POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Adverse Determination (Denial) Notices
PAGE: 1 of 10	**REPLACES DOCUMENT:**
APPROVED DATE: 3/11	**RETIRED:**
EFFECTIVE DATE: 5/11	**REVIEWED/REVISED: 7/12; 9/13; 9/2014; 02/09/2015; 1/2016; 12/2016**
PRODUCT TYPE: All	**REFERENCE NUMBER:** IL.UM.07

SCOPE:
IlliniCare Health (Plan) Medical Management Department.

PURPOSE:

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

POLICY:
Upon any adverse determination for medical or behavioral health services made by the Plan Medical Director or other appropriately licensed health care professional (as indicated by case type), a written notification at a minimum will be communicated to the member and treating/attending provider. All notifications will be provided within the timeframes as noted in the Timeliness of UM Decisions and Notifications policy. The written notification will be easily understandable and include 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.

Plan will provide availability of an appropriate practitioner reviewer to discuss any Utilization Management (UM) adverse determination decisions including medical and behavioral health services with the treating or attending physician. Availability of such peer-to-peer discussion and how to initiate such communications may be conveyed to providers through various avenues including but not limited to the provider handbook, provider newsletter, verbal denial notification, and/or within the written adverse determination letter.

PROCEDURE:
During a Level II review, the Medical Director or appropriate practitioner reviewer may make an adverse determination to deny, terminate, or reduce services. The adverse decision and rationale for the determination will be documented in the clinical documentation system event notes.

A. Notification of Reviewer Availability (UM 7 Element A)
    1. The Plan 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.

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2. Treating practitioners are notified of availability of an appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Handbook, New Provider Orientation, and/or the Provider Newsletter.
3. The Plan Medical Director may be contacted by calling the Plan's main toll-free phone number and asking for the Plan Medical Director. A Plan Case Manager may also coordinate communication between the Plan Medical Director and treating practitioner.

B. Treating practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer (UM 7 Element B, E). 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 Plan Case Manager will notify the requester of the opportunity for the treating physician to discuss the case directly with the Plan Medical Director or applicable practitioner reviewer making the determination.
      i. *The time and date of both the denial notification and the offer of physician reviewer availability is documented in the clinical documentation system event notes.*
   2. Practitioner/facility notification that a physician or other appropriate reviewer is available to discuss the denial decision is also included in the written denial notification.

C. Both the Member and requesting Provider shall receive a written notice of action (denial of medical coverage) regarding any denial, reduction or termination of service, including behavioral health services. (UM 7 Element C & Element D)
   1. The notice of action letter will be sent from the clinical documentation system and includes:
      - The specific reason for the denial, in easily understood language
      - A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based
      - 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

- A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal
- An explanation of the appeal process, including the member's right to appoint a representative and time frames for deciding appeals and the circumstances under which external independent review rights are available and how to request them
- 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 frames for resolution of an expedited appeal.

2. The Medical Director may work with the Plan Case Manager to draft the denial letter.
3. The letter must have the signature of the Plan Medical Director making the adverse determination.
4. The adverse determination letter will be mailed within the timeframes as indicated in the Timeliness of UM Decisions and Notifications policy
5. The Plan will assist any member requesting assistance in understanding an adverse determination notice, including any member with special communication needs.

D. Denial of Behavioral Health Services

1. Plan may delegate management of behavior health care benefits, including benefit and medical necessity determinations, to a behavioral health vendor such as Cenpatico Behavioral Health (CBH). The Plan remains accountable for delegated UM services and monitors performance of these services through the delegated vendor oversight process. (See associated policy and work process).

REFERENCES:

Illinois Integrated Care Program Contract
Managed Care Reform and Patient Rights Act (215 ILCS 134/45)
Health Carrier External Review Act (215 ILCS 180/)
Code of Federal Regulations: 42 CFR 438
NCQA 2016 Health Plan Standards and Guidelines
IL.UM.02 Clinical Decision Criteria
IL.UM.02.01 Medical Necessity Review
IL.UM.04 Appropriate UM Professionals
IL.UM.05 Timeliness of UM Decisions and Notifications
IL.UM.15 Oversight of Delegated UM

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ATTACHMENTS:
Attachment: Denial (Adverse Determination) Letter Template
Attachment: Authorized Representative Designation Form
Attachment: Sample Denial Letter Language (see below)

DEFINITIONS:
Action means (i) The denial or limitation of authorization of a requested service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial of payment for a service; (iv) the failure to provide services in a timely manner; (v) the failure to respond to an Appeal in a timely manner, or (vi) solely with respect to an MCO that is the only Contractor serving a rural area, the denial of an Enrollee's request to obtain services outside of the Contracting Area.

Adverse determination: a determination by a health care plan under Section 45 or by a utilization review program under Section 85 that a health care service is not medically necessary (215ILCS 134/) Managed Care Reform and Patient Rights Act)

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

REVISION	**DATE**

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

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VP, Medical Management: ______Electronic Signature on File________

***SAMPLE* DENIAL LETTER LANGUAGE**	
Inpatient Medical Necessity (Admit Denial)	Our medical director has reviewed the clinical information provided, and concluded that a hospital admission for date(s) of service [ ] was not required based on the member's condition. The reason this service cannot be approved is because an overnight stay in the hospital is not required to perform [SERVICE] the member received. Based on our InterQual acute care [SPECIFY CRITERIA] criteria, these services could be provided in an outpatient setting.
Inpatient Medical Necessity (Continued Stay Denial)	Our medical director has reviewed the clinical information provided, and concluded that a continued hospital stay for date(s) of service [ ] was not required based on the member's condition. The reason this service cannot be approved is because hospitalization for [SERVICES] is not required. Based on our InterQual acute care [SPECIFY CRITERIA] criteria, these services could be provided in an outpatient setting.
Inpatient Medical Necessity (NICU Leveling Denial)	Our medical director has reviewed the clinical information provided, and concluded that a continued hospital stay for date(s) of service [ ] can be provided at nursery level [ ]. Based on our InterQual acute care [criteria set] criteria, services cannot be approved at nursery level [ ] because continued hospitalization for [SERVICES] can be provided at nursery level [ ].
Inpatient Medical Necessity (Leveling Denial)	Our medical director has reviewed the clinical information provided, and concluded that a continued hospital stay for date(s) of service [ ] can be provided at a [ ] level. Based on our InterQual acute care [criteria set] criteria, services cannot be approved at a [ ] level because continued hospitalization for [SERVICES] can be provided at [ ] level of care.
Inpatient Behavioral Health/Substance Abuse (Admit Denial)	Our medical director has reviewed the clinical information provided, and concluded that a hospital admission for date(s) of service [ ] was not required since there is no evidence that the Criteria from Cenpatico Behavioral Health was met based on the members condition. Based on our Cenpatico Behavioral Health acute care [SPECIFY CRITERIA] criteria, these services could be provided in an outpatient setting.
Inpatient Behavioral Health/Substance Abuse (Continued Stay Denial)	Our medical director has reviewed the clinical information provided, and concluded that a continued hospital stay for date(s) of service [ ] was not required based on the member's condition. The reason this service cannot be approved is because the clinical information provided on member's condition does not meet Cenpatico's criteria. Based on our Cenpatico Behavioral Health acute care criteria, these services could be provided in an outpatient setting.
Inpatient Behavioral Health/Substance Abuse (Benefit Denial)	Our medical director has reviewed the clinical information provided for benefit coverage for [BH/SA] services. After review of the medical information provided, we have determined that this is not a covered service. According to section 4.1.4 of the Medicaid contract, Medicaid covered services not provided by contractor include [BH/SA] services. Benefits are available for [SA/BH] services through the members fee-for-service Medicaid benefit.
Insufficient Clinical Information Hospital (Admit Denial)	Our medical director has reviewed the clinical information provided. Based on the information received from the hospital we can not determine whether a hospital admission is needed because we have no information about the members' symptoms or health care needs. The diagnosis alone does not allow us to assess severity of illness or intensity of service as needed to apply InterQual [SPECIFY CRITERIA] criteria, therefore the hospital admission is not approved.
Insufficient Clinical Information Hospital	Our medical director has reviewed the clinical information provided.

(Continued Stay Denial)	Based on the information received from the hospital we can not determine whether a continued hospital stay is needed because we have no additional information about the members' symptoms or health care needs for dates of service [ ]. The information provided does not allow us to assess severity of illness or intensity of service as needed to apply InterQual [SPECIFY CRITERIA] criteria, therefore the continued hospital stay is not approved.
Out-of-Network Medical Necessity (Inpatient/Outpatient Denial)	Our medical director has reviewed the clinical information provided regarding your request to be seen by [NAME], an out-of-network specialist. As noted in your member handbook, authorization for coverage of an out-of-network physician or facility will only be provided if there is documentation of a specific medical condition that cannot be treated by an in-network specialist. Information submitted by your physician does not demonstrate that your health care needs cannot be met by an in-network specialist. Benefits are available for a physician of the same specialty in network (list some names of providers).
Outpatient Medical Necessity Denial	Our medical director has reviewed the clinical information provided, and concluded that benefit coverage for [ ] cannot be provided. Based on the information provided, there is no evidence of an adequate trial of [PROVIDE EXAMPLES].We based our decision on InterQual Procedures [SPECIFY CRITERIA] criteria
Non-Covered Benefit Denial	The Plan. has received a request for benefit coverage for [ ]. After review of the medical information provided, we have determined that this is not a covered service. Please see the Benefits Section in your Member's Handbook for a complete description of services covered and <u>not</u> covered by your health plan. This denial is not a determination based on medical necessity, and is therefore not appealable as such.
Synagis Medical Necessity Denial	Our medical director has reviewed the clinical information provided regarding your request for Synagis. Based on the information received from the provider Synagis was not required based on the member's condition. The reason this drug cannot be approved is because it is effective for children less than 32 weeks gestation with either congenital heart disease, chronic lung disease, or two risk factors such as severe neuromuscular disease, congenital abnormality of the Airway, child care attendance, school aged siblings or exposure to environmental air pollutants. The clinical information submitted does not demonstrate (list criteria not met). We based our decision on Synagis Medical Policy.
Pharmacy Medical Necessity Denial	Our medical director has reviewed the clinical information provided regarding your request for [DRUG]. Based on the information received from the provider [DRUG] was not required based on the member's condition. The reason this drug cannot be approved is because [REASON]. We based our decision on [DRUG] Medical Policy.

***SAMPLE* DENIAL LETTER LANGUAGE**	
Inpatient Medical Necessity (Admit Denial)	Our medical director has reviewed the clinical information provided, and concluded that a hospital admission for date(s) of service [ ] was not required based on the member's condition. The reason this service cannot be approved is because an overnight stay in the hospital is not required to perform [SERVICE] the member received. Based on our InterQual acute care [SPECIFY CRITERIA] criteria, these services could be provided in an outpatient setting.
Inpatient Medical Necessity (Continued Stay Denial)	Our medical director has reviewed the clinical information provided, and concluded that a continued hospital stay for date(s) of service [ ] was not required based on the member's condition. The reason

	this service cannot be approved is because hospitalization for [SERVICES] is not required. Based on our InterQual acute care [SPECIFY CRITERIA] criteria, these services could be provided in an outpatient setting.
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Inpatient Medical Necessity (Leveling Denial)	Our medical director has reviewed the clinical information provided, and concluded that a continued hospital stay for date(s) of service [ ] can be provided at a [ ] level. Based on our InterQual acute care [criteria set] criteria, services cannot be approved at a [ ] level because continued hospitalization for [SERVICES] can be provided at [ ] level of care.
Inpatient Behavioral Health/Substance Abuse (Admit Denial)	Our medical director has reviewed the clinical information provided, and concluded that a hospital admission for date(s) of service [ ] was not required since there is no evidence that the Criteria from Cenpatico Behavioral Health was met based on the members condition. Based on our Cenpatico Behavioral Health acute care [SPECIFY CRITERIA] criteria, these services could be provided in an outpatient setting.
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