POLICY AND PROCEDURE

POLICY NAME: Adverse Benefit Determination (Denial) Notices	**POLICY ID:** CC.UM.07
BUSINESS UNIT: Please refer to system of record – Archer	**FUNCTIONAL AREA:** Utilization Management
EFFECTIVE DATE: 08/01/06	**PRODUCTS:** Medicaid, Marketplace, Medicare
REVIEWED/REVISED DATE: 9/15; 09/16; 09/17; 10/18; 10/19; 09/20; 01/21; 04/21; 09/21; 11/21; 02/22; 06/22; 07/22	
REGULATOR MOST RECENT APPROVAL DATE: N/A	

POLICY STATEMENT:
This policy outlines the denial types and identifies how Members and Practitioners are to be notified of adverse benefit determinations.

PURPOSE:
To ensure members and practitioners receive sufficient information to understand and decide whether to appeal a decision to deny care or coverage.

SCOPE:
This policy apples to Population Health and Clinical Operations Utilization Management

DEFINITIONS:
Adverse Benefit Determination: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure to act within the time frames specified for making or notifying the member of such action. 'Adverse determination' and 'denial' are used interchangeably throughout this policy.

Appropriate Practitioner: An organization representative who makes UM denial decisions. Depending on the type of case, the reviewer may be a physician, pharmacist, chiropractor, dentist or other practitioner type, as appropriate.

Insufficient Clinical Information: Lack of any clinical information, even a diagnosis, required to determine medical necessity of a covered service.

Level I Review: First level of medical necessity review performed by clinical Utilization Management staff using applicable criteria.

Level II Review: Second level of medical necessity review. Performed by Plan Medical Director or another designated qualified practitioner. See associated policy for further description.

POLICY:
Upon any adverse benefit determination (denial) made by the Medical Director, or other appropriately licensed health care professional (as indicated by case type), a written notification at a minimum is communicated to the member and treating/attending provider. Adverse determinations include both medical necessity and benefit denials. All notifications are provided within the timeframes as noted in *UM.05 - Timeliness of UM Decisions and Notifications* policy. The written notification is easily understood and includes the specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision, as well as the availability, process, and timeframes for appeal of the decision.

The Plan provides availability of an appropriate practitioner reviewer to discuss any Utilization Management (UM) adverse determination decisions with the treating or attending physician.

PROCEDURE:

I. Administrative Denials

A requested service may be denied during a Level I review for non-clinical reasons, such as member ineligibility, failure to obtain prior authorization, failure to provide timely notification, or failure to receive any clinical information (note: diagnosis alone is considered sufficient clinical information).

Requests based on benefits are *not* considered to be administrative denials and follow the process outlined in this policy and associated policies.

II. Non-medical Necessity/Benefit Denials

A. Determination by a Medical Director is not required for requests for services that are *specifically excluded* from members' benefit plan or that exceed limits or restrictions noted in the benefit plan and may be denied during a Level 1 review. *Note: benefit restrictions are specific to the Plan and product.*

Examples of benefit determinations include, but are not limited to:

1. Requests for additional physical therapy visits when the benefit plan clearly states a specified amount are covered.

2. Authorization for eyeglasses when vision care is specifically excluded from the benefit plan.

3. Requests for abortion services when such services are specifically excluded from the benefit plan.

4. Medical equipment or supplies for which the codes are specifically listed as excluded from coverage.

B. Medical Director Review is required if clinical judgment is needed to determine if a service may be covered, depending on the circumstances. Such requests follow the Level II review process outlined below. Examples of such requests, which are considered medical necessity decisions, include but are not limited to:

1. Breast reduction surgery for back pain, versus cosmetic reasons.

2. Use of an out-of-network provider if no in-network provider has the appropriate clinical experience.

3. Experimental procedure unless the requested service is specifically listed as excluded from the member's benefit plan.

III. Insufficient Information

When insufficient clinical information is received to determine medical necessity for requested service(s), attempts to obtain additional information are made and are documented in the clinical documentation system. If the Plan receives any clinical information, including only a diagnosis, the request must be reviewed by an appropriate professional and sent for Level II review if unable to approve.

IV. Level II Review

During a Level II review, the Medical Director or appropriate practitioner reviewer may make an adverse determination to deny, terminate, or reduce services. The decision and rationale for the determination is documented in the *Advisor Review* notes of the clinical documentation system.

A. Notification of Reviewer Availability

1. The Medical Director or appropriate practitioner reviewer (behavioral health practitioner, dentist, pharmacist, etc.) serves as the point of contact for treating practitioners calling in with questions about the UM process and/or case determinations.

2. Treating practitioners are notified of availability of an appropriate practitioner reviewer to discuss any UM denial decision through the Provider Manual (available in hard copy and on provider website), and/or the Provider Newsletter, in addition to the verbal denial notification and/or within written adverse determination letter.

3. The Medical Director may be contacted by calling the Plan's main toll-free phone number and asking for the Medical Director. A Care Manager may also coordinate communication between the Medical Director and treating practitioner.

B. Treating practitioners are provided with the opportunity to discuss any UM denial decisions with a physician or other appropriate reviewer. Only the treating physician/provider may participate in this peer-to-peer discussion.

1. At the time of verbal notification to the requesting practitioner/facility of an adverse determination, the Level 1 reviewer or designee notifies the requester of the opportunity for the treating physician to discuss the case directly with the Medical Director or applicable practitioner reviewer making the determination.

a. The time and date of both the denial notification and the offer of physician reviewer availability is documented in the clinical documentation system notes.

2. Practitioner/facility notification that a physician or other appropriate reviewer is available to discuss the denial decision may also be included in the written denial notification.

C. Both the member and requesting provider (and facility if applicable) receive a written notice of action (adverse determination) regarding any denial, reduction, or termination of service, including behavioral health and pharmacy services.

1. The notice of action letter is sent from the clinical documentation system and includes:

a. The member specific reason for the denial, in easily understandable language.

b. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.

c. Notification that the member can request a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.

d. Notification the member has access to and can request copies of all documents used in making the decision.

e. A description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal.

f. An explanation of the appeal process, including the member's right to representation by anyone (including an attorney), contact information for the state Office of Health Insurance Consumer Assistance or ombudsman (if applicable), the time frames for filing and deciding appeals, exhausting the internal appeal process and the circumstances under which additional external appeal rights are available and how to request them, including State Fair Hearings where applicable.

g. A description of the expedited appeal process including under what circumstances an expedited appeal can be requested, how to request an expedited appeal, and the time frame for resolution of an expedited appeal.

h. Notification that an expedited external review can occur concurrently with the internal appeals process for urgent and ongoing treatment, *if applicable per product and/or state requirement*.

i. The member's right to have benefits continue pending the resolution of an appeal and the circumstances under which the Plan may seek reimbursement.

2. The Medical Director may coordinate with the Care Manager to draft the denial letter.

3. The letter must include the signature of the Medical Director making the adverse determination, *if applicable per product and/or state requirement*.

4. The adverse determination letter is mailed within the time frames as indicated in *UM.05 - Timeliness of UM Decisions and Notifications* policy (or the more stringent of NCQA, product, state, or plan policy). The notice to the practitioner (and facility if applicable) may be faxed or provided electronically.

5. The Plan may inform the hospital Utilization Review (UR) department of an urgent concurrent denial and rely on the UR Department to inform the attending/treating practitioner. The denial letter must be addressed to the attention of the "attending" or "treating" practitioner if name of the attending/treating practitioner is unknown.

6. The Plan assists any member requesting assistance in understanding an adverse determination notice, including any member with special communication needs.

REFERENCES:
UM.05 - Timeliness of UM Decisions and Notifications
NCQA Health Plan Standards and Guidelines

ATTACHMENTS:
Arkansas Health and Wellness and Arkansas Total Care Addendum
Western Sky Community Care Addendum
Nebraska Total Care Addendum

ROLES & RESPONSIBILITIES: N/A

REGULATORY REPORTING REQUIREMENTS: N/A

REVISION LOG

REVISION TYPE	REVISION SUMMARY	DATE APPROVED & PUBLISHED
Annual Review	Annual review; no substantive changes.	09/17
Annual Review	Annual review; removed revision history prior to 2015, changed all instance of “Case Manager” to “Care Manager.”	10/18
Annual Review	Annual review; removed revision history prior to 2016, no other substantive changes.	10/19
Ad Hoc Review	Added “Marketplace” as product type in header. Updated section **“C”** to clarify Marketplace needs.	09/20
Ad Hoc Review	Updated section **‘IV.C.1’** by adding language to support notification of a member’s right to continuation of benefits pending appeal resolution.	0121
Ad Hoc Review	Added addendum for *Arkansas Health and Wellness* and *Arkansas Total Care*.	04/21
Ad Hoc Review	Updated addendum for *Arkansas Health and Wellness* and *Arkansas Total Care.*	09/21
Ad Hoc Review	Added addendum for *Western Sky Community Care.*	11/21
Ad Hoc Review	Added addendum for Nebraska Total Care.	02/22
Ad Hoc Review	Added Medicare to Product type.	06/22
Ad Hoc Review	Clarifying elements added to Procedure IV C.1.d. and C1.e for NCQA MED9B.	07/22

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in RSA Archer, the Company’s P&P management software, is considered equivalent to a signature.