AmeriHealth Caritas Louisiana

Policy & Procedure			
Subject:	Post-Service Review		
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POLICY

At certain times ACLA conducts Post-service reviews of medical services received by Members. In these instances, the Member's medical record is reviewed and a decision is reached within thirty (30) days of receiving all information reasonably necessary to make a determination but in no event later than One-hundred eighty (180) days from the date of service.

For members who are retro-enrolled into the Plan, post service reviews will be completed for services provided within the member's retrospective enrollment period. The retrospective enrollment period is identified as the time between when the member becomes eligible and when they are linked to the MCO. A member may be retroactively enrolled with a plan up to twelve (12) months before the member's linkage add date. Providers have up to twelve (12) months from the member's MCO linkage add date to submit claims to the plan for services with dates of service during the retrospective enrollment period. In the case of an adverse determination, the attending or treating health care Practitioner and institutional Provider are notified of the decision and the reason for the decision.

A retrospective/post-service review will be performed in the following circumstances:

1. When a member has been admitted and discharged from a facility during a time period when Plan staff were not available (i.e., weekends, holidays).

2. In the case of patient retroactive eligibility, up to twelve (12) months before the member's linkage add date to the MCO.

3. When pertinent coverage information is not available, or incorrect, upon admission (i.e. member presented as self-pay or with altered level of consciousness).

Post-service review is performed by licensed qualified clinicians who are supported by licensed physicians. Post-service Review decisions are based on nationally accepted guidelines as outlined in ACLA Policy # UM.008L, *Clinical Criteria.* UM staff can approve requested services when Utilization Management Criteria have been met. Any decision to deny, a service authorization request or to authorize a service in an amount, duration or scope that is less than

requested, is made by the ACLA Medical Director or physician designee after evaluating the individual health needs of the Member, characteristics of the local delivery system and, as needed, consultation with the treating physician.

Post-service Review determinations are documented in the appropriate information system to facilitate claim payment, and are communicated to the requesting Practitioner/Provider in accordance with ACLA Policy # UM.010, *Timeliness of UM Decisions.* The UM documentation system generates and stores an authorization number and the effective dates of the authorization to servicing and requesting providers, regardless of contracted status. Any decision to deny or limit coverage is communicated in writing to the facility and attending physician, in accordance with ACLA Policy # UM.017L, *Notice of Adverse Determination.*

An ACLA Associate may need to Use and/or Disclose a Member's Protected Health Information (PHI) for the purpose of Treatment, Payment, and Operations (TPO). Federal HIPAA privacy regulations do not require Health Plans to obtain a Member's written consent or Authorization prior to using, disclosing, or requesting PHI for purposes of TPO. Therefore, ACLA is not required to seek a Member's authorization to release his/her PHI for any one of the aforementioned purposes (See ACFC Policy #168.227*, Use and Disclosure of Protected Health Information Without Member Consent or Authorization*).

ACLA Associates may not Use, request or Disclose to others any PHI that is more than the Minimum Necessary to accomplish the purpose of the Use, request, or Disclosure (with certain exceptions as outlined in ACFC Policy #168.217, *Minimum Necessary Rule*). ACLA associates are required to comply with specific policies and procedures established to limit uses of, requests for, or disclosures of PHI to the minimum amount necessary.

ACLA will maintain adequate administrative, technical and physical safeguards to protect the privacy of PHI from unauthorized use or disclosure, whether intentional or unintentional, and from theft and unauthorized alteration. Safeguards will also be utilized to effectively reduce the likelihood of use or disclosure of PHI that is unintended and incidental to a use or disclosure in accordance with ACLA policies and procedures (see ACLA Policy #161.112*, Safeguards to Protect the Privacy of Protected Health Information*). ACLA will reasonably safeguard PHI to limit incidental uses and disclosures. An incidental use or Disclosure is a secondary use or disclosure that cannot reasonably be prevented, is limited in nature, and occurs as a by-product of an otherwise permitted use or disclosure (see ACFC Policy #161.112, *Safeguards to Protect the Privacy of Protected Health Information*).

All documentation created or maintained in this policy will be recorded in the appropriate information system. ACLA shall retain documents relating to Protected Health Information for seven (7) years in accordance with ACLA Policy #161.001, *Document Retention Period: Documents Relating to the Privacy of Protected Health Information*, unless otherwise required by Law or regulation.

ACLA Associates must follow facsimile guidelines in handling PHI that is transmitted or received in accordance with the company policy (see ACFC Policy #161.110, *Facsimile Machines and Transmission of Protected Health Information*).

PURPOSE

Outlines the process of request for coverage of care or service that a member has already received and where authorization was not obtained prior to the delivery of the service.

DEFINITIONS

See: Glossary of Terms – ACLA Policy #UM.001L
See: HIPAA Privacy Definitions – ACFC Policy #168.235

PROCEDURE

1. Requests for Post-service review are submitted electronically, by telephone, fax, or written request to the ACLA Utilization Management (UM) department. Members may request, orally or in writing, a retrospective review of initial services, or continuation of previously requested services, in the event a provider refuses a service or does not request a service within appropriate timelines. Practitioners/Providers must submit a request for Post Service Review in writing.

2. The information gathered for use in a Post Service determination includes some or all of the following:
   - Medical history
   - History of present illness
   - Presenting symptoms
   - Prior treatment outcomes
   - Current clinical status
   - Plan of care
   - ER treatment
   - Current treatment
   - Discharge plan
   - Information regarding condition and instructions at prior discharge if readmission is at the same facility

3. In the instance a Health Care provider indicates the member was retro-enrolled into ACLA, or submits a request for authorization for services already rendered, UM staff will verify the member's eligibility within our documentation system, with enrollment and reference the LDH website for member eligibility verification (MEV's) to determine the members

retrospective review eligibility period. Once the eligibility is verified the request is sent for medical necessity review.

4. The UM clinician may make a determination that coverage for the requested service(s) is Medically Necessary based on the ACLA's accepted Utilization Management Criteria (See ACLA Policy #UM.008L, *Clinical Criteria)*. The requesting Practitioner/Provider is notified of this determination as outlined in ACLA Policy #UM.010L, *Timeliness of UM Decisions*.

5. If the UM clinician is not able to approve the requested service(s), he/she will refer the case to the Medical Director or physician designee for review. As part of the Physician review process, the Physician reviews the clinical information submitted in support of the request.

6. In the instance where the Medical Director gives verbal approval after discussion with the UM clinician, the UM clinician will document the approval, along with the reason for approval, within the specific case notes in the medical management information system.

7. Under no circumstances may the UM clinician deny, alter, or approve a lower or different level of care or scope of services than requested; any such denial or downgrade must be made by either the Medical Director or physician designee.

8. The UM clinician is responsible for communicating the Medical Director or physician designee's determination to the requesting Practitioner/Provider as outlined in ACLA Policy #UM.010L, *Timeliness of UM Decisions.*

9. If the Medical Director or physician designee's determination is to deny, alter, or approve a lower or different level of care or scope of services than requested, the requesting Practitioner/Provider is notified of the determination and applicable appeal rights as outlined in ACLA Policy #.017L, *Notice of Adverse Determination.*

REFERENCES (Cited Policies and Procedures and Source Documents)

- ACLA Policy #UM.001L Glossary of Terms
- ACLA Policy #UM.008L Utilization Management Criteria
- ACLA Policy #UM.010L Timeliness of UM Decisions
- ACLA Policy #UM.017L Notice of Adverse Determination
- ACLA Policy #161.110 Facsimile Machines and Transmission of Protected Health Information
- ACFC Policy #168.217 Minimum Necessary Rule
- ACLA Policy #161.112 Safeguards to Protect the Privacy of Protected Health Information
- ACFC Policy #168.227 Use and Disclosure of Protected Health Information Without Member Consent/Authorization
- ACFC Policy #168.235 HIPAA Definitions

- ACLA Policy #161.001 Document Retention Period: Documents Relating to the Privacy of Protected Health Information

ATTACHMENTS

N/A

[-End of Policy-]