Timeframes of UM Decisions and Notification

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Related Policies

Utilization Management Overview

Policy Number	**316**
Original Effective Date:	2/2000
Current Approval Date:	4/23/20
Next Review:	4/2021
Category:	Compliance

Policy Statement

Optum* by OptumHealth Care Solutions, LLC makes utilization management (UM) decisions in a timely manner to accommodate the clinical urgency of the situation. Optum adheres to the following standards unless State or Federal regulations require otherwise.

1. Non-urgent pre-service decisions and notification will be made within fifteen (15) calendar days of receipt of the request. Preservice is defined as any care or service that must be approved, in whole or in part, in advance of the member obtaining the medical care or services.

2. Urgent preservice decisions and notification will be made within seventy-two (72) hours of receipt of the request. See UM Program for definition of urgent care.

3. Urgent concurrent review decisions and notification will be made within twenty-four (24) hours of receipt of the request.

4. Post-service decisions and notification will be made within 30 calendar days of receipt of the request. Post-service is defined as any review for care or services that have already been received.

Notification of UM decisions will be made in writing and by telephone where required by state and Federal law.

Extending the time frame for urgent preservice decisions

For urgent pre-service decisions, if Optum is unable to make a decision due to a lack of necessary information, it may extend the decision time frame once, for up to 48 hours. Within 24 hours of receipt of the request, Optum must notify the member or the member's authorized representative what specific information is necessary to make the decision.

Optum must give the member or the member's authorized representative at least 48 hours to provide the information and notify the member or the member's authorized representative of this time period.
The 48-hour extension period, within which a decision must be made by Optum, begins on either of the following:

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The date on which the member's response is received (without regard to whether all of the requested information is provided), ***or***

At the end of the specified time period given to the member or the member's authorized representative to supply the information, if no response is received from the member or the member's authorized representative.

Optum may deny the request* if it does not receive the requested information needed to make a decision within the allowed time frame. At this point, the member may request an appeal.

Extending time frames for non-urgent pre- and postservice decisions

For non-urgent pre-service and post-service decisions, if Optum is unable to make a decision due to matters beyond its control, it may extend the decision time frame once, for up to 15 calendar days. Within 15 calendar days of a preservice request or 30 calendar days of a post-service request, Optum must notify the member or the member's authorized representative of the need for an extension and the date by which it expects to make a decision.

The 15-day extension period, within which a decision must be made by Optum, begins on either of the following:

The date on which the member's response is received by Optum (without regard to whether all of the requested information is provided), *or*

At the end of the specified time period given to the member or the member's authorized representative to supply the information, if no response is received from the member or the member's authorized representative.

If Optum is unable to make a decision due to lack of necessary information, it may extend the decision time frame if it meets the following criteria:

Optum notifies the member or the member's authorized representative of the specific information required within the decision time frame for the pre-service or post-service request, whichever is applicable, *or*

Optum gives the member or the member's authorized representative at least 45 days to provide the information.

Optum may deny the request* if it does not receive the requested information needed to make a decision within the allowed time frame. At this point, the member may request an appeal.

Requests to extend urgent concurrent care

Optum must make a decision regarding approval or denial of urgent care within the urgent concurrent time frame, but may extend the time frame for the following reasons:

The request to extend urgent concurrent care was not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Optum may treat it as an urgent pre-service decision and make the decision within 72 hours.

The request to approve additional days for urgent concurrent care is related to care not previously approved by Optum and Optum documents that it made at least one attempt and was unable to obtain the needed clinical information within the initial 24 hours after the request for coverage of additional days. In this case, Optum has up to 72 hours to make the decision.

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The member voluntarily agrees to extend the decision-making time frame.

**Please note: Denials that involve reviews with lack of information can be performed by a clinician, based on the clinical information received and evaluated after the allowed waiting period, or the denial can be denied administratively (i.e., by a non-clinician), based on lack of information only. If denied administratively, failure to submit information will result in an administrative denial to the provider with no financial impact to the member.*

Purpose

This policy defines the timeframes for utilization management (UM) decisions and notification of those decisions.

Scope

These timeframes apply to all UM decisions, whether they are made on the basis of benefits or on medical necessity and whether they are for approved or denied services.

Where NCQA standards, URAC standards or CMS requirements vary, Optum has implemented and will adhere to the most stringent requirement. In all instances, state or federally mandated requirements, if more stringent, will supercede NCQA and URAC.

References

1. MCO standards and guidelines. *National Committee for Quality Assurance (NCQA):* www.**ncqa**.org
2. Revised standards for health care utilization management. *American Accreditation Health Care Commission [formerly - Utilization Review Accreditation Commission] (URAC):* www.**urac**.org/
3. 29 CFR 2560.503-1 - Claims procedure. *United States Department of Labor. Accessed 1/26/2016: https://www.gpo.gov/fdsys/granule/CFR-2010-title29-vol9/CFR-2010-title29-vol9-sec2560-503-1*
4. Centers for Medicare and Medicaid (CMS) National Coverage Policy Manual(s): *http://www.cms.hhs.gov*
5. New York State Public Health Law, Article 49 (4903)

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Policy History/Revision Information

Date	Action/Description
2/23/2000	Original effective date
9/20/2002	Annual review and approval completed
11/11/2003	Annual review and approval completed
10/18/2004	Annual review and approval completed
2/14/2006	Annual review and approval completed
4/10/2008	Annual review and approval completed
10/09/2008	Policy revised and approved. Key elements from UM Policy 315 (Lack of Information for Review) were incorporated. The policy establishes explicit time frames including circumstances where time frames may be extended. The draft was vetted through Compliance/Legal dept.
1/15/2009	Policy reformatted
4/30/2009	Annual review and approval completed
4/08/2010	Annual review completed
10/26/2010	Policy rebranded to "OptumHealth Care Solutions, Inc. (OptumHealth)"
4/07/2011	Annual review completed
4/19/2012	Annual review completed
4/18/2013	Annual review completed
4/17/2014	Annual review completed; Policy rebranded "Optum* by OptumHealth Care Solutions, Inc."
4/16/2015	Annual review completed
4/21/2016	Annual review and approval completed; Updated references
4/20/2017	Annual review and approval completed; Updated references; Legal entity name changed from "OptumHealth Care Solutions, Inc." to "OptumHealth Care Solutions, LLC."
4/26/2018	Annual review completed
4/25/2019	Annual review completed
4/23/2020	Annual review completed

Contact Information

Please forward any commentary or feedback on Optum utilization management policies to: policy.inquiry@optumhealth.com with the word "Policy" in the subject line.

The services described in Optum* by OptumHealth Care Solutions, LLC policies are subject to the terms, conditions and limitations of the Member's contract or certificate. Optum reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Optum's administrative procedures.

Certain internal policies may not be applicable to self-funded members and certain insured products. Refer to the member's Summary Plan Description (SPD) or Certificate of Coverage (COC) to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member's SPD or COC, the member's SPD or COC will govern.

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