

**MEDICAL ASSOCIATES HEALTH PLANS**  
**HEALTH CHOICE POLICY AND PROCEDURE MANUAL**  
**POLICY NUMBER: PP2A**  
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POLICY TITLE: HEALTH CHOICE DENIAL POLICY

**POLICY STATEMENT:** When the Health Choices (HC) Case Managers 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 participant or the participant's ability to regain maximum function, based on a prudent layperson's judgment or in the opinion of a practitioner with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

NOTE: Denial letters are not sent on benefit/contractual requests.

**PROCEDURE:**

1. Non-certifications/Denials will be issued in the following manner:
  - a. The HC Case Managers have the authority to deny only HC (benefit/coverage requests) for those other than medical necessity. This would include exhaustion of benefits, limitations, etc.
  - b. The Chief Medical Officer or physician designee can be utilized as a resource in determining medical necessity.
  - c. The Plan Administrator can be utilized as an additional resource if deemed appropriate per 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 HC Case Managers.
  - b. Services are delivered by a non-contracted practitioner.
  - c. Non-covered services per the Plan Document of the specific group.
  
4. Non-certifications/Denials for out-of-network referral requests can be issued for the following reason:
  - a. Services are provided by a non-contracted practitioner.
  - b. An unauthorized referral was made.

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- c. Service determined not medically necessary as it does not meet standard medical criteria utilized by the HC Case Managers.
  - d. Service requested is a non-covered service under the specific Plan.
5. The initial denial notification can be made orally, in writing or electronically. The notification for denials will be communicated by the HC Case Manager to the Participant and attending practitioner in the following manner:
- a. For **pre-service of non-urgent care decisions** the Health Choices Case Manager must give oral, written or electronic notification of the decision to practitioners and participants within 15 calendar days of the request.

For non-urgent pre-service decisions, if the Health Choices Case Manager 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, Medical Associates Health Plans (MAHP) must notify the participant or the participant's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the Health Choices Case Manager is unable to make a decision due to lack of necessary information, the participant or the participant'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 participant or to the participant's authorized representative to provide the information. The participant or the participant'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 participant 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 participant.

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

The Health Choices Case Manager may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the participant can request an appeal.

- b. Written or electronic notification of the decision to practitioners and participants within 72 hours of the request. For urgent pre-service decisions,

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if the Health Choices Case Manager 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 participant or the participant's authorized representative must be notified within 24 hours of the specific information needed.

- c. For **urgent concurrent review decisions** the Health Choices Case Manager must give oral, written or electronic notification of the decision to practitioners and participants within 24 hours of the request.
- d. For **post-service (retrospective review) decisions**, the Health Choices Case Manager must give oral, written, or electronic notification of the decision to practitioners and participants within 30 calendar days of the request.

For non-urgent post-service decisions, if the Health Choices Case Manager 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 participant or the participant's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the Health Choices Case Manager is unable to make a decision due to lack of necessary information, the participant or the participant'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 participant or the participant's authorized representative to provide the information. The participant or the participant'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 participant until the earlier of either the date on which the Health Choices Case Manager receives any information from the participant or 45 days after the notification of the participant.

The 15 day extension, within which a decision must be made by MAHP, begins on the date on which the participant'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 participant or the participant's authorized representative to supply the information, whichever is earlier.

The Health Choices Case Manager may deny the request if it does not receive the information needed to make a decision within this time frame. At this point, the participant can request an appeal.

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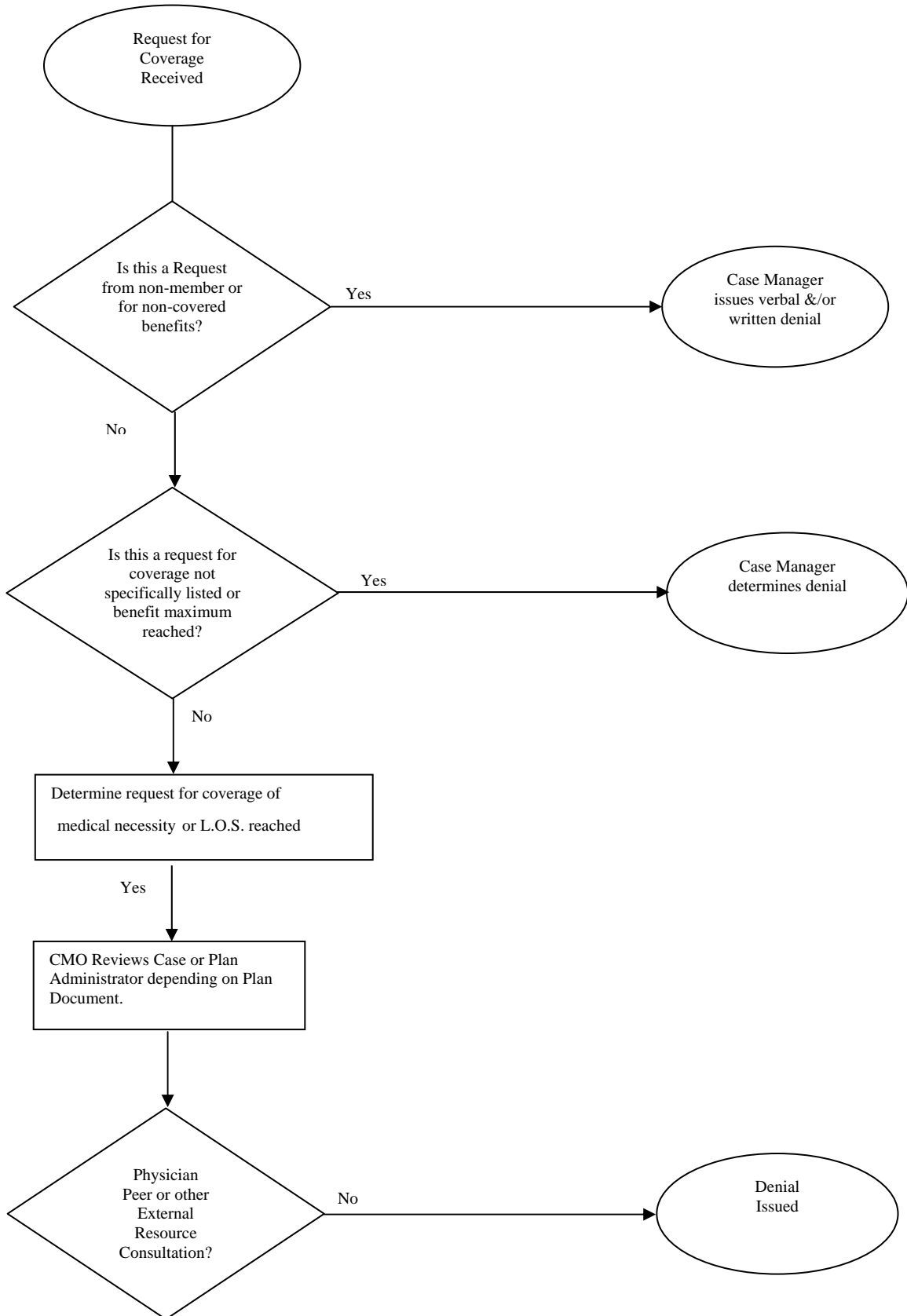
- e. Denials referred to as non certifications.
6. Written or electronic Notification of Denial will be sent to the patient, and practitioner and will include: (see-attached example):
  - a. Clinical rationale or principal medical reason used for the denial determination.
  - b. Information regarding the right of the participant, and practitioner to appeal this determination either on an expedited or standard time frame (per specific plan document), instructions on how to proceed with the appeal and the HC office address, telephone number and fax number.
  - b. Specific information on when coverage will cease.
  - c. 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.
  - d. This letter is signed by the Health Choice Case Managers.
  - e. The flow sheet is signed by the Chief Medical Officer when he has made the decision to deny the request.
7. When HC coverage of service ends (such as in exhaustion of benefits) and the participant still needs care, Health Choice Case Manager offers to educate the participant about other alternatives for continuing care as appropriate, and informs the participant of ways to obtain that care. This may be accomplished by informing the participant about ways to obtain continued care through other means such as community resources.

Instances where Health Choices has assisted the participant 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 HC Department, the participant may chose to follow the Appeal/Grievance procedure outlined in their Plan Document or the Health Choice Policy Manual, Policy #2.
9. All denials are tallied by the HC Case Manager in the Denial Binder that is located in the Health Choices binders. (Remarks must include date, time or receipt of request, date, time of notification of participant, practitioner, documentation of decision-maker, basis of denial and date of resolution.)
10. Documentation of denial will be documented in the denied authorization.
11. Totals of all denials will be provided to the Manager and Director on a monthly basis for the Director's monthly report.
12. Cost savings for the group is calculated on each denial for reporting purposes.
13. See attached flow chart and Denial Flow Sheet.

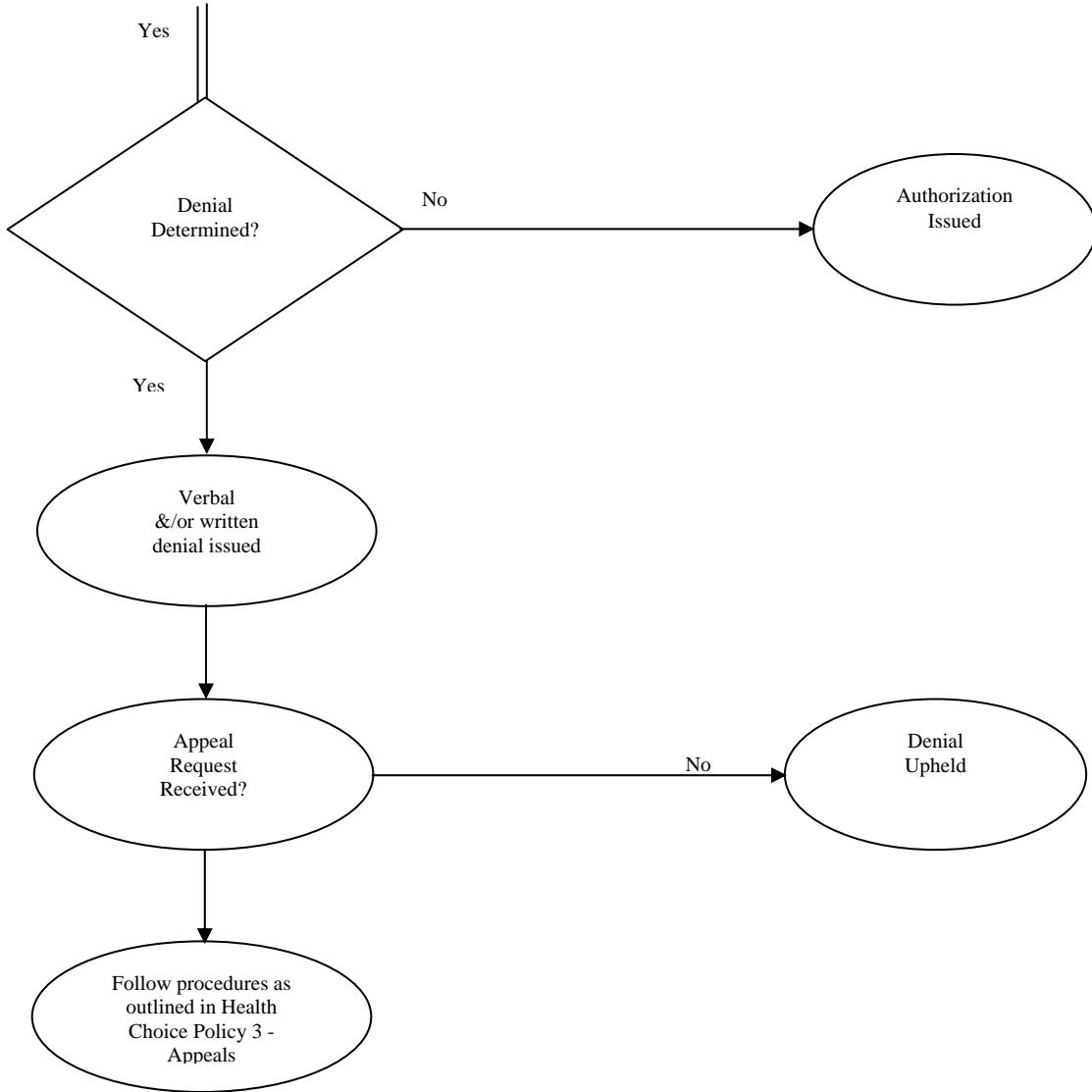


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Health Choices  
Denial  
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**ISSUES – DENIALS - APPEALS**

Auth # \_\_\_\_\_ Member Name \_\_\_\_\_  
Member # \_\_\_\_\_ Contract \_\_\_\_\_ State \_\_\_\_\_  
Case Manager \_\_\_\_\_ Plan Type: (HC, HMO, POS, Medicare)  
Date Request Received \_\_\_\_\_ Phone # of Dr. Office \_\_\_\_\_  
Summary of question/issue:

**CMO decision:**

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Date Member/Practitioner Informed of Decision/Denial/Redirect:**

Verbal \_\_\_\_\_ Written \_\_\_\_\_

**Date of Appeal Request:** Verbal \_\_\_\_\_ by: \_\_\_\_\_ Written \_\_\_\_\_ by: \_\_\_\_\_

Expedited \_\_\_\_\_ (IA/WI 72 hrs) \_\_\_\_\_ (IL 24 hrs) Standard: \_\_\_\_\_ (14 days)

Original decision maker \_\_\_\_\_

Entered into appeals log: \_\_\_\_\_

Person appointed to review 1<sup>st</sup> level \_\_\_\_\_

Copy of notes, emails pertaining to denial/redirect, supporting documents with member's rationale, copy of denial letter.

Date above documents forwarded to decision maker \_\_\_\_\_

1<sup>st</sup> Level Decision:

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Date Member Notified:** Verbal \_\_\_\_\_ Written \_\_\_\_\_