Utilization Review Determinations— CCS307

Subject: Utilization Review Determinations	**Revised Effective:** 11/1/2020
Policy #: CCS307	**Review Schedule:** Annual or as needed

Applicability:
CHP+ HMO, CHP SMCN, RAE

Exclusions: This policy does not address administrative denials, which means a claim denial due to the provider's failure to follow contractual requirements and/or established procedures regarding authorization requirements (e.g. untimely notification, failure to submit necessary information, etc.). Providers may dispute claim denials according to process outlined in the Provider Manual.

Policy: Colorado Access (COA) will maintain processes for Utilization Review determinations that assures appropriate and timely determination and notification of authorizations and denials. When conducting Utilization Review, COA:

- Accepts information from any reasonably reliable source that will assist in the authorization process;
- Collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;
- Requires only the section(s) of the medical record necessary in that specific case to determine whether Medically Necessary or appropriateness of the admit or extension of stay, frequency or duration of service; COA does not routinely request copies of all medical records on all patients reviewed – additional medical records will only be requested when there is difficulty in making a review determination;
- Offers the opportunity for a peer review if authorization is not issued after the initial clinical review;
- Notifies providers of the peer review procedures through publication on the website;
- Administers a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or providers; and
- Does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition to the member.

Definitions:

Adverse Benefit Determination:	Any of the following: • The denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit • The reduction, suspension or termination of a previously authorized service • The denial, in whole or part, of payment for a service • Failure to provide services in a timely manner as defined by the State • The failure to act within the timeframes defined by the State for the resolution of grievances and appeals • The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other)

	• The denial of a member's request to exercise his or her right to obtain services outside the network for members in rural areas with only one Medicaid managed care organization under the following circumstances:
	  o The service or type of provider (in terms of training, expertise, and specialization) is not available within the network.
	  o The provider is not part of the network but is the main source of a service to the member—provided that:
	    ▪ The provider is given the opportunity to become a participating provider.
	    ▪ If the provider does not choose to join the network or does not meet the Contractor's qualification requirements, the member will be given the opportunity to choose a participating provider and then will be transitioned to a participating provider within 60 days.

Appeal:	Request for review of an Adverse Benefit Determination.
Concurrent Review:	The ongoing review of inpatient and outpatient episodes of care to determine if services and/or treatments are medically appropriate, occur in the appropriate setting, and are being administered by appropriate providers. Concurrent Review determinations are based solely on the medical information obtained at the time of the review. The frequency of reviews is based on the severity or complexity of the patient's condition or on the necessary treatment and discharge planning activity regardless of the clinical setting.
Emergency Medical Condition:	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: • Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part
Emergency Services:	Covered inpatient and outpatient services that are: • Furnished by a qualified provider under 42 CFR 438 • Needed to evaluate or stabilize an Emergency Medical Condition
Grievance/Appeal Representative (GAR):	Any person, including a treating health care professional, authorized in writing by the member or the member's legal guardian to represent his or her interests related to complaints or appeals about health care benefits and services. GARs may be designated using the authorization form.
Intermediate Level Reviewer (ILR):	Individuals who conduct initial clinical review and possess an active, professional license or certification to practice in Colorado with a scope of practice relevant to the clinical areas addressed.

Lack of Timely Notification:	Request for authorization for non-Emergency services that would routinely require prior authorization, and the request is made after the service has been rendered.
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)
Prospective Review:	Utilization Review process that is conducted prior to a scheduled admission or course of treatment or service. Prospective Review is necessary for the pre-authorization of healthcare services to determine if services or treatments are Medically Necessary, planned in the appropriate setting and will be provided by participating providers, whenever possible. Prospective Review determinations are based solely on the medical information obtained at the time of the review. The frequency of reviews is based on the severity or complexity of the patient's condition or on the necessary treatment and discharge planning activity regardless of the clinical setting.
State Fair Hearing:	Is the formal adjudication process for appeals described in the Code of Colorado Regulations 2505-10, HCPF Rule §8.057.
Urgent Care Request:	A request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination that: • Could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function; or for persons with physical or mental disability, create imminent and substantial limitation on their existing ability to live independently; or • In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request. • Except as provided in paragraph (3) of this definition, in determining whether a request is to be treated as an Urgent Care Request, an individual acting on behalf of COA shall apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. • Any request that a physician with knowledge of the member's medical condition determines and states the request is an Urgent Care Request within the meaning of Paragraph (1) above shall be treated as an Urgent Care Request.
Urgently-Needed Services:	Covered services that are not Emergency Services, as defined above, which are provided when a member is temporarily absent from the service area or, under unusual and extraordinary circumstances, provided when the member is in the service area, but the COA provider network is temporarily unavailable or inaccessible and when the services are medically necessary and immediately required such as: • As a result of an unforeseen illness, injury, or condition • It was not reasonable, given the circumstances, to obtain the services through COA

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, 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 member's medical circumstances when necessary to determine if an exclusion applies in a given situation.

Procedures:

1. **Authorization Administrative Review**:
   A. Requests for authorization of service may be received by phone, fax, or mail.

   B. Member eligibility is verified UR staff prior to clinical review. If a member is found to be ineligible, this information is communicated to the requestor directly and is not considered to be an adverse benefit determination.

   C. Provider contract status is verified by an intake coordinator prior to clinical review.

      1. If COA has no participating providers or there exists a need beyond the scope of participating specialty services, UM staff will work with the primary care provider or behavioral health provider to arrange for a referral to a provider with the necessary expertise to ensure that the member has access to the covered benefit.
      2. UR staff will coordinate services with other available payer sources when appropriate.

2. **Medical Necessity Criteria**: UR staff will apply the established criteria or guideline available and consider the individual needs of the member during the review. If no written criteria or guideline is available, the request will be forwarded to a physician reviewer for determination as described in COA policy and procedure CCS302 Medical Criteria for Utilization Review.
   A. UR Staff may consult with a COA Medical Director at any point during the review process.

   B. If the UR staff is able to meet the established criteria or guideline, the request will be authorized accordingly.

   C. If the UR staff is unable to match the request to the established criteria or guideline, the request will be forwarded to the physician reviewer for determination.

   D. If the request requires mandatory physician review, the request will be forwarded to the physician reviewer for determination. COA physician reviewers will consult with the requesting provider when appropriate.

   E. All information used to make an Adverse Benefit Determination and associated notices will be maintained in COA's transaction system and retained in the member's record for ten (10) years (see policy and procedure CMP210 Record Retention and Destruction).

3. **Prospective Review Request, Determination, and Notification (Standard Request)**
   A. When a request for Prospective Review (standard request) fails to meet COA review request procedures, a written notice will be sent to the member and provider with the reason for the failure and the proper procedures as soon as possible and no later than five (5) calendar days following the date of the original request.

B. Prospective Review determinations will be made within in a reasonable period of time appropriate to the member's medical condition, no later than ten (10) calendar days after receipt of the request for services. A written notification to the provider and/or facility will be faxed which includes a reference number. Upon request of the patient, a written notification can also be mailed.

C. If the review determination is adverse to the member, COA will send notification to the member as required by state law, rule and regulations and with the elements contained in this policy and procedure (please reference Section 7 below).

D. In the case of a determination to authorize or deny a service, UR staff will notify the provider in the case of an approval, and the member and the provider in the case of a denial of the determination within a reasonable period of time appropriate to the member's medical condition, no later than ten (10) calendar days after receipt of the request for services.

E. If an Adverse Benefit Determination occurs during a member's hospital stay or course of treatment, the service will continue without liability to the member until COA notifies the member of the determination.

F. Extension of prospective review period:

1. The time period for making a determination may be extended one (1) time for up to fourteen (14) calendar days. Extensions will be utilized if the member or provider requests an extension or COA justifies a need for additional information. The extension must be in the member's best interested in order to be granted.

2. COA will send a written Notice of Extension to the member within the first ten (10) calendar days from the date the initial request was received. COA will include in the Notice of Extension the reasons for the delay and the expected date of determination. The Notice of Extension will inform the member of the right to file a Grievance with COA if he or she disagrees with the decision to extend.

3. If an extension is necessary due to the failure of the member to submit necessary information in order to reach a determination, COA will inform the member through the Notice of Extension of the needed information and a fourteen (14) calendar day deadline for the information to be submitted.

4. Prospective Expedited Review Request, Determination, and Notification (Urgent Care Requests)

A. If the provider indicates (or COA determines) that standard prospective timeframes could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, COA will review the request within a reasonable period of time appropriate to the member's medical condition, no later than seventy-two (72) hours after receipt of the request for services.

G. If the review determination is adverse to the member, COA will send a notification to the member as required by state law and rules and regulations and with the elements contained in this policy and procedure (please reference Section 7 below).

B. Extension of the prospective expedited review period:

1. The time period for making a determination may be extended one (1) time for up to fourteen (14) calendar days. Extensions will be utilized if the member or provider requests an extension or COA justifies a need for additional information. The extension must be in the member's best interested in order to be granted.

2. COA will send a written Notice of Extension to the member within the first ten (10) calendar days from the date the initial request was received. COA will include in the Notice of Extension the reasons for the delay and the expected date of determination. The Notice of Extension will inform the member of the right to file a Grievance with COA if he or she disagrees with the decision to extend.
3. If an extension is necessary due to the failure of the member to submit necessary information in order to reach a determination, COA will inform the member through the Notice of Extension of the needed information and a fourteen (14) calendar day deadline for the information to be submitted.

5. Concurrent Expedited Review Request, Determination and Notification (Urgent Care Requests)

A. Concurrent Review Urgent Care Requests to extend the course of treatment beyond the initial period of time or the number of treatments must be submitted seventy-two (72) hours prior to the expiration date of the original authorization.

B. Concurrent Review urgent care determinations will be made as soon as possible taking into account the member's medical condition and no later than seventy-two (72) hours following the receipt of the request.

C. A written confirmation of continued certification is faxed to the facility and includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

D. If the review determination is adverse to the member, COA will send a notification to the member as required by state law and rules and regulations and with the elements contained in this policy and procedure (please reference Section 7 below).

6. Retrospective Review Requests, Determination, and Notification

A. Retrospective Review Determinations will occur within a reasonable period of time and no later than thirty (30) calendar days after the date of receiving the review request.

B. The time period for making a Retrospective Review determination begins on the date the request is received by COA regardless if all the information necessary to make the determination accompanies the request.

C. If the determination is adverse to the member, COA will send notification to the member and the member's provider as required by state law and rules and regulation and with the elements contained in this policy and procedure (please reference Section 7 below).

D. Extension of retrospective review period

1. COA may extend the time period for making a determination and notifying the member and provider one time for up to fifteen (15) calendar days, provided the extension is necessary due to extenuating circumstances beyond COA's control and it notifies the member prior to the expiration of the initial 30-day time period, of the circumstances requiring the extension of time and the date by which it expects to make a determination.
2. With an extension, the time period for making a determination starts on the date when COA sends the notice of extension to the member or the date when the member submits necessary information or the due date when the specified information was to be sent in, whichever is earlier.
3. COA will send a written notice of extension to the member and the provider within the first thirty (30) calendar days from the date the initial request was received. COA will include in

the Notice of Extension the reasons for the delay and the expected date of determination. The notice of extension also informs the member of the right to file a Grievance with COA if they are not in agreement with the extension.

4. If an extension is necessary due to the failure of the member to submit necessary information in order to reach a determination, COA will inform the member through the Notice of Extension of the information necessary to complete the request and provide a thirty (30) calendar day deadline from the date of receipt of the notice for the information to be submitted. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline shall be extended to the next business day.

7. Adverse Benefit Determinations.

A. Written notification will be sent to the member and provider when COA makes an Adverse Benefit Determination. A Notice of Adverse Benefit Determinations will be mailed within the following timeframes:

1. For standard prospective service authorization decisions, no later than 10 calendar days after the receipt of the request for service.
2. For expedited service authorization decisions, no later than 72 hours after receipt of the request for service.
3. For extended service authorization decisions, no later than the date the extension expires.
4. For service authorization decisions not reached within the required timeframes, no later than the date the time frame expires.
5. For denial of payment, at the time of any denial affecting the claim.

B. As standard practice, COA does not reduce, suspend, or terminate previously authorized services. On the rare occasion that this type of adverse benefit determination would occur, COA will give notice at least 10 calendar days before the intended effective date of the proposed adverse benefit determination unless one of the following exceptions are met:

1. Notice may be mailed no later than the date of the adverse benefit determination if:

a. COA has factual information confirming the death of the member;

b. COA receives a clear written statement signed by the member stating that: he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this is the result of supplying the information;

c. The member has been admitted to an institution where he/she is ineligible under the plan for further services;

d. The member’s whereabouts is unknown and the post office returns mail directed to him or her indicating no forwarding address;

e. COA establishes that the member has been accepted for services by another local jurisdiction, state, territory, or commonwealth;

f. A change in the level of medical care is prescribed by the member’s physician; or

g. The notice involves an action made with regard to the preadmission screening requirements of 1919(e)(7) of the Social Security Act.

2. If COA has verified probable member fraud, COA will provide notice five (5) calendar days before the effective date of the proposed adverse benefit determination.

C. Adverse Benefit Determination notifications will be written (paper or electronically) and in an easily understood manner to include the following:

1. The specific action COA has taken or intends to take;
2. The reasons for the Adverse Benefit Determination, including an explanation of the specific medical basis for an Adverse Benefit Determination;
3. Reference to the specific plan provision on which the determination was based;
4. Description of any additional material or information necessary for the member to complete the benefit request, including the reason why the material or information is needed;
5. The member's right to request reasonable access to and copies of all documents and records relevant to the adverse benefit determination;
6. A statement referencing the specific rule, clinical guideline, protocol, or similar criterion used to make the determination, and/or the scientific or clinical judgment for making the determination for cases where service was denied based on medical necessity, experimental or investigation treatment or similar exclusions, along with instructions that these materials or further explanations will be provided to the member free of charge upon request and how to request them. Upon request from the member, attending physician or other ordering provider or facility rendering service for clinical criteria, the request will be forwarded to a Manager of Utilization Management. The Manager will copy the specific rule, clinical guideline, protocol or similar criteria upon which the non-certification was based and send to the requestor via mail;
7. For mental health, behavioral health, or substance use disorder benefits, the Notice of Adverse Benefit Determination will also include a statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which providers that limitations placed on access to mental health and substance use disorder benefits may be no greater than any limitations placed on access to medical and surgical benefits. The statement also includes information about contacting the office of the ombudsman for behavioral health care if the member believes his or her rights under MHPAEA have been violated;
8. The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable;
9. The member's and the provider's right to file an Appeal on behalf of the member and the procedures for filing an Appeal, including the telephone number(s) of the department responsible for handling Appeals, who may be contacted for additional information;
10. The date the Appeal is due;
11. The circumstances under which expedited resolution is available and how to request it;
12. The member's right to request a State Fair Hearing and the procedures for exercising the right to a State Fair Hearing, and the availability of assistance in the filing process;
13. Written assurance that the filing of an Appeal will not result in a loss of Medicaid or Child Health Plan Plus coverage and will not subject the member to retaliation;

14. The member's right to have benefits continue if the member files an Appeal or a request for State Fair Hearing within the timeframes specified for filing and pending resolution of the Appeal, and how to request that benefits be continued;
15. The circumstances under which the member may be required to pay the cost of services furnished while the Appeal is pending if the final decision is adverse to the member; and
16. The name, date, signature, and credentials of the physician issuing an Adverse Benefit Determination.

D. The Notice of Adverse Benefit Determinations will be written in language easy to understand, available in prevalent non-English languages in the region (English and Spanish), and available for translation in non-prevalent languages by request. Alternative formats (e.g., large print, Braille, audio recording) are also available upon request.

8. **Appealing Adverse Benefit Determinations**. COA has established a process for providers and members to appeal Adverse Benefit Determinations. See ADM219 Member Appeal Process.
9. **Monitoring Compliance**. A random sample of Adverse Benefit Determinations will be audited periodically for compliance and potential improvement opportunities.
10. **Patient Safety.** To improve patient safety and reduce medical errors UM staff are also responsible for identifying potential or known patient safety issues. If a potential safety concern is identified during Utilization Review, the UM staff will complete the referral form for a Quality of Care Concern according to the Quality of Care Concern Policy.

References:
ADM203 Member Grievance Process
ADM291 Member Appeal Process
CCS302 Medical Criteria for Utilization Review
CCS309 Emergency and Post-Stabilization Care
CCS315 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
QM201 Quality of Care Concern Investigations

Attachments:
N/A