

# Humboldt Del Norte Foundation for Medical Care 2011 Utilization Management (UM) Policy

## Reporting Structure and Content

The Chief Medical Officer is involved with key aspects of the utilization management program, such as setting policies, reviewing cases, participating on all UM committees and supervising the UM program. The medical director(s) and other Foundation staff are responsible for implementation of the UM program. The QMAC (Quality Management Administrative Committee) oversees the UM program (see Section II. Quality Management, C. Governing Body and Content). All physicians involved in the UM program must possess an unrestricted California medical license.

The Medical Management Committee (MMC) develops the annual Utilization Management Program (UMP) goals and presents the UMP to the QMAC for review, revision, and final approval. The annual UMP is developed using the Industry Collaborative Effort (ICE) format. The QMAC reviews all recommendations and revisions before submitting the UMP to the Board of Directors. The Board of Directors of the Foundation and IPA conduct an annual review of the Foundation's UMP and periodically as needed.

## Utilization Review Clinical Criteria and Decision Making

The Foundation adheres to State of California, NCQA and/or health plan mandated criteria for consistency of reviewing utilization. The Foundation's *Approved Resources* (see Appendix C) are objective and based on sound medical evidence. Additions to the Approved Resources are reviewed and approved by QMAC as needed. Appropriate, actively practicing medical and behavioral health practitioners are involved in development and adoption of standardized clinical criteria.

The Foundation's prior authorization requirements are based on the following general principles.

- Patient care should be coordinated by their primary care practitioner (PCP).
- Consultation services ordered from a PCP to local IPA or Foundation member specialists do not require prior authorization.
- Services received by HMO plan members from non-contracted providers are not covered unless pre-authorized as medically necessary from that non-contracted provider.
- Prior authorization is required for services which are only covered when the health plan's medical necessity criteria are met.
- Prior authorization is required for all elective inpatient stays but, once admitted, the services provided during the hospital stay are affected only by claims review.
- Prior authorization is not required for services provided in a medically emergent situation.
- When a PPO plan member accesses services from out of network providers without prior authorization, the services are covered at a reduced rate based on their plan coverage.

All information and rationale used during the utilization review process is disclosed upon written request to the Foundation from a practitioner, member or the public. The Foundation may charge a fee to cover the copying and postage expenses associated with the request for information. Disclosure notice sent with criteria or guidelines requested by members and the public include the following statement: "*The materials provided to you are guidelines issued by the Foundation to authorize, modify or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under the member's contract.*"

The Foundation's UM responsibilities are allocated among staff based on the type of service being reviewed. The Foundation's Medical Management Department staff is delegated to approve some service requests for approval following specific Foundation policies. Clinically competent licensed California IPA/Foundation physicians review/issue all denials and modifications of services based on

medical necessity. "Medically Necessary", medically necessary services and procedures are those services that are "clinically appropriate and in accordance with generally accepted standards of medical practice". Such services shall not be primarily for the convenience of the patient or health care provider; and not be more costly than an alternative service that is likely to produce equivalent therapeutic or diagnostic results. When a requested service is reviewed for potential denial for lack of medical necessity without a previously approved guideline, the Medical Director will initiate a clinical consult with a physician knowledgeable in the requested service for input. This consult is documented and included in the authorization documentation.

Reviewers must consider at least the following factors when applying criteria to a given individual:

- Age
- Progress of Treatment
- Member desires
- Co-morbidities
- Psychosocial situation
- Ethnic and Cultural beliefs and practices
- Complications
- Home environment
- Other as appropriate

Reviewers refer to the *Approved Resources* (Appendix C) and apply all the relevant criteria within the context of the local delivery system in making their decision. Reviewers also consult with appropriate board certified specialty providers as needed. (Note: To provide this resource, all IPA member physicians make themselves available for telephone consultations with the Foundation.) In compliance with Department of Labor (ERISA) regulations, the identity of experts whose advice was obtained in connection with an adverse determination is made available upon member's request (this must be done without regard to whether the advice was relied upon to make the determination).

The rationale for all authorization decisions, whether approved, denied or modified are noted in the electronic authorization by the reviewer(s) to ensure that subsequent reviewers will be able to clearly understand the decision made. When making a determination based on medical necessity, the Foundation staff obtains relevant clinical information and consults with the treating physician or clinician expert as necessary.

When the reviewer determines that an alternate treatment plan is more appropriate, the authorization request is denied with information recommending the alternate treatment plan. When a request for services by an out-of-plan provider is denied, the denial letter includes options for in-plan providers. When the reviewer is considering denial of concurrent inpatient care, the care will not be discontinued until the member's treating provider is contacted about the pending decision and the treating provider has agreed to a care plan.

## **Utilization Management Policies and Procedures**

### **1. Authorization Process**

The Foundation's customer service staff is available from 8:00 am to 4:30 pm on business days to answer questions from providers and members. Each day the Foundation posts the status of all authorization requests received within the past 90 days on the web site at [www.hdnfmc.com](http://www.hdnfmc.com). Providers interested in viewing authorizations, claims and PPO plan member eligibility can contact customer service for more information.

Providers and members are responsible for ensuring that prior authorization is obtained for services according to the requirements of the member's health plan. The Foundation will deny payment for any services requiring authorization that are rendered without prior authorization. All services, whether pre-authorized or not, are subject to post-service claims review for appropriate coding and documentation.

Local in-plan providers may directly refer to local in-plan specialists without prior authorization. Specifically, they may refer directly to: Cardiology, Dermatology, Ear/Nose/Throat, Endocrinology, Gastroenterology, General Surgery, Hematology, Neurology, OB/GYN, Oncology, Ophthalmology,

Orthopedic Surgery, Podiatry, Routine Laboratory, Routine X-ray, Urology, etc. Specialists must indicate the referring provider on the claim form.

All local in-plan providers may request prior authorization. Authorization requests received from non-contracted advanced practice clinicians working under a contracted physician will be accepted under the contracted supervising physician's name only. Authorization requests received from all other non-contracted providers will be returned.

**Services Requiring Prior Authorization** are described generally in Appendix A and more specific information is available on the Foundation's website at [www.hdnfmc.com](http://www.hdnfmc.com). **Emergent and urgent services that require prior authorization should be requested but not at the expense of delaying such treatment pending authorization.** When one service being provided in a visit requires authorization, then all services for that visit will require authorization.

Approved authorizations are effective on the date received and expire in three months. Effective dates for retroactive authorization requests will be determined at the time of review (see Retroactive authorization requests below). If requested in advance of the expiration date, extensions may be granted by the Foundation's UM staff.

Secondary Insurance Authorizations are not required by the Foundation except when:

- The requested service is not a covered benefit under the primary insurance, and/or
- The benefits for the requested service have been exhausted under the primary insurance. In this case, evidence of the exhaustion of benefits will be required.
- The Foundation will not authorize services denied as not medically necessary by the primary insurance.

Authorizations may be submitted by IPA member physicians (MD and DO), podiatrists, advanced practice clinicians and optometrists. Requests submitted by specialists must be related to the problem/condition they are managing.

Authorization Request Forms: All authorizations must include medical information necessary to establish the medical necessity of the requested services in order to be considered for approval. Authorizations may be submitted on paper or electronically. Paper based authorization requests are available on the Foundation's website at [www.hdnfmc.com](http://www.hdnfmc.com), by mail upon request or see Appendix D... The completed form can be faxed to (707) 442-2047 or mailed to the Foundation at P.O. Box 1395, Eureka, CA 95502. Many authorization requests may be submitted through the web-based Northcoast Referral Network (NCRN) using the IRIS program located at <https://ncrn.proxhealth.com>.

- Incomplete Member or Provider Information – The Foundation returns requests that do not adequately identify the member or provider within one business day of receipt. The specific information missing is indicated on the *Notification of Incomplete Authorization Request* form, which is faxed with the returned incomplete request form.
- Incomplete Medical Necessity Information – The Foundation may delay processing (“pend”) a request if required information is not submitted (see Appendix B: Foundation Utilization Management Timeliness Standards) with the request. When requests are delayed, the notification includes the reason for pending the request, the specific information needed, and the time frame for submitting the information.
- Multiple service locations - Complete a separate Authorization Request Form for each location of service.
- Multiple providers in a group - The requested provider must be indicated on the Authorization Request Form but the authorized service(s) may be provided by any provider within the group's tax identification number.
- Professional and Technical components - Authorization for the technical or professional component of a procedure includes authorization for the technical and professional components of the procedure.

- Surgical Assists – Authorized surgeries include authorization for surgical assist when medically indicated.
- Second opinion requests with a non-contracted provider for HMO members are referred to the health plan for authorization and referral processing. Foundation staff process second opinion requests for PPO health plans (see also separate Foundation Access Policy and Procedure.)
- Experimental or Investigational treatment requests for HMO plan members are referred immediately to the health plan for authorization and referral processing. The Foundation has adopted HMO Experimental and Investigational treatment guidelines for all health plans it administers.
- Unlisted Codes - Unlisted codes will not be authorized. If necessary, request authorization for the service most similar to the one being performed and submit documentation with the claim for post-service review.

Retroactive authorization requests are not generally approved by the Foundation. Retroactive authorization requests must be received within 90 days of the date of service to be considered for approval. Claims for services billed with an approved retroactive authorization must be submitted within 30 days of the date of the retroactive approval or they will be denied for claim timeliness.

Retroactive authorizations for the following services when they are deemed medically necessary per documentation received will be approved for payment:

- Emergent or urgent services
- Durable Medical Equipment ordered by an in-plan provider and dispensed by a non-contracted vendor (see separate policy on Durable Medical Equipment)
- CT provided during the course of radiotherapy treatment.
- “First Contact” services when the requesting provider presents documentation showing that the member provided them with incorrect insurance information prior to the service being performed.
- Services provided when the Foundation-administered plan is secondary to other coverage (no prior authorization is needed for services other than rehabilitative therapies).

Retroactive Authorizations will be considered for possible approval for the following services when they are deemed medically necessary:

- Procedures provided as a result of a decision made during an office visit when the procedure was carried out at the visit
- Services requested within 2 business days of receipt of the authorization request
- Out of area services that were not pre-authorized
- Other exceptions presented to the Medical Management Committee for review.

IPA and Foundation network professional claims for services authorized retroactively for medically necessary services that could have been authorized in advance or within days of the date of service will be allowed at 50% of the regular allowed amount.

Emergency Services are authorized without review of medical necessity. Post emergency services are also authorized based on the treating practitioner’s determination of medical necessity for continued care.

Member eligibility is verified by the Foundation prior to processing authorization requests and must be verified by the provider at the time of service. If the member is not eligible on the date of service, the member is financially responsible for the cost of those services.

Timeliness of the Foundation’s UM decisions is based on the ICE timeliness standards, which apply turnaround times based on medical necessity (see Appendix B: Foundation Utilization Management Timeliness Guidelines). Urgent care services are assigned priority status and routine requests are processed within five days, unless additional information is necessary to process the request.

Notification of all UM decisions are sent to the requesting and requested providers via fax or via a .pdf upload through IRIS and to the member via mail. Denied and modified authorization notifications are written following ICE standards. Denied and modified letters include the specific reason for the denial or modification, an alternate treatment plan, information about the option to appeal the decision, and instructions on how to initiate an appeal. Denied and modified letters also include notification to practitioners that the Foundation's reviewer is available to discuss the UM denial decision and the reviewer's name and specific telephone number is provided as a method of contacting the reviewer.

### **Care Management**

During the UM process, a member may be recommended by any Foundation staff to receive care management (CM) services. CM activities can improve medical outcomes, provide effective benefit management and increase member and provider satisfaction. CM activities are documented in the member's CM file. Case Managers also assist high-risk patients who are affected when providers terminate from the Health Plan. See Case Management Policy and Procedure for more detail.

### **Utilization Management Quality Assurance Activities**

The Foundation's quality assurance activities are reported at least quarterly to the QMAC. The following reports are routinely reviewed.

Interrater reliability studies - The Foundation conducts interrater reliability studies at least quarterly to evaluate consistency in decision making between both physician and non-physician reviewers.

Denial letter reviews – The Foundation conducts monthly review of denial letters focusing on letter content and format, decision-making consistency and timeliness of decision. One week's worth of denial letters (approximately 25% of all denied or modified authorizations) will be reviewed monthly by the Executive Director for consistency criteria, including but not limited to dispute information, letter criteria, rationale and timeliness of decision and format.

Adverse outcomes – The Foundation staff investigates and reports all adverse outcomes to the Medical Management Committee (MMC).

Turnaround time reports – The Medical Management Committee (MMC) reviews turnaround time reports and makes recommendations for change as needed.

Emergency Room and Urgent Care utilization – The QMAC compares emergency room and urgent care utilization against standards. Utilization patterns by members and providers are investigated and action plans initiated as needed.

Bed Days per 1000 member – The QMAC reviews inpatient utilization and compares against standards. High and low bed day rates are investigated and action plans initiated as needed.

## Appendix A: Foundation Authorization Requirements; Reviewed January 2011

Authorization requirements and potential benefit issues are available on the Foundation's website at [www.hdnfmc.com](http://www.hdnfmc.com). PLEASE REFER TO OUR WEBSITE PRIOR TO SUBMITTING AN AUTHORIZATION REQUEST. Search by CPT code or service description. Updates and an Authorization Request form can be found at our website <http://hdnfmc.com> or phone Customer Service (707) 443-4563

**Note: HMO and PPO plans may have different criteria. Please refer to the table below:**

HMO Specific Information:

- Primary Care Practitioners may refer immediately without prior authorization for consultation with the following contracted specialists: Cardiology, Dermatology, Ear/Nose/Throat, Endocrinology, Gastroenterology, General Surgery, Hematology, Neurology, OB/GYN, Oncology, Ophthalmology, Orthopedic Surgery, Podiatry, and Urology. They may also order Routine Laboratory and Routine X-ray without prior authorization.
- All services provided by out of plan (non-contracted) providers require prior authorization.
- All services provided outside of Humboldt or Del Norte County require prior authorization.

PPO Specific Information: Services provided by out of plan (non-contracted) providers are covered at a reduced benefit level and incur a higher cost to the member.

**The following services require prior authorization to receive maximum financial coverage and to avoid any penalties for non-compliance, depending on the specifics of the health plan.**

Service	HMO Plans Anthem & Blue Shield	PPO Plans		
		Blue Lake Rancheria	Open Door Community Health Centers	Trinidad Rancheria
<b>Biopharmaceuticals / High cost injectables / Chemotherapy*</b> HCPCS Codes requiring prior authorization can be found on our website.	Yes	Yes	Yes	Yes
<b>DME – Durable Medical Equipment and related supplies</b> Use purchase price if equipment will be rented	Yes > \$50.00	Yes > \$250	Yes > \$250	Yes > \$250
<b>Genetic Testing</b>	Yes	Not covered	Yes	Yes
<b>Hearing Aids</b> Not all HMO members have this benefit; verify	Yes	Yes	Yes	Not covered
<b>Home Health Services</b>	Yes	Yes	Yes	Yes
<b>Hospital Inpatient Services</b> (non emergent only)	Yes	Yes	Yes	Yes
<b>Hospital Outpatient Services</b> (non emergent only) Lab, plain x-ray and Ultrasounds are excluded, no auth required	Yes	Yes	Yes	Yes
<b>Hospice</b>	Yes	Yes	Yes	Yes
<b>Imaging</b> – includes CT, MRI, MRA, PET scans and DEXA scans	Yes	Yes	Yes	Yes
<b>Infusion Therapy</b> – ambulatory or home bound	Yes	Yes outpatient only	Yes outpatient only	Yes outpatient only
<b>Mental Health Services and Substance Abuse Treatment</b> Inpatient, outpatient, residential services	Contact Anthem or Blue Shield	Not covered	Yes	Yes
<b>Rehabilitative Therapy Services:</b> Acupuncture, Chiropractic Care, Physical, Occupational and Speech Therapy. May not be a covered benefit; please verify. Benefit limitations may apply	Yes	Yes Auth after 12 combined rehab visits	Yes Auth after 12 combined rehab visits	Yes Auth after 12 combined rehab visits
<b>Respiratory Care</b> May not be a covered benefit; please verify	Yes	Yes	Yes	Yes
<b>Skilled Nursing Facility Services</b> May not be a covered benefit; please verify	Yes	Yes	Yes	Yes
<b>Transplants</b> (organ and tissue), peripheral stem cell replacement and similar procedures	Yes	Yes	Yes	Yes

**Utilization Management Timeliness Standards  
(Commercial HMO - California)**

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>	<b>Practitioner:</b> Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials).  <b>Member:</b> 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>Note:</b> If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
<b>Urgent Pre-Service</b> - Extension Needed  • Additional clinical information required	<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 is received, 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>  <b>Practitioner:</b> Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials).  <b>Member:</b> 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.  <b>Note:</b> If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
	<u>Additional information not received:</u>  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>  <b>Practitioner:</b> 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).  <b>Member:</b> 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.  <b>Note:</b> If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
<b>Urgent Concurrent</b> - (i.e., inpatient, ongoing/ambulatory services)  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.  <b>Exceptions:</b> <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>	Within 24 hours of receipt of the request.	<b>Practitioner:</b> Within 24 hours of receipt of the request (for approvals and denials).  <b>Member:</b> Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request.  <b>Note:</b> If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.

**Utilization Management Timeliness Standards  
(Commercial HMO - California)**

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>Standing Referrals to Specialists / Specialty Care Centers</b> - All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request.  <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.	<b>Practitioner and Member:</b> Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.	<b>Practitioner and Member:</b> Refer to appropriate service category (urgent, concurrent or non-urgent) for specific notification timeframes.
<b>Non-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 not to exceed 5 business days of receipt of request.	<b>Practitioner:</b> Within 24 hours of the decision (for approvals and denials).  <b>Member:</b> Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
<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 business 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 received, 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.	<b>Practitioner:</b> Within 24 hours of the decision (for approvals and denials).  <b>Member:</b> Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
	<u>Additional information not received</u> 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>  <b>Practitioner:</b> Within 24 hours of the decision (for approvals and denials).  <b>Member:</b> 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.

**Utilization Management Timeliness Standards  
(Commercial HMO - California)**

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> - 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.	<b>Practitioner:</b> Within 30 calendar days of receipt of request (for approvals).  <b>Member:</b> Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.
<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 <u>is 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.
	<u>Additional information not received</u>  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.	<u>Additional information not received</u>  <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>  Within 15 calendar days after the timeframe given to the practitioner & member to supply the information.
	<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.
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.