coordinated care

CoordinatedCareHealth.com

March 29, 2016

IMPORTANT PROVIDER UPDATES

Dear Provider,

Please find attached important updates, reminders and policy changes for Coordinated Care providers regarding:

Page Number	Title	Summary
2	NOTICE 1: SON Review for all Psychotropic Medications (6/1)	Coordinated Care will coordinate with HCA to obtain a medication consultation by an HCA approved Second Opinion Network provider (SON).
2	NOTICE 2: Apple Health New Enrollment Policy (4/1)	Health Care Authority (HCA) will backdate the effective date of enrollment into a managed care plan to the first day of the month.
2	NOTICE 3: Trauma Informed Care Webinar	Join us Wednesday, 3/30, for a webinar on trauma informed care.

Thank you for being our partner in care and for helping us collectively improve the health of our members.

To be removed from these notices or to request to be added to our email list for these notices, please reply to CoordinatedCareProvider@centene.com.

7 pages total.

NOTICE 1: Second Opinion Network (SON) review for all psychotropic medications EFFECTIVE 6/1/16

HB 1879 mandates that children in Foster Care receive a Second Opinion Network (SON) review for all psychotropic medications, rather than the subset of medications reviewed in non-Foster children. This law was enacted due to heightened concerns around overuse of psychotropic medication in this population. **In order to comply with this law, effective 6/1/2016, Coordinated Care will coordinate with HCA to obtain a medication consultation by an HCA approved Second Opinion Network provider (SON) when any antipsychotic medication is prescribed for a child or youth in foster care.**

Other than the broader set of medications reviewed, the SON process will remain the same. After the second opinion review has been completed by the HCA, Coordinated Care will receive a copy of the second opinion review documents from the HCA. The second opinion review documents will have recommendation explaining the approval or unable to approve determination of the psychotropic prescription request. Coordinated Care will then notify the prescribers the approval or denial decision.

If you have any questions, please contact Coordinated Care Pharmacy Department at 1-877-644-4613 ext. 69622.

NOTICE 2: Apple Health New Enrollment Policy EFFECTIVE 4/1/16

Beginning Friday, April 1st, Health Care Authority (HCA) will backdate the effective date of enrollment into a managed care plan to the first day of the month in which a client is eligible.

This is specifically for individuals applying for or renewing Apple Health (Medicaid) coverage and enrolling into Coordinated Care.

Due to the change in earlier enrollment we have updated our Retrospective review policy (see attachment below)

NOTICE 3: Trauma Informed Care Webinar

Please register for Trauma Informed Care Overview presented by Coordinated Care and Cenpatico on Wednesday, March 30, 2016 12:00 PM - 1:00 PM at:

https://attendee.gototraining.com/r/2053515359689470722

Attendees will need to log into the Go To Training room and will also need to call into the conference number:
Toll-free: 1 888 936 7423
Access Code: 295-336-111

We will be covering the following areas:
- Define the types of trauma
- Review the Adverse Childhood Experiences Study outcomes
- Examine effects of trauma on biopsychosocial development
- Learn the key elements and principles of Trauma Informed Care
- Identify trauma-focused Evidence Based Treatment and resources

**This event qualifies for 1.0 CE hours. Cenpatico has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6673.*

After registering you will receive a confirmation email containing information about joining the training.

Please reach out to your Provider Services team if you have questions.

Coordinated Care Provider Services

(877) 644-4613

POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Retrospective Review For Services Requiring Authorization
PAGE:	**REPLACES DOCUMENT:** CC.UM.05.01
APPROVED DATE: 10/2012	**RETIRED:**
EFFECTIVE DATE: 10/2012	**REVIEWED/REVISED**: 5/13; 5/14; 8/14; 1/15; 1/16; 3/16
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** WA.UM.05.01

SCOPE:
Coordinated Care Medicaid Medical Management Department.

PURPOSE:
To ensure a consistent and standard approach to retrospective (post-service) review of services delivered without prior authorization and/or timely Plan notification.

WORK PROCESS:
Medical Management makes retrospective medical necessity review decisions for the following services delivered without prior authorization (PA), and/or timely notification to CC:

- Inpatient admissions when the member is still hospitalized with extenuating circumstances
- Outpatient services when the patient is still receiving the out-patient services requiring authorization
- Timely notification of inpatient admissions when the member has already been discharged
- Provider has documentation that timely notification was submitted.

For requests regarding PA of services that are untimely and post-discharge of an inpatient admission, or untimely and post-completion of outpatient services, the caller will be advised that CC will not make retrospective review determinations for services that have already been rendered unless the provider is able to present an extenuating circumstance as to why the PA was not requested timely. The following circumstances will qualify the provider for a retrospective review:

- The provider has documentation advising that they were informed that no authorization was required.
- There was a catastrophic event that substantially interfered with normal business operations of the provider or damage or destruction of the provider's business office or records due to a natural disaster.
- A pending or retroactive eligibility issue exists, and the provider is able to provide documentation of the earliest date that CC eligibility was identified following the start date of service.
- When member is qualified for earlier enrollment to Apple Health, and HCA has retroactively assigned Coordinated Care eligibility at the beginning of that month.
- Provider was unaware that the member was eligible for services at the time services were rendered. PA is granted in this situation only if one of the following conditions are met:

- Provider's records document that the member refused or was physically unable to provide the ID number, name with correct spelling, or date of birth. If two identifiers are given, then the provider should be able to find coverage in Provider One.
- Any situation that the physician cannot determine the exact procedure to be done until after the service has been performed; providers are permitted to call 1 business day post-procedure to request a PA. Any request outside 1 day post-procedure can only be granted based on an eligibility awareness issue.
- For outpatient services providers may submit a request for authorization one day post-service to allow for late day emergent care, and health plan processing time.

Inpatient Emergent admissions – CC will allow a post-service PA up to 1 business day following the admission for participating and non-participating facilities.

All medical necessity reviews are conducted according to the process as outlined in policy **WA.UM.02.01 - Medical Necessity Review Trucare**

Note: In cases where a member was transferred from another Medicaid program, CC will honor the treatment that has been approved by that program for the 90 calendar day transition period, assuming that the approved treatment program (authorization for service) has been communicated from the legacy Medicaid program to CC prior to request for payment by the provider.

For telephonic inquiries regarding procedures for authorization of services that that do not meet the criteria described above, the caller is advised that the Plan does not retrospectively authorize services that have already been rendered, and informed of the proper procedures to follow when requesting a pre-service decision.

Written requests that are received regarding the authorization of services that are *untimely* and *post discharge* of an inpatient admission or *untimely* and *post completion of* outpatient services, will be handled as formal requests with the appropriate administrative denial notification procedures, per *WA.UM.05. Timeliness of UM Decisions and Notifications.*

PROCEDURE:

A. In order to render an informed and objective review determination, the Plan requires submission of a complete inpatient chart for review. No submission is considered complete for any type of post-discharge review without a complete hospital medical record, which includes the discharge summary as well as any other relevant clinical information.

B. Retrospective review guidelines are the same for both participating and non-participating providers. All medical necessity reviews are conducted according to *Clinical Decision Criteria and Application (WA.UM.02)* and *Medical Necessity Review (WA.UM.02.01)* policies, and based solely on the medical information available to the attending physician or ordering provider at the time the care or service was rendered.

C. Requests and supporting clinical information for review may be submitted to the Medical Management Department by phone, facsimile or web portal (as available) from the servicing/managing provider and/or the facility. Medical necessity review decisions and time-frames will occur as follows for the following request types:

1. **Untimely Notification - Inpatient Admission - Member Still Hospitalized:**

When an untimely request is made for PA of an inpatient admission or post-stabilization services more than 1 business days after the admission date and the member is still receiving the services, the UM Nurse or UM Manager will conduct a Level I Review if extenuating circumstances prevented the provider of services from notifying CC within the 1 business day notification timeframe, and will make a determination. Urgent concurrent and post-stabilization review decision and notification timelines apply. If no extenuating circumstances are found, the Program Coordinator/Concurrent Review Nurse will deny the authorization in TruCare as an administrative denial, generate an administrative denial letter and document the reason the authorization was not granted, in accordance with Medical Management Training Manual.

2. **Timely Notification - Inpatient Admission - Post Discharge:**
   When a request is made for authorization of hospital services and the member has been discharged, but the request is still within the required inpatient admission notification timeframe of 1 business days, the Program Coordinator / Concurrent Review Nurse will request the information needed and conduct a Level I Review. Post-service review decisions and notification timelines apply. The member and provider will be notified of the outcome, whether approval or denial, within 2 business days of the date of determination.
3. **Untimely Notification – Outpatient/Ancillary Services - Member Still Receiving Services:**
   When a request for PA of outpatient/ancillary services is made after initiation of the services and the member is still receiving the services, the Prior Auth Nurse performs a Level I Review if extenuating circumstances prevented the provider of services from notifying CC within the 1 business day notification timeframe, and makes a determination. Non-urgent, pre-service decision and notification timelines apply.

   If extenuating circumstances prevented the provider of services from notifying CC within the 1 business day notification timeframe, the provider will be instructed to submit the request for retrospective review via claims reconsideration, unless it is due to retro-eligibility by HCA, in which case a retrospective review will be done by the Plan. The caller must be notified of the failure to follow plan processes and the proper procedures to be followed for future service requests.

   The notification will be made within 5 days of the untimely request for non-urgent pre-service requests and within 24 hours for urgent pre-service decisions. This notification will be given verbally followed by an administrative denial letter.

   The Referral Specialist/Prior Auth Nurse will deny the PA request in TRUCARE as an administrative denial, create an administrative denial letter and document the reason the PA was not granted, in accordance with Medical Management Training Manual. If the service is continuing, CC will need to do a separate review for PA for the continuation of the service following the denied dates from the administrative denial.

4. **Untimely Notification – Post Discharge Inpatient Admission Untimely Notification – Post Completion Outpatient Services**
   When a provider or facility makes an untimely request for PA of inpatient services after the member has been discharged or outpatient/ancillary services after those services have been rendered, the Referral Specialist/ Program Coordinator reviews the eligibility information via ProviderOne to determine if HCA has assigned retroactive eligibility. If retro-eligibility exists, the Referral Specialist / Program Coordinator will process the authorization per standard workflow. If retro-eligibility is not determined, the Referral Specialist / Program Coordinator informs the requesting provider that CC will not retrospectively authorize services that have already been rendered. The provider will be instructed to submit the claim for processing, which will be denied as “services not authorized,” at which time the provider may initiate the appeal process. Post-

service decision and notification timelines apply. If extenuating circumstances prevented the provider of services from notifying CC within the 1 business day notification timeframe, the provider will be instructed to submit the entire medical record for retrospective review. The caller must be notified of the failure to follow plan processes and the proper procedures to be followed for future service requests. The notification will be made within 5 days of the untimely request for non-urgent pre-service requests and within 24 hours (1 business day) for urgent pre-service decisions. The notification will be given verbally followed by an administrative denial letter.

If there is no HCA retro-eligibility, the Referral Specialist/Program Coordinator will deny the authorization in TruCare as an administrative denial, create an administrative denial letter and document the reason the authorization was not granted, in accordance with Medical Management Training Manual.

D. Documentation:

- If a phone call is received requesting authorization when notification is untimely, The Referral Specialist/Program Coordinator makes a notation in the *Notes* section within the clinical documentation system. Plan staff document the education provided to the caller regarding proper Plan procedures to be followed when requesting pre-service decisions.
- If a written/faxed request is received requesting authorization when notification is untimely, The Referral Specialist/Program Coordinator will deny the authorization in TruCare as an administrative denial, generate an administrative denial letter and document the reason the authorization was not granted, in accordance with Medical Management Training Manual.
- If a request for retrospective review is made, and it is determined that the request is appropriate to review:
    a. Upon receipt of a request for post-discharge authorization of services, the Utilization Management (UM) designee reviews the submission for completeness of medical record information.
    b. If any piece of the medical record is missing, including the discharge summary, the UM designee attempts to, within the contractual timeframes, obtain the additional information from the provider/facility. The discharge summary is required in lieu of a summary from the attending physician or a peer- to-peer review of the case.
    c. If there is no response or continued lack of required information, the UM designee documents the request for Advisor Review in the clinical documentation system, and forward to the physician reviewer for determination.
    d. The physician reviewer completes the review based on the available information and documents the decision and rationale in the Advisor Review section of the clinical documentation system.
    e. A denial for lack of medical record information is only made if there is *no* clinical information available; otherwise the determination is made based on the available clinical information.
    f. Should the physician reviewer decision result in a denial, the UM designee sends a denial letter to member/provider/facility, as outlined in the following policy: *WA.UM.07, Adverse Determination (Denial) Letters*.

REFERENCES:
WA.UM.07 Adverse Determination (Denial) Letters
WA.UM.05 Timeliness of UM Decisions and Notifications
NCQA Health Plan Standards & Guidelines

WA.UM.02.01 - Medical Necessity Review Trucare
WA.UM.02- Clinical Decision Criteria and Application

ATTACHMENTS:

DEFINITIONS:
Post-Service Review: the initial review for medical necessity for services that delivered to a member, but for which authorization and / or timely CC notification was not obtained.
Timely Request – Unscheduled Inpatient*:* Urgent / emergent / post stabilization inpatient services require plan notification within 1 business day following the admission.
Timely Request – Scheduled Services: For all non-hospital services and elective or pre-scheduled hospital based services requiring pre-service authorization, the provider must notify CC within 2 business days prior to the requested service date.
Untimely Request*:* An authorization request from a provider, facility or member received: more than 1 business days after an inpatient admission or after outpatient services have been initiated.

REVISION LOG

REVISION	DATE
Change in language	5/13
Updated to reflect grace period for outpatient services rendered by both par and non par providers, 1 business post service for late day or urgent services.	8/14
Updated notification requirements on post-service authorizations. Member and provider must be notified within 2 business days of determination for post-service authorizations.	1/15
Updated extenuating circumstance language, staff titles, and policy names	1/16
Added language for HCA retro-eligibilty	3/16

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.