

Comprehensive Behavioral Health Management/College Health IPA Policy and Procedure Manual	
Policy Name: UM Review Process	Utilization Management
Date: 3-98 Reviewed by QI Committee: 04-07, 09-07, 9-08, 9-09, 10-09, 02-10 Revised by QI Committee: 04-07, 09-07, 9-08, 9-09, 10-09, 02-10	Page: 1 of 13 Policy Number: UM-4

Purpose: The purpose of this guideline is to ensure that all utilization management decisions made by Comprehensive Behavioral Health Management/College Health IPA (CBHM/CHIPA) are in accordance with State and Federal timeliness regulations. Reference “*Utilization Management Timeliness Standards*” at end of document.

Definitions:

Non-Urgent Care: Any request for a utilization management determination which the application of the time periods for making determinations does not jeopardize the life or health of the patient.

Urgent/Emergent Care: Any request for a utilization management determination with respect to which the application of the time periods for making non-urgent care determinations 1) could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or 2) in the opinion of a provider or prudent lay person with knowledge of the patient’s condition, would subject the patient to severe consequences that cannot be adequately managed without the care or treatment that is the subject of this case.

Staffing:

Intake Specialists: Non-clinical administrative staff who use a Pre-Review Screening tool to collect demographic and structured clinical information for purposes of pre-screening screening. Reference AR-2 “Intake and Referral”.

Licensed Clinicians: Healthcare professionals with current licensure (LVN, RN, MFT, LCSW) who are immediately available to complete Initial Reviews and risk assessments. They may also complete Pre-Review Screenings as needed. May be Care Managers or UM Coordinators.

Medical Director/Physician Reviewers: Licensed and board certified psychiatrists with current and unrestricted licenses to practice in California who are on call 24/7 to provide Peer Review and/or consultation with the licensed clinician who is conducting the Initial Review.

Policy:

1.0 Clinical Information

- 1.1 CBHM/CHIPA relies on the minimal clinical information necessary to make a determination as outlined in Appendix E, Utilization Management Review Guidelines.
- 1.2 CBHM/CHIPA will accept information from any reasonably reliable source that will assist in the review process.
- 1.3 All patient specific clinical information obtained during Utilization Management is considered confidential in accordance with Policies RR-6, Confidentiality, and HP-8, Release of Personal Health Information.
 - 1.1.1 Clinical information is used solely for the purpose of utilization management, case management, quality management, discharge planning, and claims payment.

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- 1.1.2 Clinical information is shared only with those entities who have authority to receive such information and who need access in order to conduct utilization management and related processes.
- 1.4 CBHM/CHIPA bases Pre-service and concurrent review determinations solely on the clinical information obtained at the time of the review. For retrospective reviews the determination is based solely upon the information available at the time the services were provided.
- 1.5 CBHM/CHIPA does not routinely require providers or facilities to submit medical records as part of the review process. If and when records are requested, the request is limited to only those medical records, which pertain directly to the authorization request.
- 1.6 CBHM/CHIPA does not conduct on-site utilization management reviews.
- 1.7 Providers are not required to give diagnostic information by designated codes unless the diagnosis cannot be concluded from the written description.
- 1.8 To eliminate duplication of information requests all demographic and clinical information is contained in a central electronic file, which can be accessed by all appropriate staff.
- 1.9 A provider or facility can request a retro-review determination and/or a determination can be pended for additional information. However, no review will be pended longer than forty-five calendar days without making a determination.
- 1.10 Reproduction Costs - CBHM/CHIPA, for review purposes other than an appeal or a legal request, will reimburse reasonable costs of medical record duplication, unless otherwise provided for by contract or law.

2.0 Pre-Service Review*

- 2.1 Outpatient Services
 - 2.1.1 Pre-Service requests for non-urgent outpatient services are reviewed and determination issued per *UM Timeliness Standards**
 - 2.1.1.1 Intake Specialists review non-urgent requests using the Pre-Review Screening tool (Reference Appendix D). If medical necessity cannot be determined during a Pre-Review Screening, the Intake Specialist refers request to a licensed clinician for an Initial Review. Denials are not issued as a result of a Pre-Review Screening.
 - 2.1.1.2 Licensed clinicians/Care Managers complete Initial Reviews for non-urgent requests forwarded from Intake Specialist, and for all urgent and/or emergent requests. If medical necessity cannot be determined during Initial Review, request is forwarded to Medical Director for Peer Review. Denials are not issued as a result of an Initial Review. *Reference Policy UM-6, Denials and Appeals.*

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2.1.2 Non-urgent requests for outpatient services may be pended for either additional administrative information (e.g., eligibility and benefit verification or provider agreement) or for additional clinical information. Providers and patients are notified per *UM Timeliness Standards** regarding the need for additional information.

2.1.2.1 If request was pended for administrative information and the information was not received within the timeliness standard an administrative denial would be issued (e.g., unable to determine coverage or no response from provider)

2.1.2.2 If request was pended for clinical information and the information was not received within the timeliness standard a determination would be made based upon the clinical information that was available.

2.1.3 Urgent pre-service requests for outpatient services may be pended if additional information is needed. Providers and patients are notified per *UM Timeliness Standards**. If additional information is not received within the timeliness standard a determination is made based upon the information available. Reference 2.1.2 above.

2.1.4 If Pre-service requests are for services, which are potentially excluded from benefit coverage (Reference Policy UM-5, Potentially Excluded Services), they are forwarded immediately to the Vice-President of Clinical Services who will consult with the health plan representative to determine benefit coverage. The requests will be reviewed and determination issued within five calendar days of receipt. If determination is recommendation for denial *Policy UM-6, Denials and Appeals* will be followed.

**Outpatient Pre-service and concurrent review does not apply to payers with an Open Access benefit or clinical model.*

2.2 Inpatient/Alternative Level of Care Services

2.2.1 UM Coordinators complete Initial Reviews for all inpatient/alternative level of care services. Providers and patients are notified per *UM Timeliness Standards**

2.2.1.1 When additional clinical information is needed to determine medical necessity the provider and patient are notified *per UM Timeliness Standards** of the pended authorization.

2.2.1.2 If the additional clinical information is not received within the *UM Timeliness Standards**, a determination is made based upon the available clinical information.

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2.2.2 If patient does not meet the clinical indicators for level of care requested, the UM Coordinator will forward to the Medical Director for peer review per *UM Timeliness Standards**. Determination will include recommendation for the appropriate level of care based upon clinical indicators. Reference *Policy UM-6, Denials and Appeals*.

3.0 Outpatient Concurrent Review

3.1 Urgent Cases

- 3.1.1 Whenever a provider determines that an immediate modification or extension of an authorization is medically necessary s/he should call CBHM/CHIPA and provide information related to their request to a licensed clinician or fax a *Progress Report/Authorization Request (PAAR)* marked “Urgent”.
- 3.1.2 The urgent request will be reviewed and determination issued per *UM Timeliness Standards**.
- 3.1.3 Authorization for urgent concurrent care cannot be discontinued until the member’s treating provider has been notified of the decision and a care plan has been agreed to by the treating provider. If the treating provider is not in agreement, the denial and appeal process will be followed. *Reference UM-6 “Denial and Appeals Overview.”*

3.2 Non-urgent Cases (Also Considered Pre-Service Reviews)

- 3.2.2 Providers must submit a legible and complete CBHM/CHIPA standardized *Progress Report/Authorization Request (PAAR)* when continuing care is indicated.
- 3.2.3 Office Assistant date stamps the request form with date received, creates a pending authorization, and verifies current eligibility.
- 3.2.4 Once eligibility has been verified, the Office Assistant reviews the request form using the Clinical Review Algorithms for Non-Clinical Staff (Reference Appendix H). Appropriate authorization is granted if the request passes the algorithms. If the request form does not pass the algorithms, it is forwarded to a licensed clinician for review. If additional clinical information is needed to determine medical necessity the provider and patient are notified in writing per *UM Timeliness Standards** and determination is pending. If the additional clinical information is not received within the *UM Timeliness Standards**, a determination is made based upon the available clinical information.
- 3.2.5 All non-urgent concurrent review requests are reviewed and determination issued per *UM Timeliness Standards**.

4.0 Inpatient/Alternative Levels of Concurrent Review

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- 4.1 UM Coordinator conducts concurrent review based upon the severity or complexity of the patient’s case. Typically these reviews occur every two to three days for inpatient admissions, every three to five days for partial admissions, and every ten to fourteen days for intensive outpatient admissions. The current status of the case is compared with CBHM/CHIPA Guidelines and Clinical Indicators and/or the health plan medical necessity criteria to determine the appropriate level of care.
- 4.2 UM Coordinator may request a psychiatrist-to-psychiatrist review by CBHM/CHIPA Medical Director at any time it is deemed necessary.
- 4.3 All concurrent reviews for certification of continued stay or for changes in level of care are completed and determination issued per *UM Timeliness Standards**. At any time medical necessity cannot be determined and a recommendation for denial is made, the provider will be given the option of Peer Review. Reference *Policy UM-6, Denials & Appeals*.
- 4.4 Authorization for urgent concurrent care cannot be discontinued until the member’s treating provider has been notified of the decision and a care plan has been agreed to by the treating provider. If the treating provider is not in agreement, the denial and appeal process will be followed. *Reference UM-6 “Denial and Appeals Overview.”*
- 4.5 Non-urgent pre-service requests for Inpatient/Alternative Levels of Care certification may be pended per *UM Timeliness Standards** if additional information is needed. Providers are notified verbally per *UM Timeliness Standards**
 - 4.5.1 If additional information is received, a determination will be made within *UM Timeliness Standards**.

If additional information is not received within *UM Timeliness Standards**, a determination will be made based upon the information available.

- 4.6 At time of discharge the UM Coordinator arranges for appropriate after care with a CBHM/CHIPA provider. CBHM/CHIPA Policy *UM-10, Urgent and Emergent Appointment Follow-up*, is followed in assigning providers and following up on the patient’s compliance with discharge appointments.

5.0 Retrospective Review

- 5.1 Outpatient Services
 - 5.1.2 Providers submit a Request for Retrospective Review indicating dates of service and clinical justification. Medical record documentation is requested for dates of service older than 90 calendar days or greater than five dates of service.
 - 5.1.3 The request is stamped with date of receipt.
 - 5.1.4 A CBHM/CHIPA clinician completes retrospective review and issues determination per *UM Timeliness Standards**.

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- 5.1.5 If additional clinical information is required the provider and patient will be notified per *UM Timeliness Standards**. The retrospective review will be pended per *UM Timeliness Standards**
 - 5.1.5.1 If additional clinical information is received, a determination will be issued within *UM Timeliness Standards**.
 - 5.1.5.2 If no additional clinical information is received within *UM Timeliness Standards**, a determination will be issued based upon available clinical information.
- 5.1.6 If recommendation is for denial, Policy *UM-6, Denials and Appeals*, is followed.
- 5.2 Inpatient/Alternative Level of Care Services
 - 5.2.2 Facility submits clinical chart for retrospective review.
 - 5.2.3 The chart is stamped with date of receipt.
 - 5.2.4 A licensed clinician reviews the chart and issues a determination per *UM Timeliness Standards**.
 - 5.2.5 If additional clinical information is required the provider and patient will be notified per *UM Timeliness Standards**. The retrospective review will be pended per *UM Timeliness Standards**.
 - 5.2.5.1 When additional clinical information is received, a determination will be per *UM Timeliness Standards**.
 - 5.2.5.2 If no additional clinical information is received within *UM Timeliness Standards**, a determination will be issued based upon available clinical information.
 - 5.2.6 If recommendation is for denial, Policy *UM-6, Denials and Appeals*, is followed.

6.0 Notification of Authorization Determinations

CBHM/CHIPA provides both verbal and written notification of authorization. Verbal notification includes voice mail messages. Written notification can be by mail or facsimile.

6.1 Outpatient Services

- 6.1.1 At the time of referral patients receive verbal notification of authorization per *UM Timeliness Standards**. Upon request by the patient written notification letters are mailed. Notification includes:
 - 6.1.1.1 Reference number
 - 6.1.1.2 Number and type of sessions authorized
 - 6.1.1.3 Benefit limitations
- 6.1.2 Providers receive written notification of authorization per *UM Timeliness Standards**. They may also receive verbal authorization if they call to request authorization. Notification includes:
 - 6.1.2.1 Reference number
 - 6.1.2.2 Patient demographic information

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- 6.1.2.3 Benefit information
- 6.1.2.4 Number and type of sessions authorized
- 6.2 Inpatient/Alternative Level of Care Services
 - 6.2.1 Providers, facilities, and patients receive written notification of determinations per per *UM Timeliness Standards**. In addition, providers/facilities receive verbal notification. Written notification includes
 - 6.2.1.1 Reference number
 - 6.2.1.2 Level of service authorized
 - 6.2.1.3 Start date of authorization
 - 6.2.1.4 Description of review process for ongoing authorization.
 - 6.2.2 During concurrent review, requesting facilities and providers are verbally notified, either by phone or voice mail, per *UM Timeliness Standards** regarding
 - 6.2.2.1 Additional days/services authorized
 - 6.2.2.2 Total services authorized from time of admission
 - 6.2.2.3 Next review date
 - 6.2.3 Per *UM Timeliness Standards** a final notification letter describing all services authorized is mailed to patients, facilities, and providers. Notification includes:
 - 6.2.3.1 Reference number to be used for future reference
 - 6.2.3.2 Level of service authorized
 - 6.2.3.3 All dates of service authorized

7.0 Notice of Pended Determinations

CBHM/CHIPA provides both verbal and written notification of determinations pended for additional information. Notification is completed per *UM Timeliness Standards** and includes the following information:

- 7.1 Requested services
- 7.2 Reason review of request was pended
- 7.3 Specific information needed to complete review process
- 7.4 Time frame for submitting information
- 7.5 Expected date of decision
- 7.6 Type of expert reviewer required, if applicable.
- 7.7 Notice that if information is not received within the time frame requested services may be denied

8.0 Notice of Non-Authorization (Denial) Determinations

Based upon the health plan delegation agreement CBHM/CHIPA will either make a denial determination and verbally notify patient and provider within *UM Timeliness Standards** or will communicate a recommendation for denial to the health plan designee

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within *UM Timeliness Standards**. When CBHM/CHIPA is making denial determination written confirmation of denial and appeal process will be mailed or faxed per *UM Timeliness Standards**. When CBHM/CHIPA is only making denial recommendations the Health Plan Designee who makes denial determination is responsible for providing written or verbal notification to patient, provider, and/or facility. All written denial communications will include

- 8.1 The principal reasons for the denial determination
- 8.2 The specific clinical criteria and rationale used in making the denial decision; and
- 8.3 Instructions for initiating an appeal and/or requesting more detailed information regarding clinical rationale.

Reference Policy *UM-6, Denials and Appeals*.

9.0 Monitoring Timeliness of UM Decisions

9.1 Pre-Authorization

- 9.1.1 Timeliness of pre-authorization is monitored through monthly reporting which compares date of request to date of determination.
- 9.1.2 Results of the report are communicated in the monthly Utilization Management Meeting and corrective action initiated if target is not met.

9.2 Concurrent Review

- 9.2.1 Timeliness of concurrent review is measured through a monthly report, which compares date of request to date of determination. The report includes number of requests received and percentage completed within *UM Timeliness Standards**. The target to be met is 90% of requests reviewed and determination issued within *UM Timeliness Standards**.
- 9.2.2 Results of the report are communicated in the monthly Utilization Management Meeting and corrective action initiated if target is not met.

9.3 Inpatient/Alternative Level of Care Case Management

- 9.3.1 UM Coordinators will document when a clinical review was done and the next date of review. All concurrent reviews will be completed and determination issued within *UM Timeliness Standards**. Target for compliance is 100%.
- 9.3.2 Chart audits will be conducted quarterly to ensure that timeliness of reviews is met and documented. Results of the audit are communicated in the Utilization Management Meetings and corrective action initiated if target is not met.

9.4 Retrospective Review

- 9.4.1 Office Assistant for Intensive Services documents receipt of request in chart as well as date of determination.

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- 9.4.2 A Retrospective Review Log is maintained to track number of days from receipt of request to ensure review and determination is completed within *UM Timeliness Standards**. Target for compliance is 100%.
- 9.4.3 The QI Assistant monitors the Retrospective Review Log monthly.

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**Utilization Management Timeliness Standards*

Pre-Service Request –Prospective Reviews							
Urgent				Non-Urgent			
<i>Information Complete</i>		<i>Need Information</i>		<i>Information Complete</i>		<i>Need Information</i>	
24 Hours from receipt of request to Make Decision		24 hours from receipt of request to pend and verbally notify provider and patient. Written pend notification sent to provider and patient within 24 hours of verbal notification		5 Calendar Days from receipt of request to Make Decision. CBHM/CHIPA does not extend the time frame for decision. If additional information is needed the request is pending.		5 Calendar Days from receipt of request to pend and verbally notify provider and patient. Written pend notification sent to provider and patient within 24 hours of verbal notification.	
Approval	Denial	Pend for 48 hours		Approval	Denial	Pend for 45 Days	
Verbal Notification to patient and provider Within 24 hours of decision	Verbal Notification to patient and provider Within 24 hours of decision	24 hours to make decision after information is received or at the end of 48 hours, whichever comes first		Verbal Notification to patient and provider Within 24 hours of decision	Verbal Notification to patient and provider Within 24 hours of decision	5 business days to make decision after information is received or at the end of 45 calendar days, whichever comes first	
Written Notification to patient* and provider Within 72 hours of decision *Note: for Outpatient Services , written notification is only given to patient upon request	Written Notification to patient and provider Within 72 hours of decision unless verbal notification given within 24 hours then 3 Calendar Days following verbal notification			Written Notification to patient* and provider Within 24 hours of decision *Note: for Outpatient Services , written notification is only given to patient upon request	Written Notification to patient and provider Within 2 business days of decision		
		Approval	Denial			Approval	Denial
		Verbal Notification to patient and provider Within 24 hours of decision	Verbal Notification to patient and provider Within 24 hours of decision			Verbal Notification to patient and provider Within 24 hours of decision	Verbal Notification to patient and provider Within 24 hours of decision

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		Written Notification to patient* and provider Within 48 hours of decision *Note: for Outpatient Services , written notification is only given to patient upon request	Written Notification to patient* and provider Within 48 hours of decision for written notification unless verbal notification given within 24 hours then 3 Calendar Days following verbal notification			Written Notification to patient* and provider Within 24 hours of decision *Note: for Outpatient Services , written notification is only given to patient upon request	Written Notification to patient* and provider Within 2 business days of decision
Concurrent Request							
Urgent				Non-Urgent			
<i>Information Complete</i>		<i>Need Information</i>		<i>Information Complete</i>		<i>Need Information</i>	
24 hours from receipt of request to make decision and complete verbal notification to provider		CANNOT PEND -24 hours to make decision and complete verbal notification		5 Calendar Days to Make Decision CBHM/CHIPA does not extend the time frame for decision. If additional information is needed the request is pended.		5 Calendar Days to Pend and send written notification to provider and patient	
Approval	Denial			Approval	Denial	Pend for 45 Days	
Written Notification to provider Within 24 hours of decision Note: For Outpatient Services written notification to patient is only given upon request. For Higher Level of Care services written notification to patient is given at admission and discharge or upon request	Written Notification to patient and provider Within 24 hours of decision unless verbal notification given within 24 hours then 3 Calendar Days following verbal notification			Verbal Notification to provider Within 24 hours of decision Note: For Outpatient Services written notification to patient is only given upon request. For Higher Level of Care services written notification to patient is given at admission and discharge or upon request	Verbal Notification to patient and provider Within 24 hours of decision	5 business days to make decision after information is received or at the end of 45 calendar days, whichever comes first	

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			Written Notification to provider Within 24 hours of decision Note: For Outpatient Services written notification to patient is only given upon request. For Higher Level of Care services written notification to patient is given at admission and discharge or upon request	Written Notification to patient and provider Within 2 business days of decision		
Exceptions:					Approval	Denial
If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to Urgent, Pre-Service Category					Verbal Notification to provider Within 24 hours of decision	Verbal Notification to patient and provider Within 24 hours of decision
If the request to extend a course of treatment beyond the period of time , or number of treatments previously approved does not involve urgent care, default to Non-urgent Pre-Service category					Written Notification to provider Within 24 hours of decision Note: For Outpatient Services written notification to patient is only given upon request. For Higher Level of Care services written notification to patient is given at admission and discharge or upon request	Written Notification to patient and provider Within 2 business days of decision

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Post Service (Retro-Request)							
Urgent - Not Applicable				Non-Urgent			
				<i>Information Complete</i>		<i>Need Information</i>	
				30 Calendar Days from receipt of request to Make Decision CBHM/CHIPA does not extend the time frame for decision. If additional information is needed the request is pending.		30 Calendar Days to Pend and send written notification to provider and patient requesting information	
				Approval	Denial	Pend for 45 Days	
				Both verbal and written notification to patient and provider must be completed within the 30 calendar days *Note: for outpatient services, written notification is only given to patient upon request	Both verbal and written notification to patient and provider must be completed within the 30 calendar days	15 calendar days to make decision after information is received or at the end of 45 calendar days, whichever comes first	
						Approval	Denial
						Both verbal and written notification to patient and provider must be completed within the 15 calendar days *Note: for outpatient services, written notification is only given to patient upon request	Both verbal and written notification to patient and provider must be completed within the 15 calendar days