

**MEDICAL ASSOCIATES HEALTH PLANS
HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL
POLICY NUMBER: PP 2**

POLICY TITLE: HEALTH CARE SERVICES DENIAL POLICY

POLICY STATEMENT:

When the Health Care Services Staff makes a non-certification for a medical service the following denial procedure will be implemented. Pre-certification decisions are now known as **pre-service decisions**. Retrospective decisions are now known as **post- service decisions**. **Concurrent review decisions** are any reviews for extension of a previously approved ongoing course of treatment over a period of time or a number of treatments. If the request isn't considered urgent care, then the decision must either meet pre-service or post-service time frame, as applicable. **Urgent care** is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

PROCEDURE:

1. Non-certifications/Denials will be issued in the following manner:
 - a. The Case Managers will discuss the case with the CMO or Director/Manager of HCS as outlined below for final determination. The Case Manager will document in the Amisys system who the case was reviewed with including, date and time of discussion, and reason for coverage denial. For all denial cases, the case must be reviewed by or discussed with the CMO, Director and/or Manager of HCS as part of the denial process. This includes redirects. The CMO will review all denial letters and initial them after review of the content.
 - b. The Director of Health Care Services *or* the Manager has the authority to deny requests for Health Plans' coverage for those other than medical necessity if the subscriber's contract does not list the service as a covered benefit or if the benefit maximum has been reached. (Ex: PT visits if the contract states a total of 30 visits per calendar year).
 - c. The Chief Medical Officer or physician designee is the only person who has the authority to deny Health Plans' coverage for questions of medical necessity. He/she may also deny services rendered by a non-participating Health Plans practitioner or when a maximum length of stay has been reached.
 - d. A psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist reviews any denial of behavioral health care that is based on medical necessity. This can not be the treating physician.
2. Non-certifications/Denials for hospital admissions or continued hospitalization can be made for the following reasons:
 - a. The acuity level of the patient does not warrant ongoing inpatient hospitalization.
 - b. Quality care can be provided at a lower level of care, i.e.: SNF, home care.
 - c. A medical service or hospitalization was determined not medically necessary as it does not meet standard medical criteria utilized by the Case Managers.
 - d. Services are delivered by a non-contracted practitioner.

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- e. Non-covered services per the plan document.
3. Non-certifications/Denials for outpatient medical services and/or surgery can be made for the following reasons:
 - a. A medical service or surgery was determined not medically necessary, as it does not meet standard medical criteria utilized by the Case Managers.
 - b. Services are delivered by a non-contracted practitioner.
 - c. Non-covered services per the plan document.
 4. Non-certifications/Denials for out-of-plan referral requests can be issued for the following reason:
 - a. Services are provided by a non-contracted practitioner.
 - b. An unauthorized referral was made.
 - c. Service determined not medically necessary as it does not meet standard medical criteria utilized by the Case Managers.
 - d. Service requested is a non-covered service.
 5. The initial denial notification must be in writing or electronically. The notification for denials will be communicated by the Health Care Services Staff to the Health Plans' subscriber, and attending practitioner in the following manner:
 - a. For **pre-service of non-urgent care decisions** the organization must give oral, written or electronic notification of the decision to practitioners and members within 15 calendar days of the request.

For non-urgent pre-service decisions, if the organization is unable to make a decision due to matters beyond the control of the organization, it may extend the decision time frame up to 15 calendar days. Within 15 calendar days of the pre-service request, MAHP must notify the member or the member's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the organization is unable to make a decision due to lack of necessary information, the member or the member's authorized representative must be notified of the specific information needed within 15 calendar days of the preservice request. The written or electronic notice must describe the required information specifically. It must also specify the time period given to the member or to the member's authorized representative to provide the information. The member or the member's authorized representative must be given 45 days to provide the information. The decision time frame is suspended from the date of the notification to the member until the earlier of either the date on which the organization receives any information from the member or 45 days after the notification of the member.

The 15 day extension period, within which time a decision must be made by MAHP, begins on the date on which the member's response is received (without regard to whether all of the requested information is provided) or the end of the specified time

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period given to the member or the member's authorized representative to supply the information, whichever is earlier.

The organization may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the member can request an appeal.

- b. Written or electronic notification of the decision to practitioners and members within 72 hours of the request. For urgent pre-service decisions, if the organization is unable to make a decision due to lack of necessary information, it may extend the decision time frame once for up to 48 hours. The member or the member's authorized representative must be notified within 24 hours of the specific information needed.
- c. For **urgent concurrent review decisions** the organization must give oral, written or electronic notification of the decision to practitioners and members within 24 hours of the request.
- d. For **post-service (retrospective review) decisions**, for **pre-service of non-urgent care decisions** the organization must give oral, written, or electronic notification of the decision to practitioners and members within 30 calendar days of the request.

For non-urgent post-service decisions, if the organization is unable to make a decision due to matters beyond the control of the organization, it may extend the decision time frame up to 15 calendar days. Within 30 calendar days of the post service request, MAHP must notify the member or the member's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the organization is unable to make a decision due to lack of necessary information, the member or the member's authorized representative must be notified of the specific information needed within 30 calendar days of the post service request. The written or electronic notice must describe the required information specifically. It must also specify the time period given to the member or the member's authorized representative to provide the information. The member or the member's authorized representative must be given at least 45 days to provide the information.

The decision time frame is suspended from the date of the notification to the member until the earlier of either the date on which the organization receives any information from the member or 45 days after the notification of the member.

The 15 day extension, within which a decision must be made by MAHP, begins on the date on which the member's response is received by MAHP (without regard to whether all of the requested information is provided) or the end of the specified time period given to the member or the member's authorized representative to supply the information, whichever is earlier.

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The organization may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the member can request an appeal.

- e. Denials in the UM organization certification program are referred to as non certifications.
6. Written or electronic Notification of Denial will be sent to the patient, and practitioner and will include: (see-attached example):
 - a. Clinical rationale or principal medical reason used for the denial determination.
 - b. Information regarding the right of the member, and practitioner to appeal this determination either on an expedited or standard time frame, instructions on how to proceed with the appeal and the Health Care Services' office address, telephone number and fax number.
 - c. Specific information on when coverage will cease.
 - d. The letter will give the member the right to appeal the decision further, the right to representation, and the right of the member to submit written comments, documents, records, or other relevant material.
 - e. The letter will include notification that the member can obtain a copy of actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
 - f. Each denial letter is signed by the case manager or decision-maker (Chief Medical Officer or designee).
 - g. Letter may be stamped and initialed by Case Manager to expedite mailing when Chief Medical Officer or physician designee is not available to sign letter.
 - h. The Chief Medical Officer or physician designee will initial all denial letters that have been name stamped.
 7. When MAHP's coverage of service ends (such as in exhaustion of benefits) and the member still needs care, Health Care Services Case Manager offers to educate the member about other alternatives for continuing care as appropriate, and informs the member of ways to obtain that care. This may be accomplished by informing the member about ways to obtain continued care through other means such as community resources.

Instances where MAHP has assisted the member with transition of care are documented in the information system and /or written correspondence.

8. If patient is not satisfied with the outcome of the denial by the Health Care Services Department, the patient may chose to follow the Appeal/Grievance procedure outlined in the Administrative Policy Manual, Policies #10 through 10E Appeals/ Grievances Procedure For Commercial Members and Medicare Members.
9. All denials are entered into the information system. Remarks must include date, time or receipt of request, date, time of notification of member, practitioner, documentation of decision-maker, basis of denial and date of resolution.

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- 10. Documentation of denial will be documented on the Denial Flow Sheet. This sheet will be kept along with copies of denial letters, notes in the Denial Chron File. Information is scanned into the ApplicationXtender system by member name.
- 11. Totals of all denials will be provided to the Manager and Utilization Management Committee on a quarterly basis.
- 12. See attached flow chart and Denial Flow Sheet.

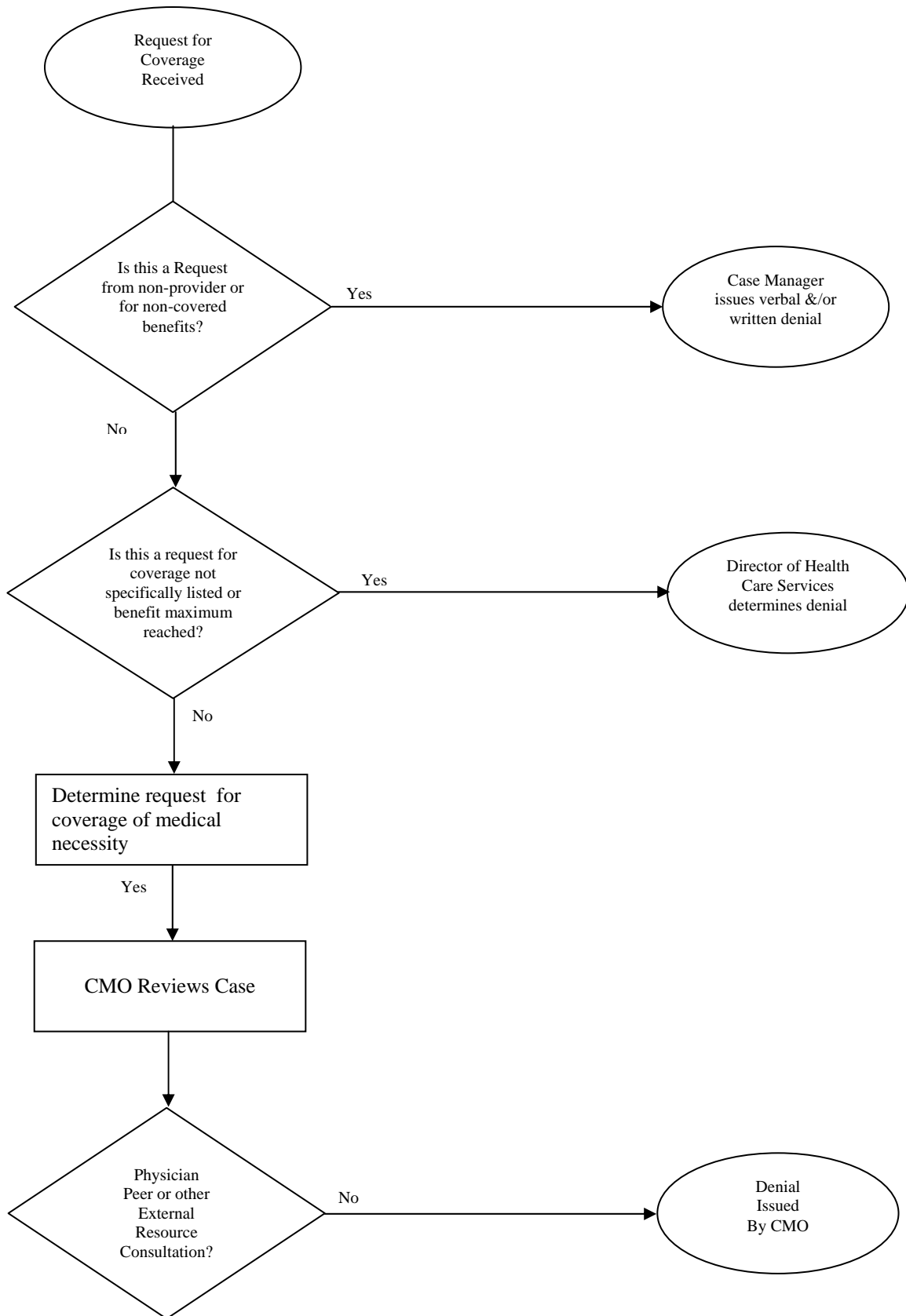
Judy Riniker, R.N.
 Manager of Health Care Services/Quality Improvement

Date

Mary Leary, R.N.
 Director of Health Care Services/Quality Improvement

Date

Original: 07/89	Revised: 05/97	Revised: 05/00	Revised: 03/08
Revised: 02/90	Revised: 08/97	Revised: 05/01	Revised: 09/08
Revised: 03/92	Revised: 09/97	Revised: 03/02	Revised: 03/09
Revised: 05/93	Revised: 02/98	Revised: 11/02	Reviewed: 02/10
Revised: 07/94	Revised: 02/99	Revised: 03/03	Revised: 01/11
Revised: 08/94	Revised: 04/99	Reviewed: 03/04	Reviewed: 01/12
Revised: 10/95	Revised: 09/99	Revised: 03/05	
Revised: 01/95	Revised: 02/00	Revised: 03/06	
Revised: 05/96	Revised: 03/00	Revised: 03/07	



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