Procedure

DEPARTMENT: Utilization Management	**TITLE: Utilization Management Time Frames**
DATE: 7/21/2022	**VERSION:** 1.0

Table of Contents

Purpose

Timeliness of Utilization Management decisions is imperative. The Utilization Management Department is responsible for ensuring that all timelines are met according to standards, regulations, and guidelines and aligned with LHP policies.

Procedure

Utilization Management Decision Timeframes for Medical and Behavioral Healthcare Covered Services

Prospective (Pre-Service) Standard

Determination and notification must be made within 14 calendar days of the receipt of the request. Within 14 calendar days of receipt of request, Utilization Management is to use the Notice of Denial of Medical Coverage (NDMC) template for written notification of a denial decision. Notification of Utilization Management determinations will be made in writing, electronically, and by telephone where required by state and federal law to members and providers. All verbal, electronic, and written requests will be documented and maintained in the case file.

Prospective (Pre-Service) Expedited/Urgent

The Utilization Management Department will request the medical and behavioral information to make a determination within 72 calendar hours of the initial request, including receipt on weekends and holidays. Regardless of the information that is received from a non-participating provider, the Utilization Management Department is responsible for meeting the same timeframe and notice requirements as it does for in-network, contracted, participating providers. Notification of Utilization Management determinations will be made in writing, electronically, and by telephone where required by state and federal law to members and providers. All verbal, electronic, and written requests will be documented and maintained in the case file.
Determination must be made within 72 calendar hours of receipt of the request.
Approvals: Oral or written approval must be given to the member and provider within 72 calendar hours of receipt of the request. The Utilization Management Department will document the date and time that the oral notification of approval is provided in the case file. If written notice is provided in lieu of verbal communication of the approval, it must be received by the member and provider within 72 calendar hours of receipt of the request. Facsimile transmission logs will be maintained within the case file. Records will be maintained in the case file for any written communication mailed to the member.

Concurrent Determinations and Notifications

The Utilization Management Department will request the medical and behavioral information to make a determination with 24 business hours or 1 business day, whichever occurs first of the initial request. Regardless of the information that is received from a non-participating provider, the Utilization Management Department is responsible for meeting the same timeframe and notice requirements as it does for in-network, contracted, participating providers. Notification of Utilization Management determinations will be made in writing, electronically, and by telephone where required by state and federal law to members and providers. All verbal, electronic, and written requests will be documented and maintained in the case file.

Retrospective (Post-Service)

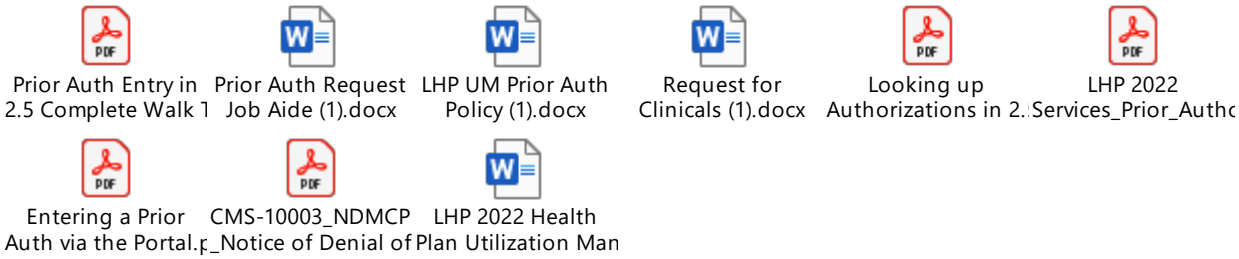
The provider will have 14 calendar days to submit a retrospective request. Retrospective requests will not be accepted for Interventional Radiology Revascularization procedures not related to dialysis. Determinations and notifications (where applicable) will be made within 30 calendar days of receipt of the request. Notification of Utilization Management determinations will be made in writing, electronically, and by telephone where required by state and federal law to members and providers. All verbal, electronic, and written requests will be documented and maintained in the case file.

Extensions

The member may extend the timeframe up to 14 calendar days for preservice determinations only. For Part B Medications, there are no allowances for extensions.
The extension is allowed to occur if the enrollee requests the extension or a need for additional information is justified in the interest of the member and must be documented in the case file.
When an extension is made, the member must be notified in writing for the reasons for the delay and must inform the member of their right to file a grievance if they disagree with the decision to grant an extension.
The Utilization Management Department must notify the members in writing of its determination as expeditiously as the member's health condition requires, but no later than the expiration date of any extension that occurs.

Note:
NCQA considers 24 hours to be equivalent to 1 calendar day and 72 hours to be equivalent to 3 calendar days.
Verbal notification does not replace electronic or written notification of denial decisions, but when provided, LHP may extend the time frame for electronic or written notification for Medicare decisions. Verbal notification requires communication with a live person, the organization may NOT leave a voicemail, and the organization records the time and date of the notification along with the staff member who spoke with the practitioner or member and the organization provides verbal and written notification within the time frames specified for an urgent concurrent or urgent pre-service request.

Appendices



Change Log

Document Version	Major or Minor Revision?	Date	Name	Comments
1.0	New	7/20/2022	Courtney Gonzales	Initial creation