UTILIZATION MANAGEMENT DECISION TIMEFRAME STANDARDS 2018

Non-Urgent Pre-Service Requests:
- Requests for non-urgent service requests (before treatment is rendered) will have a decision made within 11 calendar days of receipt of the request for Elite Product Line and 11 calendar days for all Product Lines excluding Elite.
- Requesting provider will be notified by telephone within or electronic confirmation within 3 calendar days of making decision.
- Written or electronic notification of the decision is given to the provider and the member within 2 calendar days of making the decision.
- For Paramount Advantage, written notification of a denial decision and the Notice of Action is sent to the provider and the member on the same day as the coverage determination except in those cases when the coverage determination occurs after the close of regular business hours. Written denial notification for coverage determinations made after regular business hours occur the next business day.

Precertification of Urgent Care:
- Urgent care outside of the service area does not require precertification. The PCP is responsible to coordinate all follow-up care. Members are encouraged to call their PCP for urgent care treatment when in the service area. Urgent care, if received at an in-Plan Urgent Care facility is covered without precertification.
- Requests for urgent pre-service requests will have a decision made within 48 hours of the receipt of the request.
- The requesting provider will be notified by telephone or electronic confirmation within 48 hours of the request. In cases of a denial, member will also be notified of the decision.
- For urgent care services within the service area at a non-Plan provider office, telephone or electronic confirmation of the decision is given to the provider the same day the decision is made.
- Written or electronic notification of the denial decision is given to the provider and member within 48 hours of the receipt of the request. Members will also be notified of the decision in cases of a denial.
- For Paramount Advantage, written notification of a denial decision and the Notice of Action is sent to the provider and the member on the same day as the coverage determination except in those cases when the coverage determination occurs after the close of regular business hours. Written denial notification for coverage determinations made after regular business hours occur the next business day.
Concurrent Review:
• Concurrent review decisions (review during course of treatment/while member is receiving services) will be made within 72 hours/3 calendar hours of receipt of request for Advantage and Elite product lines and 24 hours/1 calendar day for Commercial and Marketplace product lines. Behavioral Health – Advantage product line only decisions for concurrent review of ACT, IHBT, and SUD Residential services will be made within 48 hours/2 calendar days of receipt of request.
• Practitioners/Providers are notified of the decision telephonically or electronically within 72 hours of receipt of request. In cases of a denial, where members will be financially liable, members will also be notified (telephonically or electronically) of the decision within 72 hours of receipt of request for Elite and Advantage product lines, 24 hours for Commercial and Marketplace product lines.
• Written notification of the decision is sent to the provider within 72 hours of receipt of request.

Retrospective Review:
• Retrospective review decisions (review after services have been rendered) are made within 30 calendar days of receipt of request.
• The requesting provider will be notified by telephone or electronic confirmation within 30 calendar days of the request.
• Written or electronic confirmation of the decision is given to the provider and member within 30 calendar days of the request.

Paramount Advantage - Pharmacy requests:
• Decisions are made within twenty-four (24) hours of receipt of request.
• Decision results are communicated by telephone or electronically the same day as the decision.
• Written notification of a denial decision and the Notice of Action is sent to the provider and member on the same day as the coverage determination except in those cases when the coverage determination occurs after the close of regular business hours. Written denial notification for coverage determinations made after regular business hours occur the next business day.

Paramount Elite- Expedited Requests:
• Requests for Elite expedited requests will have a decision made within 72 hours of receipt of the request.
• Decision results are communicated to requesting provider and member by telephone or electronic confirmation within 72 hours of receipt of request.
• Written notification of an approval or denial decision is sent to the provider and member the same day the decision is made via UPS. Note: Per CMS, The enrollee (member) must receive the notice in the mail within 72 hours of receipt of request.