UM Initial Determination Timeframes – Medicaid Products

These timeframes take into consideration the requirements of several regulatory bodies, including the New York State Public Health Law (Article 49, section 4903), the Medicaid Managed Care/Family Health Plus Model Contract Appendix F, the Balanced Budget Act requirements, and NCQA. Determinations not made within these timeframes will automatically result in an adverse determination subject to appeal and the Health Plan will send a denial notification to the member and provider on the date the timeframes expire.
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Type of Review	If You Have All Necessary Information To Make A Decision:	If You Still Need Information To Make A Decision:
Pre-Service (Non-Urgent)	Decision, verbal notification and written notification to member and provider must be completed within 3 business days of the receipt of all necessary information, but no later than 14 calendar days after receipt of original request or as fast as the member's condition requires. **Home Care Exception:** If the Health Plan receives a pre-service request for home care services for a Medicaid member following an inpatient stay, it must make a coverage decision within 1 business day of receipt of necessary information and not more than 3 business days from receipt of the request. If the day subsequent to the request falls on a weekend or holiday, the Health Plan has 72 hours to make the determination. These timeframes apply for members who are admitted to the hospital, even if the Health	If we do not receive the information in time to make a determination within 14 calendar days of the original request, and it is in the member's best interest to have an extension, or if the member requests it, an extension of an additional 14 calendar days may be granted. Send a written request to the member/provider for the specific information needed. We must notify the member or the member's authorized representative of the reason for an extension, the date by which it expects to make a decision, and the member's right to grieve the extension. Once the information is received, the decision, verbal and written notification must be made within 3 business days of the receipt of the necessary information or no later than the date the extension expires, whichever is shorter. If no information or incomplete information is received by the end of the specified time period given, the decision, verbal and written notification must be made no later than the date the extension expires using whatever information has already been

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	Plan determines that it should be billed as an observation stay. If home care services are requested prior to the member being discharged from the hospital and all necessary information is provided, the Health Plan cannot deny coverage for services rendered while a determination is pending, even if the services are later determined to be not medically necessary. The Health Plan cannot retro-deny services if the decision is made outside of the required timeframes. The Health Plan can only deny these services from the date of the decision forward. **<u>Behavioral Health Exception:</u>** As of 01/01/17 per NYS Substance Use Mandate: For prospective /pre-service (first review) for inpatient levels of treatment for addiction, if an in –network OASAS certified facility notifies the insurer of an admission within 48 business hours of the admission, the Plan will automatically approve the admission . NYS out of network providers who are licensed in NYS and the identified member has a contract that has OON benefit; the approval rule also should apply. The approval should be done	received. The notice of extension must specify the reason for the extension, an explanation of how the delay is in the best interest of the member, the additional information the Health Plan needs to make the determination, the right of the member to file a complaint regarding the extension, the process and timeframes for filing a complaint, the right of the member to designate a representative to file a complaint and the right of the enrollee to contact the New York State Department of Health regarding their complaint. Notice of a determination in the extension period must be made verbally and in writing as fast as the member's condition requires and within 3 business days after receipt of necessary information, but no later than the date the extension requires.

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	as follows: 14 days for inpatient substance use disorder (SUD) detoxification; 14 days for inpatient SUD rehabilitation; and 14 days for SUD residential treatment. Per the Assurance of Discontinuance (AOD), auto-approval will apply to all New York-licensed facilities. Also, per the Opiate Mandate, the Plan's UM staff must communicate an approval to the facility the same day if authorization is requested by 2 p.m. and the member has an opiate diagnosis otherwise must give an approval within 24 hours. **Behavioral Health Substance Use Exception** For New York State licensed substance use providers; for initial requests, if the member is already admitted, for inpatient detoxification and rehabilitation and residential treatment: · For opioid diagnoses received prior to 2:00 PM decision, verbal and written notification to the member and provider must be completed by the end of the day the request is received. Request may not be pended. · For opioid diagnoses, if the request	

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	is received after 2:00 PM decision, verbal and written notification to the member and provider must be completed within 24 hours of the receipt of the request. Request may not be pended. · For substance use diagnoses other than opioid decision, verbal and written notification to the member and provider must be completed within 24 hours of the receipt of the request. Request may not be pended. **<u>Court Ordered Services Behavioral Health Exception:</u>** If a request comes in the format prescribed by the Department of Financial Services (DFS) for a preauthorization, the Plan must make a determination and notify the individual or the individual's designee by phone within 72 hours of receipt of the request. Written notice must follow within three business days. Based on discussions with DFS, decisions must be made within 72 hours regardless of whether all necessary information is received.	
Pre-Service (Urgent)	Decision, verbal notification and written notification to member and provider must be completed within 72 hours from the	If we do not receive the information in time to make a determination within 72 hours of the original request, and it is in the member's best interest to have an extension, or if the

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	receipt of the request or as fast as the member's condition requires. **<u>Behavioral Health Exception:</u>** As of 01/01/17 per NYS Substance Use Mandate: For prospective /pre-service (first review) for inpatient levels of treatment for addiction, if an in –network OASAS certified facility notifies the insurer of an admission within 48 business hours of the admission, the Plan will automatically approve the admission . NYS out of network providers who are licensed in NYS and the identified member has a contract that has OON benefit; the approval rule also should apply. The approval should be done as follows: 14 days for inpatient substance use disorder (SUD) detoxification; 14 days for inpatient SUD rehabilitation; and 14 days for SUD residential treatment. Per the Assurance of Discontinuance (AOD), auto-approval will apply to all New York-licensed facilities. Also, per the Opiate Mandate, the Plan's UM staff must communicate an approval to the facility the same day if authorization is requested by 2 p.m. and the member has an opiate diagnosis otherwise must give an approval	member requests it, an extension of an additional 14 calendar days may be granted. Send a written request to the member/provider for the specific information needed. We must notify the member or the member's authorized representative of the reason for an extension, the date by which it expects to make a decision, and the member's right to grieve the extension. Once the information is received, the decision, verbal and written notification must be made within 72 hours of the receipt of the request or no later than the date the extension expires, whichever is shorter. If no information or incomplete information is received by the end of the specified time period given, the decision, verbal and written notification must be made within 72 hours of the original request or no later than the date the extension expires using whatever information has already been received. The notice of extension must specify the reason for the extension, an explanation of how the delay is in the best interest of the member, the additional information the Health Plan needs to make the determination, the right of the member to file a complaint regarding the extension, the process and timeframes for filing a complaint, the right of the member to designate a representative to file a complaint and the right of the enrollee to contact the New York State Department of Health regarding their complaint.

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	within 24 hours. **Behavioral Health Substance Use Exception** For New York State licensed substance use providers; for initial requests, if the member is already admitted, for inpatient detoxification and rehabilitation and residential treatment: · For opioid diagnoses received prior to 2:00 PM decision, verbal and written notification to the member and provider must be completed by the end of the day the request is received. Request may not be pended. · For opioid diagnoses, if the request is received after 2:00 PM decision, verbal and written notification to the member and provider must be completed within 24 hours of the receipt of the request. Request may not be pended. · For substance use diagnoses other than opioid decision, verbal and written notification to the member and provider must be completed within 24 hours of the receipt of the request. Request may not be pended.	

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	<u>Court Ordered Services Behavioral Health Exception:</u> If a request comes in the format prescribed by the Department of Financial Services (DFS) for a preauthorization, the Plan must make a determination and notify the individual or the individual's designee by phone within 72 hours of receipt of the request. Written notice must follow within three business days. Based on discussions with DFS, decisions must be made within 72 hours regardless of whether all necessary information is received.	

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Concurrent - Non-Urgent	Decision, verbal notification and written notification to member and provider must be completed within 1 business day of the receipt of all necessary information but never more than 14 calendar days from the date of the request or as fast as the member's condition requires. Notification of continued or extended services must include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. **Behavioral Health Exception:** Substance Use Mandate: All inpatient concurrent substance use reviews will have an outcome within 24 hours. (urgent and nonurgent). If a request for inpatient substance use disorder treatment is submitted at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, the Plan will make a determination within 24 hours of receipt of the request.	If we do not receive the information in time to make a determination within 14 calendar days of the original request, and it is in the member's best interest to have an extension, or if the member requests it, an extension of an additional 14 calendar days may be granted. Send a written request to the member/provider for the specific information needed. We must notify the member or the member's authorized representative of the reason for an extension, the date by which it expects to make a decision, and the member's right to grieve the extension. Once the information is received, the decision, verbal and written notification must be made within 1 business day of the receipt of the necessary information or no later than the date the extension expires, whichever is shorter. If no information or incomplete information is received by the end of the specified time period given, the decision, verbal and written notification must be made within 14 calendar days of the date of the original request or no later than the date the extension expires using whatever information has already been received. The notice of extension must specify the reason for the extension, an explanation of how the delay is in the best interest of the member, the additional information the Health Plan needs to make the determination, the right of the member to file a complaint regarding the extension, the process and timeframes for filing a complaint, the right of the member to designate a

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		representative to file a complaint and the right of the enrollee to contact the New York State Department of Health regarding their complaint.

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Concurrent - Urgent	Decision, verbal notification and written notification to member and provider must be completed within 24 hours of the receipt of all necessary information but never more than 3 business days from the date of the request or as fast as the member's condition requires. Notification of continued or extended services must include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. **Behavioral Health Exception:** Substance Use Mandate: All inpatient concurrent substance use reviews will have an outcome within 24 hours. (urgent and nonurgent). If a request for inpatient substance use disorder treatment is submitted at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, the Plan will make a determination within 24 hours of receipt of the request.	If we do not receive the information in time to make a determination within 24 hours of the original request, and it is in the member's best interest to have an extension, or if the member requests it, an extension of an additional 14 calendar days may be granted. Send a written request to the member/provider for the specific information needed. We must notify the member or the member's authorized representative of the reason for an extension, the date by which it expects to make a decision, and the member's right to grieve the extension. Once the information is received, the decision, verbal and written notification must be made within 24 hours of the receipt of the necessary information or no later than the date the extension expires, whichever is shorter. If no information or incomplete information is received by the end of the specified time period given, the decision, verbal and written notification must be made within 24 hours of the date of the original request or no later than the date the extension expires using whatever information has already been received. The notice of extension must specify the reason for the extension, an explanation of how the delay is in the best interest of the member, the additional information the Health Plan needs to make the determination, the right of the member to file a complaint regarding the extension, the process and timeframes for filing a complaint, the right of the member to designate a representative to file a complaint and the right of the enrollee to

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		contact the New York State Department of Health regarding their complaint.
Post-Service	Decision and written notification to the provider, and in some cases the member, must be completed within 30 calendar days of receipt of necessary information. No verbal notification is required on post-service decisions.	Send a written request to the member/provider for the specific information needed. Notification to the member must be sent on the date of the denial.