MedStar Family Choice		
ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**110A**	
Subject:	**UM Process**	
Section:	**Care Management**	
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Review Effective Date(s):		
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Responsible Parties:	**Theresa Bittle, Blaine Willis**	
Responsible Department(s):	**Case Management**	
Regulatory References:	**NCQA 2018: UM 4A, UM 4G; UM 5A, UM 5B; UM 6A, UM 6C** **Maryland EQRO Systems Performance Review: Standards 7.1, 7.4** **MDH Memorandum Dated 12-7-2017 RE: Hepatitis C Medications Approval Timelines (Also includes drugs other than Hepatitis C)**	
Approved:		
	Theresa Bittle, RN **AVP, Clinical Operations**	**Patryce A. Toye, MD** **Chief Medical Officer**

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 members receive appropriate, quality health services in a timely manner.**

Scope: **MedStar Family Choice (MFC), Maryland**

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

Definitions:

1. Notification of Admission: Message from any hospital entity indicating that the member is admitted but does not include clinical review. An example of Notification of Admission would be a 'Face Sheet' or a telephone call.

2. Request for Authorization: Notice of admission, including date of admission, facility, attending physician, diagnoses accompanied by clinical review.
    a. Urgent 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 member or others, due to the member's psychological state, or
        ii. 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.
    b. Non-Urgent 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 member or the member's ability to regain maximum function and would not subject the member to severe pain.
    c. Concurrent Request: A request for coverage of Inpatient or Outpatient services made while a member is in the process of receiving the requested services, even if the organization did not previously approve the earlier care.
    d. 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.
    e. Post-Service Request*:* A request for coverage of Inpatient or Outpatient services that have been received (e.g., retrospective review).

3. Clinical Review: Clinical information pertaining to the current inpatient days which is beyond the 'Diagnoses' documented on the face sheet. An example would be review prepared by the Utilization Review nurse.

4. Redetermination: Review of additional material, at the discretion of MFC, 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.

5. Peer to Peer Review: A communication between a practitioner and the MFC Medical Director to provide additional information, clinical insight or other information for pended or denied authorizations for inpatient services.

6. Appeal: A formal request to an organization by a practitioner or member for reconsideration of a decision with the goal of finding a mutually acceptable solution.

Standards & Applicability:

A. For all determinations, MFC:
    1. Bases UM determinations only on the appropriateness of care and services, individual member need, the availability of community resources and benefit coverage.
    2. Does not reward clinicians or other individuals for issuing adverse determinations of coverage or service.

    3. Does not provide financial incentives for UM decision-makers that encourage decisions that result in underutilization.

B. MFC is compliant with the standards and regulations set forth by Maryland Department of Health (MDH), National Committee for Quality Assurance (NCQA), and HIPAA.
    1. UM decisions are made within the defined timeframe requirements. When there are differences in timeframe requirements, MFC will comply with the more stringent standard.

    2. Appropriately qualified health care professionals are involved in decision-making.

    3. Relevant clinical information is consistently gathered. 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.

    4. Only the minimum information necessary will be requested. If enough clinical information relevant to the criteria is not provided with the request, MFC will document in the denial file, its attempts to gather the clinical information needed to make a decision.

    5. Member confidentiality is maintained.

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

    2. Non-Urgent Pre-Service and Post-Service Decisions: MFC notifies the practitioner or member within 5 calendar days of receiving the request for services.

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 RN Case Manager (CM).
2. Each CM will identify patients for telephonic or electronic review via their task queue or Requests for Authorization from the facility's CM/UM Department. All concurrent review is performed telephonically or electronically.

3. When performing a clinical review, the CM will identify himself/herself as a MFC employee and provide his/her name and title when receiving, initiating or returning telephone calls to members, authorized representatives, clinicians or facilities.

4. The CM will concurrently gather information necessary to make a clinical determination from the hospital CM/UM department. Facilities are permitted to fax or telephone clinical information to the CM confidential line.

5. Upon gathering the clinical information, the CM applies InterQual criteria. If the case involves a delivery of a newborn, the CM will automatically approve two days for vaginal delivery and four days for C-section delivery for both the mother and baby per State mandate.

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 CM has access to a Medical Director. If the clinical information provided to MFC fails to meet the InterQual 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. All initial Requests for Authorization of inpatient days must be accompanied by clinical review. Notification of an admission without clinical review is not considered a Request for Authorization. Clinical review is defined as clinical information pertaining to the current inpatient stay which is beyond the diagnoses documented on the face sheet. A face sheet, without clinical review, will be considered Notification of an Admission and will not constitute a Request for Authorization. Facilities have been notified of the Request for Authorization filing procedures. Upon receipt of an initial Request for Authorization, MFC will apply InterQual criteria. If criteria are not met, the days will be pended to the Medical Director. MFC will communicate a decision to authorize or deny within 24 hours of the receipt of Request for Authorization. In the event that additional clinical is indicated, MFC may elect to grant an extension for an additional 48 hours.

8. Notification of Admissions will be recorded on the Daily Communication Log in a separate section. MFC will note member name and date of admission in this section of the Daily Communication Log until clinical review is received or the patient is discharged.

9. Post initial review, MFC will document on the Daily Communication Log, the next scheduled review date. MFC will make a determination within one calendar day of the scheduled review date. Clinical not received on the scheduled review date may be subject to denial. MFC may elect to grant an extension for an additional 48 hours. MFC will send a Daily Communication Log to hospitals with reported inpatient days. Communication logs will note, at minimum, the member name, admission date, approved and/or denied dates of service, level of care approved, next scheduled review date, and the authorization #, once a Request for Authorization has been submitted.

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

11. MFC adheres to the following decision timeframe requirements in making urgent concurrent review determinations:

Table 1: Authorization Determinations – Urgent Concurrent

Review Type	Timeline for UM Decision Making	Timeline for Notification from Receipt of Request	Notification Method	Who Must Be Notified
Urgent Concurrent	Within 24 hours of the receipt of the Request for Authorization All Requests for Authorization of inpatient days must be accompanied by clinical review. Notification of an Admission without clinical review is not considered a Request for Authorization.	- Within 24 hours of the receipt of the Request for Authorization -In cases where clinical review is not complete, and extensions are granted, notifications will be made no longer than 72 hours from receipt of Request for Authorization	Verbal (optional) Electronic or written (required for denials*) within 24 hours of request for authorization.	Verbal: - Requesting Facility Written (required for denials): - Facility - Treating physician or clinician - PCP

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

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

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

14. 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 member remains an inpatient or up to 3 business days after discharge, MFC reserves the right to review the additional material and reverse the decision to deny. MFC staff will use the additional information submitted and apply the appropriate InterQual criteria. If the additional information meets the InterQual criteria, the nurse

reviewer may approve the day. If the additional information does not meet the InterQual Criteria, the nurse reviewer will pend the case to a Medical Director. The same reviewer or Medical Director may review and reverse the decision to deny. If the same reviewer or Medical Director would not overturn the denial, the facility or practitioner would be notified that the denial stands and referred to the content of the original denial letter for guidance on the appeal process.

15. 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 member remains an inpatient or up to 3 business days after discharge. A Peer to Peer Review is a communication between a practitioner at the hospital and the 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 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 if the information provided during the Peer to Peer warrants approval based on the Medical Directors clinical opinion. If the Medical Director would not overturn the denial, the facility based practitioner will be informed that the denial stands and referred to the content of the original denial letter for guidance on the appeal process.

B. Elective Admissions and Outpatient Authorizations (Urgent & Non-Urgent):
    1. All outpatient reviews, pharmacy reviews, and elective pre-certifications for admissions will be conducted by a LPN, RN or MD. A social work case manager may data enter an approved authorization.

    2. Outpatient preauthorization is required for the following:
        a. Services with a facility fee unless the Quick Authorization Guide specifies no authorization is required.
        b. Research/investigative.
        c. Out of Network (OON) procedures.
        d. Cosmetic procedures.

    3. Outpatient authorizations/elective admission requests are accepted via the Maryland Uniform Consultation Referral form, MFC Prior Authorization Request Form or telephone.

    4. When performing a clinical review, the CM will identify himself/herself as a MFC employee and provide his/her name and title when receiving, initiating or returning telephone calls to members, authorized representatives, clinicians or facilities.

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

6. Upon gathering the clinical information and the request for authorization, the CM applies InterQual criteria or MFC policies/protocols. MFC protocols supersede InterQual 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 CM has access to a Medical Director.

8. If the clinical information provided to MFC fails to meet the InterQual criteria or MFC 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. In the event that the practitioner/facility fails to provide sufficient information to make an authorization determination, the CM will make at least one attempt to obtain clinical information. An administrative denial occurs after failure to supply clinical information. Non-urgent pre-service care decisions must be made within two (2) business days of the receipt of complete clinical but no longer than fourteen (14) calendar days of the initial request for coverage under Maryland Code of Maryland Regulations (COMAR).

10. If MFC is unable to make a decision for standard pre-authorization requests, MFC may extend up to 14 calendar days, if the following conditions are met:
    a. The enrollee or the provider requests an extension
    b. If MFC justifies to MDH, upon request, a need for additional information and how the extension is in the enrollee's interest

11. If MFC successfully justifies extending the standard service authorization decision timeframe, MFC shall:
    a. Ask the member or the member's representative for the specific information necessary to make the decision within the decision time frame.
    b. Give the enrollee written notice of the reason for the decision to extend the timeframe.
    c. Inform the enrollee of the right to file a grievance if he or she disagrees with the extension decision.
    d. Issue and carry out the MFC determination as expeditiously as the enrollee's health condition requires but not later than the date the extension expires.

12. Urgent Pre-Service Authorization decisions, in which a Provider indicates or MFC determines that applying the standard Service Authorization time frame could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function, must be made as expeditiously as the Enrollee's health condition requires and the member or member representative must be verbally notified within seventy-two (72) hours of the initial request.

13. If MFC is unable to make a decision due to lack of information for urgent pre-service care, MFC may extend the decision timeframe for up to 48 hours, under the following conditions:
    a. The member or the provider requests an extension, or
    b. Within 24 hours of receipt of the Urgent Pre-Service request, MFC will ask the member (or the member's representative) for the information necessary to make the decision.
    c. MFC will give the member at least 48 hours to provide the information.
    d. The extension period, within which a decision must be made by MFC, begins:
        i. On the date when MFC receives the member's response (even if not all of the information is provided), or
        ii. At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.

14. For all Pre-service pharmaceutical requests, decisions and notifications are made within 24 hours of the receipt of the request in accordance with COMAR.
    a. For pharmacy requests accompanied by necessary clinical, MFC will make a decision to approve or deny within 24 hours of the receipt of the request.
    b. If clinical is not received with the request, MFC will request further information within 24 hours of receipt of request.
        i. If further information is requested: a decision is made within 24 hours of receiving further information, not to exceed 24 hours for Urgent-Concurrent requests, 72 hours for urgent pre-service requests and 14 days for standard pre-service.
        ii. If information is not received, a decision is made within 24 hours for Urgent-Concurrent requests, 72 hours for urgent pre-service requests and 14 days for standard pre-service
    c. For pharmacy requests, accompanied by necessary clinical, MFC will provide notification of decision within 24 hours of request.
    d. If additional clinical was required/requested, notification is made within 24 hours of decision but no more than 24 hours for Urgent-Concurrent requests, 72 hours for urgent pre-service requests and 14 days for standard pre-service.

    **See Policy 212; Pharmacy & Therapeutic Prior Auth for details of UM pharmacy management*

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

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

17. MFC adheres to the following decision timeframe requirements in making elective admission and outpatient authorization determinations:

Table 2: Authorization Determinations - Elective Admissions and Outpatient/Home/DME

Review Type	Timeline for UM Decision Making	Timeline for Notification from Receipt of Request	Notification Method	Who Must Be Notified
Urgent-Concurrent	Within 24 hours of the receipt of the Request for Authorization.	Within 24 hours of the receipt of the Request for Authorization	-Verbal (optional) -Electronic or written (required for denials)	Verbal (optional): - Requesting practitioner / provider Written (required for denials): - Requesting facility - Requesting physician or clinician - PCP -Member or member's authorized representative
Pre-Service (Urgent)	Within 72 hours of the receipt of the request.	Within 24 hours from the date of the determination, not to exceed 72 hours from the receipt of Request for Authorization *In the event that clinical is not received along with request, see section B13 above.	Verbal (optional) Electronic or written (required for denials*)	Verbal (optional): - Requesting practitioner or provider Written (required for denials): - Requesting facility - Requesting physician or clinician - PCP -Member or member's authorized representative - Quarterly Pre-service Denial: Report sent to Maryland EQRO (see Policy 144A; Denial or Action Notice) Denials only
Pre-Service (Non-Urgent)	Within 2 business days of the receipt of the information necessary to make a determination, but no longer than 14 calendar days from the date of the initial request.	Within 72 hours from the date of the determination, not to exceed 14 calendar days from the receipt of Request for Authorization	Verbal (optional) Electronic or written (required for denials*)	Verbal (optional): - Requesting practitioner or provider Written (required for denials): - Requesting facility - Requesting physician or clinician - PCP -Member or member's authorized representative Quarterly Pre-service Denial: Report sent to Maryland EQRO (see Policy 144A; Denial or Action Notice) Denials only

Pre-Service Pharmacy Requests *See Policy 218; Pharmacy Process for details of UM pharmacy management	Within 24 hours of the receipt of the Request for Authorization- MFC will approve, deny or request further information. If further information is requested: a decision is made within 24 hours of receiving further information, not to exceed 24 hours for Urgent-Concurrent requests, 72 hours for urgent pre-service requests and 14 days for standard pre-service. If information is not received, decision is made within 24 hours for Urgent-Concurrent requests, 72 hours for urgent pre-service requests and 14 days for standard pre-service requests	Within 24 hours of the receipt of the Request for Authorization, unless further information is requested. If further information is requested notification is made within 24 hours of decision, not to exceed 24 hours for Urgent-Concurrent requests, 72 hours for urgent requests and 14 days for standard pre-service requests	Notice by telephone or other telecommunication device. Electronic or written (required for denials)	Telephone or other telecommunication device (required): -Requesting practitioner/provider Written (required for denials)**:** - Requesting facility - Requesting physician or clinician - PCP -Member or member's authorized representative

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

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

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

20. The CM will generate the Member Liability Denial Letter in the clinical software system. Once the letter is completed, the CM proofreads the document. The Manager of Case Management-Utilization Management or designee must also proof read the letter for NCQA readability and compliance with standards. If the letter is correct, the CM will sign the Medical Director's name followed by his/her initials.

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 members 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).
   1. Inpatient Post-Service:
      a. The CM may review post-service authorization requests that are received within 30 days of the date of discharge. The appeals staff will prepare the post-service review for the Medical Director regarding requests for retrospective review ≥ 30

calendar days, but ≤ 180 calendar days from the date of discharge or the last date of service.

b. The CM or appeals staff will gather information necessary to make a clinical determination from the hospital CM/Appeal department. Facilities are permitted to fax or mail the clinical records.
c. Upon gathering clinical information, the CM or Medical Director applies InterQual criteria or MFC 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 fails to meet the InterQual criteria or MFC 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 CM or appeals staff may make at least one request for clinical information. An administrative denial occurs after failure to supply clinical information within 30 calendar days. If clinical information is received after the administrative denial is rendered, the practitioner/facility will be notified of the need to initiate a formal appeal process since a formal administrative adverse decision letter was sent.
g. If the facility does not follow the proper procedure for authorization, MFC personnel are to verbally inform the facility representative of the specific UM requirements and procedures.

2. Outpatient Post-Service:
   a. The appeals staff will prepare the post-service review for the Medical Director directing any requests for retrospective review within 180 calendar days from the last date of service.
   b. The appeals staff will gather information necessary to make a clinical determination from individuals involved in treating the member such as the PCP, specialist, treating clinician.
   c. Upon gathering the clinical information, the Medical Director applies InterQual criteria or MFC policies/protocols. MFC policies/protocols supersede InterQual criteria.
   d. Authorization determinations are to be based on the clinical information obtained at the time of the review determination.
   e. In the event that the facility fails to provide the clinical information to make an authorization determination, the appeals staff will make at least one attempt to request clinical information. An administrative denial occurs after failure to supply clinical information within 30 calendar days. If clinical information is received after the administrative denial is rendered, the facility will be notified of the need to initiate a formal appeal process since a formal administrative adverse decision letter was sent.
   f. If the facility does not follow the proper procedure for authorization, MFC personnel are to verbally inform the facility 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 oral, unless the practitioner or member requests written notification

3. MFC adheres to the following decision timeframe requirements in making post-service review determinations:

Table 3: Post-Service Review Determinations

Review Type	Timeline for UM Decision Making	Timeline for Notification from Receipt of Request	Notification Method	Who Must Be Notified
Post-Service (Inpatient)	Within 30 calendar days of the receipt of the request.	Electronic or written will occur within 30 calendar days of the initial request for review.	Electronic or written	-Member or member's representative (verbal approval or written denial) Written (required for denials)**:** - Facility - Treating physician or clinician - PCP -Member or member's representative (denial only and only if there is member liability)
Post-Service (Outpatient)	Within 30 calendar days of the receipt of the request. **	Electronic or written will occur within 30 calendar days of the initial request for review.	Electronic or written	-Member or member's representative (verbal approval or written denial) Written (required for denials)**:** - Facility/Agency/ Vendor - Treating physician or clinician - PCP -Member or member's representative (denial only and only if there is member liability)
Post-Service (Pharmacy) *See Policy 218; Pharmacy Process for details of UM pharmacy management	Within 30 calendar days of the receipt of the request. **	Electronic or written will occur within 30 calendar days of the initial request for review.	Electronic or written	-Member or member's representative (verbal approval or written denial) -Treating physician or clinician or requesting provider - PCP (denial only)

4. **If the request lacks clinical information, MFC may extend the Post-Service time frame up to 15 calendar days, under the following conditions:

a. MFC asks the member (or the member's representative) for the specific information necessary to make the decision within the decision time frame.
b. MFC gives the member (or the member's authorized representative) at least 45 calendar days to provide the information.

5. The extension period, within which a decision must be made by MFC, begins:
   a. On the date when MFC receives the member's response (even if not all of the information is provided), or
   b. At the end of the time period given to the member to supply the information, if no response is received from the member or the member's authorized representative.

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

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

8. Denial letters will be completed by the CM, the CM will proof read the letter and sign the Medical Director's name followed by their initials.

D. OON Facilities:
   1. Inpatient cases involving emergent/urgent admission 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 will deny unless the clinical supports emergent or urgent care.

E. OON Practitioners:
   1. These 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 will deny unless the clinical supports emergent or urgent care or continuity of care.

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

G. Member Protected Health Information (PHI):
   1. Member 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 and discharge planning, quality management, and disease 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 is to 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.

MARYLAND
Department of Health
Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

MEMORANDUM

TO: MCOs

FROM: Susan J. Tucker, Executive Director
Office of Health Services

RE: Hepatitis C Medication Approval Timeline

DATE: December 7, 2017

In response to inquiries from several HealthChoice MCOs, Maryland Department of Health (MDH) would like to clarify the CMS Managed Care Rule for providing responses to requests for covered outpatient drugs within 24 hours.

Hepatitis C medication and review is outside of the normal HealthChoice program process regarding outpatient drug coverage and is, accordingly, not subject to the covered outpatient drug rule (42 CFR 438.210 (d)(3)). MCOs should provide a response by telephone or other telecommunication device within 24 hours of receiving all required information, including the MDH response to clinical criteria review.

For drugs other than Hepatitis C, the time limit for a response for all covered outpatient drugs begins when the MCO or the MCO's Pharmacy Benefits Manager (PBM) receives the completed preauthorization form or a phone call from the provider or patient. MCOs then must approve, deny, or request further information within 24 hours. Responses may be provided by telephone or other telecommunication device. If MCOs request further information, a response should be provided within 24 hours of receiving further information and no more than 14 days from initial request, in accordance with the standard authorization timeframe.

Summary of Changes:	**07/18:** • Updated Regulatory References. • Added clarification of documentation related to attempts to gather clinical information. • Added Failure to follow filing procedures section. • Further clarified details of timeframes for compliance for medications as indicated in MDH memo date 12/07/17 Memo attached above. • Modified Effective Date to Initial Effective Dates; added Historical Revision Dates and Revision Effective Dates; and added Historical Review Dates and Review Effective Dates. **01/18:** • Table 1: updated Urgent Concurrent Inpatient Table for Notification Method with timelines. • Section A #9 updated the language to reflect the 2 business days/14 calendar days for standard pre-authorization requests from 2/7. • Section A Elective Admissions & Outpatient Authorizations added # 10 and #11 language for the process of giving an extension for standard pre-authorization requests to meet new COMAR regs. • Section A #14 added regarding timeline for decisions and notifications on Pre-service pharmaceutical requests. • Table 2: Pre-Service Urgent UM Timeline for making a decision updated from 24 hours to 72 hours from request. • Table 2: Pre-Service Nonurgent UM Timeline for making a decision updated from 2 business days, but not exceed 7 calendar days to 2 business days and not to exceed 14 calendar days. • Table 2: updated for who must be notified with appropriated time lines. • Table 2: Added Pre-Service Pharmacy time lines for making a decision & notification within 24 hours of the receipt of the request. • Table 3: Update who must be notified and added section for Post-Service Pharmacy timeline for decision making, notification and who must be notified. **07/17:** • Updated Regulatory Reference for NCQA year. • Changed Approved by from Carol Attia to Theresa Bittle and updated Dr. Toye's title from Sr Medical Director to Chief Medical Officer. • Added to the definitions what constitutes an Urgent, Nonurgent, Concurrent, Preservice and Postservice request.

	• Changed reference from Physician Advisor or PA to Medical Director throughout. • Added MFC Prior Authorization Request Form to section B #3. **10/16:** • Updated Regulatory References. • C.3.c: UM denial letter are generated and documented in the clinical software system by the CM without the use of paper trackers. • Denial/Appeal Response Form deleted from document. **07/16:** • Replaced CCMS with Clinical Software System Added pharmacy to section B, number 1. **11/15: Addendum to 10/15 'Summary of Changes' table:** The following policy changes went into effect in 10/15 as documented in the body of the 10/15 policy: • Added 'Redetermination' and 'Peer to Peer' processes. • Added definition of 'Appeal' to document distinction between this and 'Redetermination' and 'Peer to Peer' processes.