Criteria for Utilization Review— CCS302

Subject: Criteria for Utilization Review	**Revised Effective:** 11/1/2020
Policy #: CCS302	**Review Schedule:** Annual or as needed

Applicability:
CHP+
RAE

Definitions:

Medically Necessary (for RAE/Medicaid):	Those covered mental health or substance use disorder services which are determined under the applicable Utilization Management (UM) Program to be: • Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all • Is provided in accordance with generally accepted professional standards for health care in the United States • Is clinically appropriate in terms of type, frequency, extent, site, and duration • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider • Is delivered in the most appropriate setting(s) required by the client's condition • Is not experimental or investigational • Is not more costly than other equally effective treatment options
Medically Necessary (for CHP+ HMO and CHP+ SMCN):	Those covered physical health, mental health, and/or substance use disorder services which are determined under the applicable Utilization Management (UM) Program to be: • Consistent with the symptom, diagnosis, and treatment of a member's medical condition • Widely accepted by the practitioner's peer group as effective and reasonably safe based on scientific evidence • Not experimental, investigational, unproven, unusual, or not customary • Not solely for cosmetic purposes • Not solely for the convenience of the member, subscriber, physician, or other provider • The most appropriate level of care that can be safely provided to the member, and failure to provide the service would adversely affect the member's health • When applied to inpatient care—medically necessary services cannot be safely provided in an ambulatory setting
Medically Necessary (for EPSDT under Medicaid):	A program, good, or service that: • Will or is reasonable expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all

	• Is provided in accordance with generally accepted professional standards for health care in the United States • Is clinically appropriate in terms of type, frequency, extent, site, and duration • Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider • Is delivered in the most appropriate setting(s) required by the client's condition • Provides a safe environment or situation for the child • Is not experimental or investigational • Is not more costly than other equally effective treatment options Please reference CCS315 Early and Periodic Screening, Diagnostic and Treatment (EPSDT)
Utilization Review (UR):	A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, referrals, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this policy and procedure, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances, when necessary, to determine if exclusion applies in a given situation. Please reference CCS307 Utilization Review Determinations for more information about the utilization review process.

Policy: Colorado Access (COA) makes Utilization Review determinations based on professionally recognized written criteria or established guidelines and specifies the procedures to apply those criteria in an appropriate and consistent manner. COA utilizes nationally recognized clinical criteria and relevant community standards of care for utilization review. COA first purchased InterQual criteria in 1998. COA has maintained annual licensure for InterQual criteria and uses these criteria for Utilization Review determinations for all lines of business. If InterQual does not have criteria for a service or level of care, Colorado Access applies the criteria listed in the definition above (see Procedure 3 below for more information). The InterQual criteria are reviewed annually by senior medical staff and when new updates are released between the annual reviews; staff are providing training as needed based on InterQual updates.

COA assures that all clinical decision-making criteria are consistent with the Clinical Practice and Preventative Health Guidelines reviewed and approved by the COA Health Strategy Committee. Decision making criteria for the drug utilization review program are reviewed and approved by the COA Pharmacy and Therapeutics Committee in conjunction with the Pharmacy Benefit Manager (currently Navitus Health Solutions).

COA ensures that any UM criteria or service limitations for mental health disorders and substance use disorders are no more restrictive than the predominant UM criteria or service limitations under the medical/surgical benefits for the same treatment classification. The presence of a non-covered diagnosis does not preclude a member from receiving covered services for a co-occurring covered diagnosis; all medically necessary covered services for covered diagnoses are covered, regardless of any co-occurring condition.

Procedures:

1. Application of Criteria

   A. All clinical staff with decision-making authority are trained (at hire and ongoing) on InterQual criteria (see CCS301 Qualifications for Staff Engaged in UM Activities for more information about staff with decision making authority).

   B. Utilization review staff considers the individual needs of the member as well as the capacity and resources of the local delivery system when applying utilization review criteria.

   C. After available information is submitted to COA, Utilization Review staff conducts Utilization Review using adopted written criteria.

   D. If the information provided does not meet medical necessity criteria for the services being requested, the Utilization Review staff forwards the request to a physician for review. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a physician who has appropriate clinical expertise in treating the member's condition or disease.

   E. COA assures that staff and physicians performing determinations of medical necessity are consistent in the application of criteria for decision making through annual (and ad hoc, if needed) inter-rater reliability assessments.

2. Dissemination of the Criteria

   A. All Utilization Review criteria are available to members, potential members, and relevant providers upon request.

   B. New or revised criteria are published and disseminated in the applicable provider manuals and on the COA website.

   C. All adverse benefit determination notifications sent to members and providers include instructions on how to obtain a copy of the criteria used in the review.

3. Criteria Applied by Service Type: Colorado Access uses InterQual criteria for each service type/level of care available (relevant to the services that require prior authorization). If no InterQual Criteria are available, Colorado Access applies the general medical necessity criteria established by this policy. The following table lists the services that currently require prior authorization and the criteria that are applied to each type of review. If a service does not have InterQual listed, then no InterQual criteria are available for use.

Behavioral Health Service Types		
Level of Care	**InterQual Criteria**	**COA General Medical Criterial Policy**
Inpatient Hospitalization	X	X
Acute Treatment Unit (non-hospital)	X	X
Day Treatment	X	X
Partial Hospitalization	X	X
Long-term Residential Services	X	X
Short-term Residential Services	X	X
Mental Health Intensive Outpatient Services	X	X
Substance Use Disorder Intensive Outpatient Services	X	X
Psychological Testing		X

Physical Health Services Types		
Level of Care	**InterQual Criteria**	**COA General Medical Criterial Policy**
Inpatient Hospitalization	X	X
NICU	X	X
Inpatient Rehabilitation	X	X
Inpatient Transplant	X	X
Outpatient Facility Procedures	X	X
Durable Medical Equipment		X
Early intervention Rehabilitation		X
Home Health – Nursing	X	X
Home Health – Occupational Therapy	X	X
Home Health – Physical Therapy	X	X
Home Health – Speech Therapy	X	X
Outpatient Rehabilitation		X
Outpatient infusions/injections		X

References:
CCS301 Qualifications for Staff Engaged in Utilization Management Activities
CCS307 Utilization Review Determinations

Attachments:
N/A