group health Cooperative of eau claire **KMTSJ, Inc.**	DEPARTMENT:	Utilization Management
	SUBJECT:	Timeliness of UM Decisions
	PRODUCT LINE:	All
	POLICY NUMBER:	HM80
	ORIGINAL POLICY EFFECTIVE DATE:	08/10/2016
	LAST REVISED DATE:	11/24/2024
	LAST REVIEWED DATE:	11/24/2024

SCOPE:

To ensure Group Health Cooperative of Eau Claire (the Cooperative) follows all State and Federal statutes regarding member and practitioner notification of determinations for nonbehavioral, behavioral, and pharmaceutical requests. To ensure prior authorization determinations are made as expeditiously as the member's health condition requires and in a timely manner to minimize any disruption in the provision of care and to accommodate the urgency of the clinical situation.

POLICY:

Medical Exigency Standard

The Cooperative has developed standards for determining the urgency of coverage requests, for triaging incoming requests against established criteria, and for prioritizing each request according to these standards. The Cooperative does not routinely take the maximum time permitted for adjudicating coverage requests but treats each case in a manner that is appropriate for the facts and circumstances of the member's medical condition. The Cooperative applies accepted standards of medical practice in assessing a member's medical condition. Evidence of the member's condition is obtained from the treating practitioner and/or from the member's medical record.

The standards for determining the urgency of coverage requests includes classification of requests when received as outlined in the section below entitled, "Classification of UM Requests." The UM staff receive extensive training on this classification. Classification of the UM requests are documented in our electronic care management system and prioritized in the queue according to their classification so that urgent requests are easily identified and prioritized for review.

Classification of UM Requests

Urgent Request: A request where the timeframe for making a routine or non-life-threatening care determination could:

1. Seriously jeopardize the life or health of the member
2. Seriously jeopardize the member's ability to regain maximum function, based on a prudent layperson's judgement
3. Seriously jeopardize the life, health, or safety of the member or others due to the member's psychological state
4. In the opinion of a practitioner, with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request

Non-urgent Request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Pre-Service Request: A request for coverage of medical care or services that GHC must approve in advance, in whole, or in part.

Post-Service Request: A request for coverage of medical care or services that have been received or dispensed.

Concurrent Request: a request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if GHC did not previously approve the earlier service.

Reclassification of Requests

All types of requests received while the member is receiving care may be reclassified as preservice or postservice if the request does not meet the definition of "urgent." If a request to extend a course of treatment beyond the previously approved time period or number of treatments previously approved by the organization does not meet the definition of "urgent care," the request is handled as a new request and decided within the time frame appropriate for the type of decision notification (pre-service or post-service).

Change of Review Priority

After a request is initiated as a standard or expedited review, a practitioner may contact the plan to change the review priority. If the practitioner indicates that the enrollee's health requires an expedited decision, the plan must begin the applicable expedited review period at the time they receive the physician's request to expedite the decision. A change of priority does not allow for extra review time. If the remaining standard review period is less than the applicable expedited review period, the original standard deadline still applies.

Timelines for Notification of Decisions:

Non-urgent Pre-Service UM Decisions:
For standard prior authorization decisions, the Cooperative will provide written notice of the decision to the member and the treating or attending practitioner within 14 calendar days of the request for all lines of business. Medicare Part D pharmaceutical determinations will be made within 72 hours of receipt of the request.

Extension Conditions

Commercial
The timeframe may be extended an additional 14 calendar days when requests lack clinical documentation under the following conditions:

1. Must request information from the member before the end of the time frame for the determination, and
2. Member or member's authorized representative is given 45 calendar days to provide the information

3. The extension period begins on the sooner of:
    a. The date when the member's response was received (even if not all the information is provided), or
    b. The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative

Medicare
The timeframe may be extended an additional 14 calendar days under the following conditions:
1. The member requests an extension, or
2. GHC needs additional information, and
    a. GHC documents that it made at least one attempt to obtain the necessary information, and
    b. Notifies the member or the member's authorized representative of the delay

Medicaid
GHC may extend the time frame once, by up to 14 calendar days, under the following conditions:
1. The member requests an extension, or
2. GHC needs additional information, provided it documents that it made at least one attempt to obtain the necessary information.

Urgent Preservice UM Decisions:
For cases in which a practitioner indicates or the Cooperative determines that the request meets the definition of Urgent Request as defined above, the Cooperative will make a determination and provide written notice to the practitioner and the member within 72 hours of receiving the request for all lines of business. Medicare Part D pharmaceutical determinations will be made within 24 hours of receipt of the request.

Extension Conditions

Commercial
The decision notification time frame may be extended once for 48 hours due to lack of information under the following circumstances:
1. Within 24 hours of receipt of the request, the member or member's authorized representative is asked for more information to make the determination and
2. Member or member's authorized representative is given 48 hours to provide the information and
3. The extension period within which the decision must be made begins on the sooner of:
    a. The date when the member's response is received by the Cooperative (even if not all the information is provided), or
    b. The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's authorized representative

Medicare

GHC may extend the decision notification time frame once by up to 14 days under the following conditions:

1. Member requests an extension, or
2. Extension is justified in the member's interest and additional medical information from the practitioner is needed in order to make a decision favorable to the enrollee and at least one attempt to obtain the necessary information is documented, or
3. The extension is justified due to extraordinary, exigent or other non-routine circumstances and is in the member's interest.
4. Notifies the member or the member's authorized representative of the delay.

Medicaid
GHC may extend the decision notification time frame once by up to 14 days under the following conditions:

1. The member requests an extension, or
2. GHC needs additional information and has made at least one attempt to obtain the necessary information.

Urgent Concurrent UM Decisions:
Written notification is given to the member and the practitioner for urgent concurrent UM decisions.

Commercial: Behavioral, nonbehavioral, and pharmaceutical determination notifications are sent within 24 hours of the request.

Medicaid and Medicare: Behavioral and nonbehavioral determination notifications are sent within 72 hours of the request. Part B pharmaceutical determination notifications are sent within 24 hours of the request for Medicare. Medicaid pharmaceutical benefits are through ForwardHealth and not the HMO.

Extension Conditions

Commercial
Extensions are not allowed for urgent concurrent decisions.

Medicare
GHC may extend the decision notification time frame once by up to 14 days under the following conditions:

1. Member requests an extension, or
2. Extension is justified in the member's interest and additional medical information from the practitioner is needed in order to make a decision favorable to the enrollee and at least one attempt to obtain the necessary information is documented, or
3. The extension is justified due to extraordinary, exigent or other non-routine circumstances and is in the member's interest.
4. Notifies the member or the member's authorized representative of the delay.

Part B drug timeframes cannot be extended.

Medicaid
GHC may extend the decision notification time frame once by up to 14 days under the following conditions:

3. The member requests an extension, or
4. GHC needs additional information and has made at least one attempt to obtain the necessary information.

Post-Service Decisions:
Written notification is given to both member and attending or treating practitioner within 30 calendar days of the request for all lines of business. Medicare Part D pharmaceutical determinations will be made within 14 days of receipt of the request.

Extension Conditions

Commercial, and Medicaid
The timeframe may be extended an additional 14 calendar days when requests lack clinical documentation under the following conditions:

1. GHC must request information from the member or member's authorized representative before the end of the time frame for the determination, and
2. Member or member's authorized representative is given 45 calendar days to provide the information
3. The extension period within which a decision must be made begins on the sooner of:
    a. The date when the member's response was received (even if not all the information is provided), or
    b. The last date of the time period given to the member to provide the information, even if no response is received from the member or the member's representative

Medicare
Extensions are not allowed for post service requests.

Extensions for Other Reasons

In a situation beyond the organization's control (e.g., waiting for an evaluation by a specialist), GHC may extend the nonurgent preservice and post service time frames once, for up to 15 calendar days, under the following conditions:

1. Within 15 calendar days of a nonurgent preservice request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

2. Within 30 calendar days of a post service request, the organization notifies the member (or the member's authorized representative) of the need for an extension and the expected date of the decision.

Notification of Extension

The member or member's authorized representative is notified in writing of the reasons for the delay and informs the member of the right to file an expedited grievance if they disagree with the plan's decision to grant an extension. The member or the member's authorized representative is notified of the decision as expeditiously as the member's health condition requires but no later than the expiration of the extension.

Reference sources:

CMS Coverage Manual
DHS Contract Manual
NCQA UM Standards

APPROVED: Michele Bauer MD. DATE: 11/24/2024

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
08/5/2016	Lynne Komanec RN	Updated with DHS contract specified timeframes for issuance of notices of action and included denial notification with grounds for denial.
08/10/2016	Betsy Kelly, RN	Reformatted and renumbered. A combination of Timeliness of Authorizations and Denial Notifications P&Ps.
04/25/2017	Michele Bauer, MD, CMO	Reviewed with no changes.
03/05/2019	Michele Bauer, MD, CMO	Updated criteria and combined language from the P & P entitled, Timeliness of Authorizations
03/22/2020	Michele Bauer, MD, CMO	No changes
10/07/2020	Michele Bauer, MD, CMO	Updated timelines and E/I section
02/21/2021	Michele Bauer, MD, CMO	Updated definitions of requests and timeline extensions to align with NCQA standards and removed denial reasons from this policy and created policy called Denial Notices.
02/14/2022	Michele Bauer, MD, CMO	Reviewed. No changes.

02/20/2023	Michele Bauer, MD, CMO	Reviewed. No changes.
02/20/2024	Michele Bauer, MD, CMO	Reviewed. No changes.
05/11/2024	Michele Bauer, MD, CMO	Revised the extension requirements for product lines
05/30/2024	Michele Bauer, MD, CMO	Updated DSNP processes
11/24/2024	Michele Bauer, MD, CMO	Updated timeline for urgent concurrent review per NCQA standards.