Purpose:
To standardize the process for denial decisions and to ensure consistency of administration of denials.

Policy:
The Medical Directors and the Utilization Management (UM) Committee physicians make denial decisions for medical services or products based upon benefit interpretation and medical necessity which will meet regulatory referral turnaround timelines.

Procedures:
A. Authorization requests are initiated by the requesting physicians/providers on the Authorization Connection Express (ACE) online system and electronically sent to Riverside Physician Network’s Clinical Operations department. Date and time requests are sent to the department will be reflected on “Selected Authorization” screens under “Received Date” entries.
B. Authorization Coordinators receive requests and review them for accuracy and benefit documentation. Once processed, they are forwarded to the UR Nurses.
C. UR Nurses check requests for appropriate clinical guidelines, obtain any additional clinical information needed and then forward them to the Medical Directors for determinations.
D. Medical Directors review requests, when needed, with appropriate Board Certified Specialty physicians. Determinations are based upon the members’ diagnoses and/or conditions and clinical guidelines.
E. Contact may be made with a requesting practitioner prior to a denial or alternative care decision, when needed, to allow an opportunity for discussion with the UM reviewer.
F. Once denial determinations are made, Medical Directors document their decisions into ACE, time and date of decisions will be reflected on the “Selected Authorization” screens. Medical Directors will also sign off next to denial decision dates on the hard copy of this screen print in individual patient denial files.
G. UR Nurses are responsible for drafting denial letters utilizing appropriate verbiage from the Industry Collaboration Effort (ICE) Commercial Pre-Service Denial Reasons and the ICE Medicare Advantage Pre-Service Denial Reason Matrix, see Attachments One and Two. The Commercial Service Denial Notice letters will include information regarding availability of the Consumer Assistance Program and include contact information to assist individuals with internal claims, appeals, and external review processes. The Notice of Denial of
Medical Coverage (NDMC) for outpatient services, benefit exhaustion and benefit exclusions will be utilized in compliance with Medicare regulatory requirements. NDMC letters must also include the appropriate health plan federal plan statement, approval marketing number, and CMS approval date. All envelopes used for NDMC letters must state “Important Plan Information” in at least a 12-point font.

H. Denial letters will contain a specific reason(s) for the denial and an alternative treatment plan, when appropriate, in easily understandable language. Reference will be made to the benefit provision, guideline, protocol or other similar criteria on which the denial decision was based and member’s right to obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based. For each non-medical necessity denial, the reason for and the specific benefit provision, administrative procedure or regulatory limitation used to classify the denial will be documented in the ACE Notes section of the referral. The source used will be referenced (e.g., Certificate of Coverage or Summary of Benefits). The cited rationale and benefit, administrative or regulatory limitations must match the information included in the denial notice sent to the member or the member’s authorized representative. Commercial letters will indicate that members can obtain explanations or details of diagnosis or treatment codes from their practitioners or providers. A description of the member’s appeal rights, including the right to submit written comments, documents or other information relevant to the appeal will also be included. Additionally, an explanation of the appeal process, right to member representation and time frames for deciding appeals will be provided, along with a description of the expedited appeal process for urgent pre-service or concurrent denials and notification that expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.

I. Once denial letters are completed, they are sent via the ACE system to the UM Supervisor for final approval. The UM Supervisor reviews letter content and then indicates final approval by activating the ACE “Central Denial Unit” notification which causes “Select Authorization” notifications to be automatically sent to requesting physicians/providers. “Select Authorization” screens contain denial rationales and indicate how physician reviewers can be contacted. Dates and times of letter notifications are reflected on the “Authorization Letter” screens.

J. “Written Authorization” refers to either written or electronic notifications. A copy of the denial letter or an electronic notification will be sent to the member within 2 working days of determinations and to health plans according to Riverside Physician Network UM delegation contracts.

K. Hard copy denial files are made and each will contain a copy of the denial letter, “Selected Authorization” screen hard copy, “Authorization Letter History” screen hard copy, medical information and clinical guidelines. The reviewing Medical Director who made the denial determination will sign the “Selected Authorization” hard copy near the “Date of Decision.” This signature verifies denial determination and also indicates approval of denial letter verbiage (which immediately follows date notation).

L. For ERISA members: There is documented process for providing members the identity of experts whose advice was obtained in connection with an adverse determination upon a member's request (this must be done without regard to whether the advice was relied upon to make the determination). The member would contact the Customer Service Department at
and request that information. The Medical Management Department would then be notified and be responsible for relaying that information to the member.

M. If the referral request is not Riverside Physicians Network’s responsibility to make a determination, i.e. commercial mental health referral, a letter will be created utilizing the ICE template for “Informational Letter Member and/or Provider/Physician.” The same regulatory mandated timeframes for carve out services will be followed for processing and notification as for other pre-service and retrospective requests.

N. A reopening is defined as a referral reconsideration and occurs when a patient, physician, or health plan working on the patient’s behalf submits a written request for a previously denied service. The reopening rationale must show good cause, refer to item P. below. The prior denial case will be attached as part of the current referral request and will include medical information available when the initial denial was done and also include any new information. If none is sent, attempts will be made to acquire more current data. If this is not possible, the request will be reviewed by a Medical Director who did not make the initial denial determination. If new medical information is sent, any Medical Director can review this request. If the request is made by a health plan, turn-around time frames for standard and urgent initial organization determinations start at the time the patient contacted the health plan. (Medicare Managed Care Manual, Chapter 13, Section 130, 4/20/12)

O. Time frames permitted for a re-opening:
   • Within one year from the date of the prior authorization decision for any reason
   • Within four years from the date of the prior authorization decision for good cause as described in Chapter 13.
   • At any time if the prior authorization decision is unfavorable, in whole or in part, but only for the purpose of correcting a clerical error on which that decision was based.

P. Additionally, to comply with above referenced mandate, requests for previously denied services will be processed as a re-opened determination when:
   • Documentation requested but not received is provided within one year of the denial.
   • New and material evidence that was not available or known at the time of the determination or decision is furnished and may result in a different conclusion. This evidence must show facts not previously available, which could possibly result in a different decision. New information also includes a new interpretation of existing information.
   • Prior information that was considered in the making the denial clearly shows on its face that an obvious error was made at the time of the determination or decisions.
   • There is a clerical error involving human or mechanical errors such as mathematical or computation mistakes, inaccurate coding, and computer errors. If there is disagreement regarding the clerical error, the reopening request will be dismissed and the requesting party will be advised of any appeal rights, provided the time frame to request an appeal on the original denial has not expired. A verification must be done with the member’s health plan to assure the requested determination to be reopened is not under appeal. There cannot be an appeal and a reopening occurring simultaneously with respect to the same coverage determination.