Adverse Utilization Management Decisions

Medical Policy

Purpose

Provide guidelines around Utilization Management benefits 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 Member Benefit Agreement, ASO Plan Document, and organizational requirements regarding the Prior Approval process.

Definitions

Authorized Providers: (Meeting all the following)

- Submitting providers must meet state licensure requirements to practice independently.
- Rendering providers or facility must meet state licensure requirements to provide the requested service.
- Rendering facilities must meet applicable accreditation requirements.

Concurrent Review:

- A Utilization 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.
- A review that occurs during an inpatient stay to determine if continuation as an inpatient stay is medically necessary 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.

Minimum Necessary Information:

- At least one ICD-10 code and at least one CPT/HCPCS code is required to initiate a medically necessary review.

Prior Approval Request:

- A medical service must be reviewed before 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 Utilization Management before admitting to an inpatient facility 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

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

- Administrative Denial: An authorization request that is denied when the requirements of the plan are not met (e.g., requests for services outside of designated timeframes, unlisted codes not appropriate for the request, or from non-accredited facilities); or
- Benefit Denial: The requested service is not a covered benefit according to the Member Benefit Agreement or Plan Document; or

- Medical Necessity: The clinical information submitted with the authorization request for services does not meet established clinical criteria of medical necessity; including business rules.

Only the Community Health Options Medical Director or a delegated reviewer makes medical necessity denial determinations. A delegated reviewer includes a physician, a Ph.D.-level behavioral health provider, or a pharmacist.

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

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

Authorization Procedure

Eligibility: (The reviewer ensures)

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

Administrative Denials:

Community 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:

- Authorized provider, as defined above, is requesting authorization.
- Service requests must include the minimum necessary information.
- Providers must submit CPT/HCPCS code(s) to the highest specificity, if none are available an unlisted code may be appropriate.
- Providers must submit review requests within the following specified timeframes:
- Preservice ambulatory services review requests: Before the service or within 10 business days of the rendered service.
- Post-service review requests are generally discouraged and must be received within 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: Notification is required 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 (LOC) within the same facility. Failure to notify a change in LOC may result in a claim denial when the claim LOC does not match the authorized LOC for any given day.
    - Additional Clinical Requests:
        - Ambulatory Services: the provider has up to two business days to provide the additional requested clinical information.

Inpatient/Observation stays: the provider has up to one business day to provide the additional requested clinical information.

Benefit Denial:

Community 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.

Note: As a business rule, Community Health Options defines medical necessity as services or supplies that are in accordance with standards of good medical practice, consistent with the diagnosis, and the most appropriate level of care provided in the most appropriate setting, at the most appropriate time. In cases when there is a delay of care (variance day) where Community Health Options determines that the care was not performed timely, the care day may be denied. Example of a hospital variance: Internal or external department practices, actions, and policies that delay the expected course of care, such as operational inefficiencies, which are under hospital control, or unavailability of certain services or personnel.

Claims Processing Procedure

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

- 50: (Medical necessity) "Non-covered services as deemed not medically necessary by the payor"
- 186: (Level of Care: Authorized/approved level of care paid; non-paid rate line falls under this CARC) "Level of care change adjustment"
- 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"
- 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 which can be accomplished through submission of written clinical support or through verbal peer-to-peer discussion. Peer-to-peer discussions are limited to authorized providers.

A reconsideration request must be received within 15 calendar days from the date listed on the denial letter. Providers 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 reconsideration:

- Benefit Denials: Limited to experimental or investigational denials
- Medical Necessity Denials

After a reconsideration or absence of a reconsideration, providers have appeal rights.

Appeal Rights

If a service is denied; Members, Member representatives, or 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. For more information, please see the Appeal Rights and Information document listed in the Member and provider resource guide section of our website, https://www.healthoptions.org.

Related Policies

Appeal Rights and Information
Prior Approval Overview & Notification

Document Publication History

- 8/18/2023 Annual Review: minor administrative updates
- 9/1/2022 Added business rule for medical necessity related to delay care day denials
- 2/21/2022 Added language around unlisted codes
- 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 the underpinning direction stated otherwise.