

<b>Beacon Comprehensive Behavioral Health Management Policy and Procedure Manual</b>	
<b>Policy Name:</b> UM Review Process	<b>Utilization Management</b>
<b>Date:</b> 3-98 <b>Reviewed by QI Committee:</b> 04-07, 09-07, 9-08, 9-09, 10-09, 02-10, 09-10, 10-10, 06-11, 9-11 <b>Revised by QI Committee:</b> 04-07, 09-07, 9-08, 9-09, 10-09, 02-10, 09-10, 10-10, 06-11, 9-11	<b>Page:</b> 1 of 14 <b>Policy Number:</b> UM-4

**Purpose:** The purpose of this guideline is to ensure that all utilization management decisions related to authorizations and denials are made by Beacon Comprehensive Behavioral Health Management (Beacon CBHM 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. Also known as Routine.

**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. 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 Beacon CBHM relies on the minimal clinical information necessary to make a determination as outlined in Appendix E, Utilization Management Review Guidelines.
- 1.2 Beacon CBHM 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.

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- 1.1.1 Clinical information is used solely for the purpose of utilization management, case management, quality management, discharge planning, and claims payment.
- 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 Beacon CBHM 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 Beacon CBHM 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 quality review or authorization request.
- 1.6 Beacon CBHM 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** – Beacon CBHM, 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 Requiring Authorization**
  - 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

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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.*

- 2.1.2 Non-urgent requests for outpatient service authorizations 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 Director of Care Management 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 registrations created in conjunction 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\**

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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.

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 authorized services is medically necessary s/he should communicate with Beacon CBHM via phone, fax, or email and provide clinical information related to their request to a licensed clinician. Faxes or email requests must be 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 the treating provider has agreed to a care plan. 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 may submit clinical information via phone, fax, or email when continuing care is indicated.

3.2.3 When clinical information is received via fax, the Office Assistant date stamps the request with date received, creates a pended authorization, and verifies current eligibility.

3.2.4 Once eligibility has been verified, the Office Assistant reviews the faxed 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

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determination is pended. 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 When clinical information is received directly by the licensed clinician either by phone or email, the licensed clinician enters the date received and clinical information into the patient’s medical record. The licensed clinician completes the 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 pended. If the additional clinical information is not received within the *UM Timeliness Standards\**, a determination is made based upon the available clinical information.

3.2.6 All non-urgent concurrent review requests are reviewed and determination issued per *UM Timeliness Standards\**.

4.0 Inpatient/Alternative Levels of Concurrent Review

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 Beacon CBHM 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 Beacon CBHM 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 the treating provider has agreed to a care plan. 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\**

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- 4.5.1 If additional information is received, a determination will be made within *UM Timeliness Standards\**.
- 4.5.2 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 Beacon CBHM provider. Beacon CBHM 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.
  - 5.1.3 The request is stamped with date of receipt.
  - 5.1.4 A Beacon CBHM clinician completes retrospective review and issues determination per *UM Timeliness Standards\**.
  - 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\**.

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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

Beacon CBHM provides both verbal and/or 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

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 *UM Timeliness Standards\**. In addition, providers/facilities receive verbal notification. 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

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- 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

Beacon CBHM 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 Beacon CBHM 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 within *UM Timeliness Standards\**. When Beacon CBHM is making denial determination written confirmation of denial and appeal process will be mailed or faxed per *UM Timeliness Standards\**. When Beacon CBHM 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 and/or Concurrent Review

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- 9.1.1 Case Managers and UM Coordinators document the date of authorization request, the date of clinical review and determination, and the next date of review. All pre-authorization and concurrent reviews will be completed and determination issued within *UM Timeliness Standards\**. Target for compliance is 100%.
- 9.1.2 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.
  - 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 Executive Assistant monitors the Retrospective Review Log monthly.

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*\*Utilization Management Timeliness Standards*

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
<b>Urgent Pre-Service</b> - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition <b>not to exceed 72 hours after receipt of the request.</b>	<u>Practitioner:</u> Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials).  <u>Member:</u> Within 72 hours of receipt of the request (for approval decisions).  Document date and time of oral notifications.	Within 72 hours of receipt of the request.
<b>Urgent Pre-Service</b> - Extension Needed  <ul style="list-style-type: none"> <li>Additional clinical information required</li> </ul>	<b>Additional clinical information required:</b>  Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	<u>Additional information received or incomplete:</u>  If additional information <u>is received</u> , complete or not, decision must be made within 48 hours of receipt of information.  <b>Note:</b> Decision must be made in a timely fashion appropriate for the member's condition <b>not to exceed 48 hours after receipt of information.</b>	<u>Additional information received or incomplete</u>  <u>Practitioner:</u> Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials).  <u>Member:</u> Within 48 hours after receipt of information (for approval decisions).  Document date and time of oral notifications.	<u>Additional information received or incomplete</u>  Within 48 hours after receipt of information.
	Additional information not received:  If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours.  <b>Note:</b> Decision must be made in a timely fashion appropriate for the member's condition <b>not to exceed 48 hours after the deadline for extension has ended.</b>	<u>Additional information not received</u>  <u>Practitioner:</u> Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials).  <u>Member:</u> Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions).  Document date and time of oral notifications.	<u>Additional information not received</u>  Within 48 hours after the timeframe given to the practitioner & member to supply the information.

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Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
<p><b>Urgent Concurrent</b>                      - (i.e., inpatient, ongoing/ambulatory services)</p> <p>Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments.</p> <p><b>Exceptions:</b></p> <ul style="list-style-type: none"> <li>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 <u>Urgent Pre-service</u> category.</li> <li>If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to <u>Non-urgent Pre-service</u> category.</li> </ul>	<p>Within 24 hours of receipt of the request.</p>	<p><u>Practitioner:</u> Within 24 hours of receipt of the request (for approvals and denials).</p> <p><u>Member:</u> Within 24 hours of receipt of the request (for approval decisions).</p>	<p>Within 24 hours of receipt of the request.</p>
<p><b>Standing Referrals to Specialists / Specialty Care Centers</b></p> <p>- All information necessary to make a determination is received</p>	<p>Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request.</p> <p><b>NOTE:</b> Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.</p>	<p><u>Practitioner and Member:</u> Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.</p>	<p><u>Practitioner and Member:</u> Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.</p>
<p><b>Non-urgent Pre-Service</b></p> <p>- All necessary information received at time of initial request</p>	<p>Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 calendar days of receipt of request.</p>	<p><u>Practitioner:</u> Within 24 hours of the decision (for approvals and denials).</p> <p><u>Member:</u> Within 2 business days of the decision (for approval decisions).</p>	<p>Within 2 business days of making the decision.</p>

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		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
<b>Non-urgent Pre-Service</b> - Extension Needed <ul style="list-style-type: none"> <li>Additional clinical information required</li> <li>Require consultation by an Expert Reviewer</li> </ul>	<b>Additional clinical information required:</b> Notify member and practitioner within 5 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	<u>Additional information received or incomplete:</u> If additional information <u>is received</u> , complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	<u>Practitioner:</u> Within 24 hours of the decision (for approvals and denials). <u>Member:</u> Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
	Additional information not received  If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	<b>Require consultation by an Expert Reviewer:</b>  Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5 business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	<u>Require consultation by an Expert Reviewer:</u> Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	<u>Require consultation by an Expert Reviewer:</u> <u>Practitioner:</u> Within 24 hours of the decision (for approvals and denials). <u>Member:</u> Within 2 business days of the decision (for approval decisions).	<u>Require consultation by an Expert Reviewer:</u> Within 2 business days of making the decision.
<b>Post-Service</b> - All necessary information received at time of request (decision and notification is required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	<u>Practitioner:</u> Within 30 calendar days of receipt of request (for approvals). <u>Member:</u> Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.

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<b>Policy Name:</b> UM Review Process	<b>Utilization Management</b>
<b>Date:</b> 3-98 <b>Reviewed by QI Committee:</b> 04-07, 09-07, 9-08, 9-09, 10-09, 02-10, 09-10, 10-10, 06-11, 9-11 <b>Revised by QI Committee:</b> 04-07, 09-07, 9-08, 9-09, 10-09, 02-10, 09-10, 10-10, 06-11, 9-11	<b>Page:</b> 13 of 14 <b>Policy Number:</b> UM-4

Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
<b>Post-Service</b> - Extension Needed <ul style="list-style-type: none"> <li>Additional clinical information required</li> <li>Require consultation by an Expert Reviewer</li> </ul>	<b>Additional clinical information required:</b> Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	<u>Additional information received or incomplete</u> If additional information is <u>received</u> , complete or not, decision must be made within 15 calendar days of receipt of information.	<u>Additional information received or incomplete</u> <b>Practitioner:</b> Within 15 calendar days of receipt of information (for approvals). <b>Member:</b> Within 15 calendar days of receipt of information (for approvals).	<u>Additional information received or incomplete</u> Within 15 calendar days of receipt of information.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	Additional information not received <b>Practitioner:</b> Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). <b>Member:</b> Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	<u>Additional information not received</u> <b>Within 15 calendar days after the timeframe given to the practitioner &amp; member to supply the information.</b>
	<b>Require consultation by an Expert Reviewer:</b> Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30 calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	<u>Require consultation by an Expert Reviewer:</u> Within 15 calendar days from the date of the delay notice.	<u>Require consultation by an Expert Reviewer:</u> <b>Practitioner:</b> Within 15 calendar days from the date of the delay notice (for approvals). <b>Member:</b> Within 15 calendar days from the date of the delay notice (for approval decisions).	<u>Require consultation by an Expert Reviewer:</u> Within 15 calendar days from the date of the delay notice.

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Type of Request	Decision Timeframes & Delay Notice Requirements	Notification Timeframe	
		Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)	Written/Electronic Notification of Denial to Practitioner and Member
Translation Requests for Non-Standard Vital Documents  1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity)  2. Non-Urgent (e.g., post-service pend or denial notifications)	<u>LAP Services Not Delegated:</u> All requests are forwarded to the contracted health plan.  1. Request forwarded within one (1) business day of member's request  2. Request forwarded within two (2) business days of member's request		<u>LAP Services Delegated/Health Plan:</u> All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.