MedStar Family Choice

ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**110**	
Subject:	**UM Process**	
Section:	**Care Management**	
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Responsible Parties:	**Blaine Willis**	
Responsible Department(s):	**Clinical Operations**	
Regulatory References:	**NCQA 2023: UM 4A, UM 4F; UM 5A; UM 5C, 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:		**Karyn Wills, 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, Maryland**

Policy: **MedStar Family Choice (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 (Expedited) Request: A request for Inpatient or Outpatient services where application of the time frame for making routine or non-life-threatening care determinations:
        i. Could seriously jeopardize the life, health or safety of the 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 (Standard) Request: A request for Inpatient or Outpatient services for which application of the time periods for making a decision does not jeopardize the life or health of the 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.

7. Medical Director: A physician with a valid Maryland medical licensure (Medical Doctor or Doctor of Osteopathic Medicine) who provides day-to-day utilization decisions in accordance to policy/procedure and recognized criteria, participates in the development of medical criteria policy, monitors documentation for adequacy, and is available to UM staff for consultation and guidance on-site or by telephone. A Medical Director for the purpose of this policy is a Nonbehavioral Healthcare Reviewer.

8. Manager Utilization Management: A Registered Nurse (RN) with valid licensure in the state of Maryland that provides day-to-day supervision of assigned UM staff, participates/provides staff training, monitors for consistent application of UM criteria by UM staff for each level and type of UM decision, monitors documentation for adequacy, and is available to UM staff on-site or by telephone.

9. Gold Carded Hospitals: Deeming that, through history of minimal or no inpatient concurrent denials, are exempt from routine clinical review submission, beyond initial review.

10. 24-hour turnaround timeframes are the equivalent of one calendar day and 72-hour turnaround timeframes are the equivalent of three calendar days. This is in alignment with federal regulations, NCQA and COMAR.

11. Current Clinical: Is within three months or less of all requests for services except for concurrent inpatient reviews. Exception is DME/DMS clinical must be within one month of the request for service.

Standards and 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 practitioners or other individuals for issuing denials of coverage or service.
   3. Does not provide financial incentives for UM decision-makers that encourage decisions that result in underutilization.

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

4. Efforts are made to consistently obtain all necessary information including pertinent clinical information, and to consult with the treating physician as appropriate. Clinical information includes, but is not limited to, office and hospital records, a history of the presenting problem, a clinical exam, diagnostic testing results, treatment plans and progress notes, patient psychosocial history, and information on consultations with the treating practitioner.
5. 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.
6. 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 preservice or urgent concurrent coverage, MFC notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.
   1. Urgent Pre-Service, Concurrent and Non-Urgent Pharmacy Pre-Services: MFC notifies the practitioner (member's authorized representative) 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 (Non-Pharmacy) -: MFC notifies the member or the member's authorized representative within 5 calendar days of receiving the request for services
      i. MFC may not deny a Non-Urgent Pre-Service, Urgent Pre-service, Urgent Concurrent and Non-Urgent Pharmacy Per-Service request that requires medical necessity review for failure to follow filing procedures. MFC may deny a post service request without conducting a medical necessity review, even if a medical necessity review is required if the member (or the member's authorized representative) does not follow MFC's reasonable filing procedures but must provide the reason for the denial.

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

Procedure:

A. Inpatient Review (Urgent Concurrent) Procedures:
   1. All inpatient reviews will be conducted by an RN Case Manager (CM).
   2. Each CM will identify patients for telephonic or electronic review via their Open Authorizations widget or Request Received widget for 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 an 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. MFC only accepts clinical reviews which summarize each day individually. This daily summary must be done a by a licensed clinical professional and it must demonstrate clear evidence of severity of illness, intensity of services, and the medical necessity for inpatient admission and continued inpatient stay. MFC will not accept and will not review an EMR (electronic medical record) download of a member's medical health record in lieu of the above described daily summarized reviews. If MFC only receives downloaded medical records, they will be forwarded to the medical director for denial and will not be reviewed for medical necessity.
6. 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.
7. 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.
8. If InterQual criteria is met for the admit day or approved by the Medical Director as medically necessary, beginning with Day 2 through discharge the CM reviewer can review the clinical for medical necessity and:
    a. If the CM determines that the day(s) are warranted as medically necessary for continued inpatient stay, and the day(s) does not meet IQ criteria, the CM has the authority to approve the day(s) and they do not have to be pended to the Medical Director for review. Clinical will be attached into the clinical software system as per workflow.
    b. The CM will enter a care note in the clinical software system stating the day(s) are authorized per UM Process Policy Section A Inpatient Review (Urgent Concurrent) Procedures as medically necessary inpatient day(s).
    c. If criteria is not met and the CM agrees that the day(s) in question are not medically necessary, care could be provided at a lower level, there is a delay in Service/Procedure, Delay in Discharge Planning or Care Available as an Outpatient, InterQual will be applied to that day(s) and pended to the Medical Director for review.
9. 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 72 hours of the receipt of Request for Authorization. In the event that additional clinical is indicated, MFC may elect to grant an extension for up to 14 calendar days.

10. 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.
11. 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 up to 14 calendar days. MFC will send a Daily Communication Log to hospitals with reported inpatient days. Communication logs will note, at minimum, the member's 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.
12. Inpatient Review (Urgent Concurrent) timeframes may be extended for up to 14 calendar days, once due to lack of clinical information if the member requests the extension. The organization documents it made at least one attempt to obtain the necessary information. The organization may extend by the same timeframe if it needs additional information and notifies the member or the members authorized representative of its decision as expeditiously as the members health condition requires, but no later than the expiration of the extension.
13. 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.
14. 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 72 hours of the receipt of the Request for Authorization. * For extensions see A 11 above 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 72 hours of the receipt of the Request for Authorization * For extensions see A 11 above	Verbal (optional) Electronic or written (required for denials*) within 72 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*

15. Gold-Carded hospitals will submit initial clinical review and ongoing discharge plans. Once approved as meeting inpatient status, such hospitals will be exempt from routine clinical review. Focus will be on collaboration related to discharge planning. Any denials for inpatient days will be made after consultation and agreement between the MFC Medial Director and the facility Physician Advisor.

16. Documentation of all the aforementioned activities is made in the clinical software system, concurrently.
17. Any cases meeting criteria for case management or quality improvement will be referred via the clinical software system.
18. 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.
19. 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 Director's clinical opinion. If the Medical Director would not overturn the denial, the facility-based practitioner will be informed that the denial stands and 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 an LPN, RN, Pharmacy Tech, Health Plan Pharmacist or MD.
    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.
        e. Procedures related to Gender Affirming Care and Fertility Preservation.
        f. Pharmacy Prior Authorizations Table.

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 an 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. MFC requires the clinical information to be from a practitioner involved with the care of the member. The clinical must be within three months of the date of the request for service. Exception is DME/DMS clinical must be within one month of the request for service. 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.
10. Non-urgent pre-service care decisions must be made within two (2) business days of the receipt of necessary (complete) clinical information but no later than fourteen (14) calendar days of the initial request for coverage under Maryland Code of Maryland Regulations (COMAR). If additional clinical information is required, it must be requested within 2 business days of receipt of the request.
11. Standard and expedited preauthorization decisions may be extended up to 14 calendar days, if the following conditions are met:
    a. The enrollee, enrollee's representative or the provider requests an extension; or
    b. The MCO justifies to the Department, upon request, a need for additional information and how the extension is in the enrollee's interest; and
12. If the MCO successfully justifies extending the standard service authorization decision time frame, the MCO shall:
    a. Give the enrollee written notice of the reason for the decision to extend the time frame;
    b. Inform the enrollee of the right to file a grievance if he or she disagrees with the extension decision; and
    c. Issue and carry out the MCO's determination as expeditiously as the enrollee's health condition requires but not later than the date the extension expires.
13. Urgent Concurrent timeframes may be extended for up to 14 calendar days, once due to lack of clinical information if the member requests the extension. The organization documents it made at least one attempt to obtain the necessary information. The organization may extend by the same timeframe if it needs additional information and

notifies the member or the members authorized representative of its decision as expeditiously as the members health condition requires, but no later than the expiration of the extension.

14. For expedited authorization requests, the MCO shall make a preauthorization determination and provide notice in a timely manner so as not to adversely affect the health of the enrollee and no later than 72 hours after receipt if the provider indicates or the MCO determines following the standard timeframe could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.
15. For all Pre-service pharmaceutical requests, decisions to approve or deny along with notifications, or requests for additional clinical information are made within 24 hours of the receipt of the request.
    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, but will make a decision within 24 hours of receipt of request regardless if clinical is received.
    c. For pharmacy requests, accompanied by necessary clinical, MFC will provide notification of decision within 24 hours of request.
    d. *See Pharmacy & Therapeutic **Policy 212; Pharmacy Prior Authorization Policy** for details of UM pharmacy management.
    e. *For controlled substances meeting criteria specified by MDH and requiring a completed "MDH Opioid Prior Authorization Form," a course of treatment is limited to the quantity and timeframe specified on the form.* ***See Pharmacy and Therapeutic Policy 219; Opioid Prescription Parameters and Limitations policy for details related to opioid prescription management.**
16. If clinical information is received after the 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 practitioner and facility.
17. 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.
18. MFC adheres to the following decision timeframe requirements in making elective admission, outpatient, pharmacy 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 72 hours of the receipt of the Request for Authorization. * For extensions see B12 above.	Within 72 hours of the receipt of the Request for Authorization * For extension see B12 above.	-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. * For extensions see B11 and 12 above.	Within 72 hours from the receipt of Request for Authorization * For extensions see B11 and 12 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. * For extensions see B10 and 12 above.	Within 72 hours from the date of the determination, not to exceed 14 calendar days from the receipt of Request for Authorization * For extensions see B11 and 12 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 Pharmacy Requests *See Policy 218; Pharmacy Process for details of UM pharmacy management	Within 24 hours of the receipt of a pre-service. 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 the request	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	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

	regardless if clinical information is received.	receiving the request regardless if clinical information is received.		-Member or member's authorized representative

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

i. Documentation of all the aforementioned activities is made in the clinical software system, concurrently.
ii. Any cases meeting criteria for disease/case management or quality improvement will be referred via the clinical software system.
iii. 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 or Health Plan Pharmacist'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 and no administrative claim denial was issued).

1. Inpatient Post-Service:
    a. The CM may review post-service authorization requests that are received within 30 days of the date of discharge. An appeals nurse will review requests submitted after the 30-day window. The appeals staff will provide administrative support and prepare the post-service review for the appeals nurse 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 provide administrative support and 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, and treating clinician.
   c. Upon gathering the clinical information, the Medical Director applies InterQual criteria, clinical judgement 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 proofread 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, urgent care or continuity of 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.
   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.

Summary of Changes:	**03/24:** • Removed Carol Attia from Responsible Parties • Added to the Definition section Current Clinical with the time it has to be within of the request. • Section B, #1 added Pharmacy Tech and Health Plan Pharmacist. Removed reference to Social Work.

	• Section B, #7 added clarifying language that current clinical has to be within 3 months or less of the request for services**.** Exception is DME/DMS clinical must be within one month of the request for service. **07/23:** • Responsible Parties removed Theresa Bittle and added Carol Attia. • NCQA Regulatory References updated. • Approved section updated to reflect Carol Attia and Dr. Karyn Wills. • Added to the definitions that 24-hours is equivalent to 1 calendar day and 72-hours is equivalent to 3 calendar days. • In the Standards and Applicability Section C 2, I added language to mirror NCQA language for update to timely filing procedures for post service reviews. • Procedure A, # 5 added language as to the type of inpatient clinical review MFC will receive and that MFC will not accept EMR download as clinical review. **07/22:** • Updated Regulatory References to reflect 2022 NCQA Standards. • Definitions section # 7 added the following clarifying statement: A Medical Director for the purpose of this policy is a Nonbehavioral Healthcare Reviewer. • Standards and Applicability, section B # added the following language to mirror NCQA language for Timely filling procedures: MFC may not deny a Non-Urgent Pre-Service, Urgent Pre-service, Urgent Concurrent and Non-Urgent Pharmacy Per-Service request that requires medical necessity review for failure to follow filing procedures. MFC may deny a post service request if the member (or the member's authorized representative) does not follow MFC's reasonable filing procedures but must provide the reason for the denial. • Procedures A, #2 language clarified to be in line with our new clinical software system on how patients are identified for telephonic or electronic review. • Updated all references to the pharmacy timelines throughout the policy that will we make a decision and notification within 24 hours of receipt of request. If clinical is not received with the request, MFC will request further information, but will make a decision within 24 hours of receipt of request regardless if clinical is received. • Deleted all PDFs of notifications of the relaxation of UM process related to the most recent COVID surge from December of 2021 through March 15, 2022.

	02//22: • Addendum for 2/25/2022 regarding the notice sent to the provider community notifying them the MFC will end the relaxation of the utilization management processes and will resume normal UM requirements beginning March 15, 2022. **02/22:** • Addendum for 2/08/2022 regarding the notice sent to the provider community of the extension to the continued relaxation of the utilization management processes at least to the end of February. **12/21:** • Addendum for 12/28/2021 regarding the notice sent to the provider community of the relaxation of the utilization management processes. **10/21:** • Section A # 15 removed the language about not denying days due to lack of clinical information for inpatient admissions due to the COVID Pandemic now that the State of Emergency has been lifted. • Section B # 10 added language from SPR standard that if clinical information needs to be requested it must be done within 2 business days of receipt of request. **07/21:** • Updated Regulatory References to reflect 2021 NCQA Standards. • Replaced Case Management with Clinical Operations. • Added "Maryland" to scope. • Standards and Applicability section updated letter C Failure to follow filling procedures to be in line with updated NCQA text. • Table 2 removed from the Urgent Preservice notification within 24 hours from the decision, to say within 72 hours from receipt of request. **07/20:** • Updated Regulatory References to reflect 2020 NCQA Standards. • In the definitions section added Expedited to the Urgent definition and Standard to Non-urgent definition to be line with the EQRO SPR document. • Definitions section added the Gold Carded Hospitals Program. • In the Standards and Applicability section, letter B added new language for steps # 3 and 4 to be line with EQRO SPR document.

	• Inpatient Review (Urgent Concurrent) Procedures section #8 and #10 changed reference to extension timeframe from 48 hours to 14 calendar days. • Inpatient Review (Urgent Concurrent) Procedures section #11 added language for extension timeframe and process. • In the procedures section, letter A #14 added language for Gold Carded hospital process for review, once admission criteria is met. • In the procedures section A #15 added language for current UM process of not denying days to lack of clinical due to the current COVID 19 pandemic. • Section B, step 2 added the following: Procedures related to Gender Dysphoria/Transgender Surgery and Pharmacy Prior Authorizations Table. • In the procedure section letter B clarified the steps 9, 10 and 11 to be in line with COMAR for expedited and standard extension process and timeframes. • In the procedure section letter B added language for urgent concurrent extension timeframes to be in line with NCQA. • Section B step 15 clarified urgent concurrent pharmacy timeline a decision is made within 24 hours of the request. Also added language about the MDH Opioid Prior Auth form. • Section C Post Service Requests, #1 step "a" added language that the appeals nurse will review requests > 30 days from date of discharge. **12/19:** • Added Definitions: #7 Medical Director and #8 Manager of Case Management – Utilization Management for clarification. **07/19:** • Removal of "A" from policy number. • Update NCQA Reference for 2019 Standards. • Removal of "Maryland" from scope. • In the Inpatient Review (Urgent Concurrent) Procedures section # 7 was added allows the nurse to approve medically necessary days that do not meet InterQual, provided there is no delays in care or care can be provided at a lower level of care. • Table 1 and 2: Updated Urgent Concurrent timeframes for decisions and notifications to 72 hours from 24 hours to be in line with the NCQA standard. **10/18:**

	• Clarification added in Standards & Applicability: Section B. 2: All medical necessity denials are rendered by physicians. **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 timelines. • Table 2: Added Pre-Service Pharmacy timelines 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 Post service 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.