that is reasonably necessary to make this determination, inclusive of weekends and holidays.	<u>Practitioner:</u> Within 24 hours of decision.  Document date and time of oral notifications.	<u>Member:</u> Within 24 hours of decision.
<b>Non-urgent concurrent –</b> extension of a course of treatment beyond the period of time or the number of treatments previously authorized (i.e., extension of inpatient, extension of ongoing/ambulatory services)	Within 72 hours of the Plan's receipt of information that is reasonably necessary to make this determination, inclusive of weekends and holiday.	<u>Practitioner:</u> Within 24 hours of decision  Document date and time of oral notifications.	<u>Member:</u> Within 2 business days of decision.

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic / Written)	Member Notification of All Decisions (Written Only)
<b>Standing Referrals to Specialists / Specialty Care Centers</b>  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.  <b>NOTE:</b> 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.	<u>Practitioner:</u> Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	<u>Member:</u> Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.

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<p><b>Standing Referrals to Specialists / Specialty Care Centers</b> Additional clinical information required</p>	<p><b>Additional clinical information required:</b> Notify member and practitioner within 3 business days of receipt of request &amp; provide at least 5 business days for submission of requested information.</p> <p><u>Additional information received or incomplete:</u> 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 3 business days of receipt of information.</p> <p><u>Additional information not received</u> If no additional information is received within the 5 business days given to the practitioner and member to supply the information, decision must be made with the information that is available by the end of that 5<sup>th</sup> business day.</p>	<p><u>Practitioner:</u> Within 24 hours of the decision.  Document date and time of oral notifications.</p>	<p><u>Member:</u> Within 2 business days of the decision.</p>
<p>Require consultation by an Expert Reviewer</p>	<p><b>Require consultation by an Expert Reviewer:</b>  Within 3 business days or as soon as you become aware that you will not meet the 3-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 which is 15 calendar days from the date of the delay (pend) notice/letter.</p>		
	<p><u>Require consultation by an Expert Reviewer:</u>  Decision must be made in a timely fashion as appropriate for the member's condition within 3 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay (pend) notice to the practitioner and member.</p>	<p><u>Require consultation by an Expert Reviewer:</u>  <u>Practitioner:</u> Within 24 hours of the decision</p>	<p><u>Require consultation by an Expert Reviewer:</u>  <u>Member:</u> Within 2 business days of the decision.</p>
<p><b>Non-urgent Pre-Service</b> - All necessary information received at time of initial request</p>	<p>Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of information that is reasonably necessary to make this determination.</p>	<p><u>Practitioner:</u> Within 24 hours of the decision.  Document date and time of oral notifications.</p>	<p><u>Member:</u> Within 2 business days of the decision.</p>
<p><b>Non-urgent Pre-Service</b> - Extension Needed Additional clinical information required</p>	<p><b>Additional clinical information required:</b> Notify member and practitioner within 5 business days of receipt of request &amp; provide at least 45 calendar days for submission of requested information.</p>		
	<p><u>Additional information received or incomplete:</u> 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.</p> <p><u>Additional information not received</u> 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.</p>	<p><u>Practitioner:</u> Within 24 hours of the decision.  <u>Practitioner:</u> Within 24 hours of the decision.</p>	<p><u>Member:</u> Within 2 business days of the decision  <u>Member:</u> Within 2 business days of the decision.</p>



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<p>Require consultation by an Expert Reviewer</p>	<p><b>Require consultation by an Expert Reviewer:</b></p> <p>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 which is 15 calendar days from the date of the delay (pend) notice/letter.</p>		
	<p><u>Require consultation by an Expert Reviewer:</u></p> <p>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 (pend) notice to the practitioner and member.</p>	<p><u>Require consultation by an Expert Reviewer:</u></p> <p><u>Practitioner:</u> Within 24 hours of the decision.</p>	<p><u>Require consultation by an Expert Reviewer:</u></p> <p><u>Member:</u> Within 2 business days of the decision.</p>

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic /	Member Notification of All Decisions (Written Only)
<p><b>Post-Service</b> - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)</p>	<p>Within 30 calendar days of receipt of information that is reasonably necessary to make a determination.</p>	<p><u>Practitioner:</u> Within 30 calendar days of receipt of information that is reasonably necessary to make a determination.</p>	<p><u>Member:</u> Within 30 calendar days of receipt of information that is reasonably necessary to make a determination.</p>
<p><b>Post-Service</b> - Extension Needed Additional clinical information required</p>	<p><b>Additional clinical information required:</b></p> <p>Notify member and practitioner within 30 calendar days of receipt of request &amp; provide at least 45 calendar days for <u>submission of requested information.</u></p> <p><u>Additional information received or incomplete</u></p> <p>If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.</p> <p><u>Additional information not received</u></p> <p>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.</p>	<p><u>Additional information received or incomplete</u></p> <p><u>Practitioner:</u> Within 15 calendar days of receipt of information.</p> <p><u>Additional information not received</u></p> <p><u>Practitioner:</u> Within 15 calendar days after the timeframe given (45 calendar days) to the practitioner to supply the information.</p>	<p><u>Additional information received or incomplete</u></p> <p><u>Member:</u> Within 15 calendar days of receipt of information.</p> <p><u>Additional information not received</u></p> <p><u>Member:</u> Within 15 calendar days after the timeframe given (45 calendar days) to the member to supply the information.</p>



Utilization Management Policy & Procedure:  
**Treatment Authorization Process and Timeline Standards**  
**Requirement: UM 002**

Effective: Revised/Reviewed: August 2009, May 2011, January 2012, February 2013, August 2013, January 2014, October 2014, February 2015, August 2015, February 2016, May 2016, Nov 2016, February 2017, November 2017, February 2018, November 2018, February 2019, February 2020

Require consultation by an Expert Reviewer	<p><b>Require consultation by an Expert Reviewer:</b></p> <p>Upon the expiration of the 30 calendar days of receipt of request 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 which is 15 calendar from the date of the delay (pend) notice.</p>		
	<p><u>Require consultation by an Expert Reviewer:</u></p> <p>Within 15 calendar days from the date of the delay notice.</p>	<p><u>Require consultation by an Expert Reviewer:</u></p> <p><b>Practitioner:</b> Within 15 calendar days from the date of the delay notice.</p>	<p><u>Require consultation by an Expert Reviewer:</u></p> <p><b>Member:</b> Within 15 calendar days from the date of the delay notice.</p>

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification	
		Practitioner Notification of All Decisions (Notification May Be Oral as well as Electronic)	Member Notification of All Decisions (Written Only)
<p>Translation Requests for Non- Standard Vital Documents</p> <ol style="list-style-type: none"> <li>Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity)</li> <li>Non-Urgent (e.g., post-service pend or denial notifications)</li> </ol>	<p><u>LAP Services Not Delegated:</u> All requests are forwarded to the contracted health plan.</p> <ol style="list-style-type: none"> <li>Request forwarded within one (1) business day of member's request</li> <li>Request forwarded within two (2) business days of member's request</li> </ol>		<p><u>LAP Services Delegated/Health Plan:</u> All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.</p>

**Treatment Authorization Request Timeframe Workflow Grid**





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**A. Supporting Documents:** Health Services Job Aid: Electronic Referrals via Cerner; See Drug Policy: Pain Management for Terminally Ill Patients; See Drug Policy: Prior Authorization of Medications; TAR Timeframe Workflow Grid

**B. References:** None

**C. History:**

Reviewers: UM Committee; Medical Director; QA Manager; Health Services Director  
 Reviewed/Revised: Lita Catapang, RN & Albert Reeves, MD  
 Committee Review: UM: August 2009; QAC: August 2009 Reviewed/No  
 Reviewed/Updated: Faustine Dela Cruz, RN & Albert Reeves, MD  
 Committee Review: UM: August 11, 2011; QAC: August 23, 2011  
 Reviewed/No Changes by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD  
 Committee Review: UM: February 9, 2012; QAC: February 28, 2012  
 Reviewed/No Updates by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD  
 Committee Review: UM: February 14, 2013; QAC: February 26, 2013  
 Reviewed/Updated by: Ramona Truwe, RN; Faustine Dela Cruz, RN; Catherine Sanders, MD  
 Committee Review: UM: August 8, 2013; QAC: August 27, 2013  
 Reviewed/No Changes by: Faustine Dela Cruz; Catherine Sanders, MD  
 Committee Review: UM: February 13, 2014; QAC: February 25, 2014  
 Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD  
 Committee Review: UM: November 13, 2014; QAC: November 25, 2014  
 Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD  
 Committee Review: UM: February 12, 2015; QAC: February 24, 2015  
 Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD  
 Committee Review: UM: August 13, 2015; QAC: August 25, 2015  
 Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD  
 Committee Review: UM: February 11, 2016; QAC: February 23, 2016  
 Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD  
 Committee Review: UM: May 12, 2016; QAC: May 24, 2016  
 Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD  
 Committee Review: UM: February 9, 2017; QAC: February 28, 2017  
 Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD  
 Committee Review: UM: November 9, 2017; QAC: November 28, 2017  
 Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD  
 Committee Review: UM: February 8, 2018; QAC: February 27, 2018  
 Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD  
 Committee Review: UM: November 8, 2018; QAC: November 27, 2018  
 Reviewed/Revised by: Faustine Dela Cruz; Catherine Sanders, MD & Robert Sterling, MD  
 Committee Review: UM: February 14, 2019; QAC: February 26, 2019  
 Reviewed/No Updates by: Faustine Dela Cruz; Howard Taekman, MD & Robert Sterling, MD  
 Committee Review: UM: February 13, 2020; QAC: February 25, 2020

Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes

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2/9/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review; updated timeframes to remove NCOA timelines and replace with DMHC timelines
9/29/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Updated to remove language that member is provided an information packet that includes the IMR application instructions, application form and an envelope addressed to the Department of Managed Health Care (DMHC) in Sacramento. DMHC provided clarification that the Plan does not need to include the IMR application and addressed envelope on initial UM denials.
11/29/17	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Changed “prudent layperson” to “reasonable person” language as required by DMHC.
9/12/18	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Written communication to a Physician or other health care provider of a denial, delay, or modification of a request include the direct telephone number or an extension of the healthcare professional responsible for the denial, delay, or modification to allow the requesting Physician or health care provider to easily contact them. Physician peer to peer is completed within 1-2 business days. Plan physician reviewers document the peer to peer discussion in the medical management clinical notes section. Timeliness of peer to peer completion will be reported in the Utilization Management Committee.

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2/14/19	Yes	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	DMHC requirements: For medication requests, please refer to Drug Policy: Pain Management for Terminally Ill Patients; See Drug Policy: Prior Authorization of Medications  Added MED EXIGENT to TAR Timeframe Workflow Grid
2/13/20	No	Howard Taekman, MD; Robert Sterling, MD; Faustine Dela Cruz, RN	Annual review