Adverse Utilization Management Decisions

Medical Policy

Purpose

Provide guidelines around Utilization Management benefit and administrative denial decisions. This includes correspondence criteria required for all adverse administrative and benefit determinations. This Policy is written in accordance with the Community Health Options ("Health Options") Member Benefit Agreement, Pioneer ASO Plan Document and organizational requirements regarding the Prior Approval process.

Definitions

Authorized providers: (Meeting all the following)

a. Submitting provider must meet State licensure requirements to practice independently.
b. Rendering provider or facility must meet State licensure requirements to provide the requested service.
c. Rendering facility must meet applicable accreditation requirements.

Concurrent Review: 1) A Medical Management technique used by managed care organizations to ensure that Medically Necessary care is delivered in the most appropriate setting during a Member's hospitalization or other episode of care. 2) a review that occurs during an inpatient stay to determine if continuation as an inpatient stay is Medically Necessary (includes review of appropriate level of care) or a review during a Member's course of treatment to determine if continuation of the treatment is Medically Necessary. Concurrent Reviews may be urgent or non-urgent based on the medical situation.

Level of Care (LOC): The most appropriate setting, according to evidenced based guidelines, in which medical care can be provided based on the severity of the health condition (i.e. acute, intermediate, intensive care unit)

Minimum Necessary Information: At least one (1) ICD-10 code and at least one (1) CPT/HCPCS code are required to initiate a medical necessary review.

Prior Approval Request: a medical service must be reviewed prior to the service(s) being performed or the service(s) will not be covered by the plan; also known as prior certification or pre-approval.

Prior Notification: a medical service for which the Member or Provider must notify Medical Management before admittance to an inpatient Organization or rendering a service.

Post Service Request: the services have already been rendered and a review for Medical Necessity occurs due to a submitted claim or a request.

Policy

Health Options ensures all adverse determinations (denials) are issued appropriately, within the specified timeframe, and contain required and applicable information. An authorization denial by Medical Management may be issued for any of the following reasons:

1. Administrative Denial: An authorization request that is denied when requirements of the Plan are not met (i.e. requests for services outside of designated timeframes or from non-accredited facilities); or
2. Benefit Denial: The requested service is not a covered benefit according to the Member Benefit Agreement or Plan Document; or
3. Medical Necessity: The clinical information submitted with the authorization request for services does not meet established clinical criteria of Medical Necessity.

Only the Health Options Medical Director or a delegated reviewer makes medical necessity denial determinations. A delegated reviewer includes a physician, a PhD level Behavioral Health Provider, or a pharmacist.

Designated Medical Management staff make administrative and benefit denial determinations based on business rules, policies, and established procedures.

This Policy applies to all Health Options decisions for Utilization Management preservice, post-service, and concurrent review requests.

Authorization Procedure

Eligibility:

The reviewer ensures:

1. Member is eligible for benefits (if Member is not eligible for services, the request is voided);
2. Requested service is a covered benefit under the applicable plan (taking into consideration all special circumstances with each individual request when applying the criteria, i.e., comorbidities, disabilities, special needs); and
3. The requested service is subject to authorization review.

Administrative Denials:

Health Options authorization requirements must be met for all service requests or an administrative denial will be issued by the reviewer. Requirements are as follows:

1) Authorized Provider requesting authorization;
2) Service requests must include minimum necessary information;
3) Providers must submit review requests within the following specified timeframes:

- **Preservice ambulatory services review requests:** Prior to the service or within 10 business days of the rendered service
- **Post Service review requests** are generally discouraged and must be received within ten (10) business days of the date of service.
- **Inpatient Admissions/Observation Stays (Concurrent Review):** Notification is required within 48 hours (or by noon on the first business day after the weekend) even if the patient is already discharged.
- **Concurrent Review Extended Stay Requests:** A request for an extended stay concurrent review with supporting clinical documentation must be made within 24 hours of the authorization expiration date.
- **Level of Care Change:** Notification is required within 24 hours of transition to a higher or lower level of care within the same facility. Failure to notify a change in LOC may result in a claim denial when claim LOC does not match the authorized LOC for any given day(s).
- **Additional Clinical Requests:**
    - Ambulatory Services: provider has up to two (2) business days to provide the additional requested clinical information.
    - Inpatient/Observation stays: provider has up to one (1) business day to provide the additional requested clinical information.

Benefit Denial:

Health Options benefit coverage requirements must be met for all service requests or a benefit denial will be issued by the reviewer.

- All conditions of benefit coverage must be met (e.g., covered service, within benefit limit, meets network status requirements, etc.) in accordance with the Member Benefit Agreement or Plan Document.

Medical Necessity Denial:

Once administrative rules, benefit coverage, and prior approval requirements have been verified, the service request is reviewed for medical necessity.

- A delegated reviewer (physician, PhD Behavioral Health provider or pharmacist) makes adverse medical necessity determinations based on submitted clinical information that takes into consideration the individual's unique circumstances and nuances of the local delivery system.

Claims Processing Procedure

The following Claims Adjustment Reason Codes (CARC) are used for claim denials based on Utilization Management rules and determinations: (Not an all-inclusive list)

- 197: (Administrative denial)– "Precertification/Authorization notification is absent"
- 198: "Precertification/Authorization exceeded"
- 204: (Benefit Exclusion)– "This service/equipment/drug is not covered under the patient's current benefit plan"
- 50: (Medical necessity)- "Non covered services as deemed not medically necessary by payor"
- 186: (Level of Care: Authorized/approved level of care paid; non-paid rate line falls under this CARC)– "Level of care change adjustment"
- 284: "Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services"

Reconsideration Process (Optional)

In some instances, providers may request a reconsideration of a denial. Reconsiderations include review of additional information. Accomplished through submission of written clinical support or through verbal peer-to-peer discussion. Peer-to-peer discussions are limited to authorized providers.

Timeline for reconsideration is within 15 calendar days of the date listed on the denial letter. Provider may request a written reconsideration and a peer-to-peer discussion as long as both are submitted within the 15-calendar day timeframe.

The following denial types are eligible for a reconsideration:

- Benefit Denials: Limited to Experimental or Investigational Denials
- Medical Necessity Denials

After a reconsideration, or absence of a reconsideration, provider/facility has Appeal rights.

Appeal Rights

If a service is denied; Members, Member representatives, or health care providers have the right to request an appeal if there is disagreement with the decision. An appeal request must be made within 180 calendar days of the date on the notification of a denial decision. Expedited appeal reviews with decisions made within 72 hours can occur when applicable criteria are met. Please see the Appeal Rights and Information document listed in the Member and Provider Resource Guide section of our website (HealthOptions.org) for more information.

Related Policies

Appeal Rights and Information
Prior Approval Overview & Notification (2021)

Document Publication History

2/16/2021 Update to include additional definition around level of care reviews
10/7/2020 Initial publication

This policy provides information on Community Health Options' claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion. Policies are enforced unless underpinning direction stated otherwise.