

TREATMENT AUTHORIZATION REQUEST: DENIAL MODIFICATION AND APPEAL PROCESS

Purpose

To ensure that the Plan makes appropriate utilization decisions and sends notification of the decision within the timeframes set out under the law.

Scope

The scope of this policy includes the utilization review processes that approve, modify, delay, or deny treatment authorization requests which are based in whole or in part on medical necessity. These processes include prospective, retrospective, or concurrent reviews.

Policy

The Plan notifies its Members and Providers, in a consistent and timely manner, when it denies or modifies a request by a provider for member services.

Members and Providers are provided with a sufficient explanation for denial or modification of requested medical services.

The Plan Medical Director and/ or UR Physician are available to speak to the requesting provider(s) about these actions.

VCHCP maintains a process for Member's and Providers to ask for reconsideration of decisions to deny or modify a requested medical service.

Process

VCHCP's Denial and Modification Process includes prospective and retrospective reviews in accordance with internal and external guidelines and regulatory statute. This process requires attention from the UM staff, with substantial involvement from the Plan's Medical Director in the denial/appeal process. Other VCHCP departments, such as Quality Assurance, Claims, and Member Services may also be asked to assess the request prior to denial.

VCHCP's goal is to ensure that accurate information is given to the Members and Providers when a denial for service is processed. Decisions to approve, deny, or modify services based on medical necessity are made in accordance with established Plan and

regulatory timeline standards and as appropriate to the nature of the enrollee's condition. (Refer to Policy on *Authorization Process and Timeline Standards*). Written notification of determination includes prescriptive regulatory guidelines for Member and Provider appeals.

When necessary, VCHCP utilizes its panel of physicians from appropriate specialty areas to assist in making determinations of medical necessity for prospective, concurrent, and retrospective authorization requests. Reports of all Denials and Modifications are routinely presented to the UM Committee.

Procedure for Modification or Denials of Requests for Services

1. UR Staff obtains information regarding the request for service. If the request does not meet specified criteria, it is forwarded to a qualified health professional.
2. With the exception of denials based on limitations or conditions contained in the Evidence of Coverage. Or "EOC", only a licensed physician or other licensed health care professional who is competent to evaluate the specific clinical issues can modify or deny requests for services.
3. The UR physician and/or Medical Director reviews requested services that are determined not medically necessary.
4. Documentation for case review and requests for services include information about the efforts made to obtain all necessary information, including pertinent clinical information.
 - a. The treating physician may be consulted as appropriate.
 - b. The UR physician reviewer and Medical Director are available to physicians to conduct telephone discussions regarding the determinations that are made based on medical appropriateness.
 - c. Information that is collected to support UM decision-making is documented.
5. After the qualified health professionals have obtained and assessed the clinical information and if an initial determination of modification or denial has been made by the UR Physician, the UM staff notifies Members and Providers of the decision.
6. All decisions are transmitted by written notification (facsimile to provider, US Mail to member) generated by VCHCP's "Insure" MIS system.
7. The written notification, the Plan's Referral and Authorization for Consultation or Other Services form ("Authorization"), is sent by the UM Staff to notify Member's and Providers that the requests are modified, or denied, the medical reason(s) for the decision, the criteria used, alternative treatment plan, and the appeal process. In addition, the Authorization includes the name and contact number of the physician making the decision.

8. When the Plan denies services deemed experimental and the member is identified as having a terminal illness, notification of the denial includes information regarding the process for requesting a conference as part of the appeal procedure.
9. Requests for service authorization are commonly denied for the following reasons:
 - a. Provider is not contracted with VCHCP
 - b. Service is not medically necessary
 - c. Member is not eligible
 - d. Service is not a covered benefit
 - e. Member's benefits for the service have been exhausted
 - f. The primary care physician can provide the requested services.
 - g. Referring physician is not contracted with VCHCP.
10. All appeals are handled in an efficient manner, in accordance with established procedure.

Procedure for a Routine Appeal

1. If the Member or the Provider chooses to appeal the initial determination of modified or denied services, the appropriate information is gathered by qualified health professional for an evaluation by the Medical Director or physician disagree.
2. The initial request for reconsidering a decision is deemed an appeal.
3. The appeal is reviewed by a VCHCP appointed physician who was not involved with the initial determination.
4. Previous decisions are reconsidered.
5. A new determination is made regarding the reversal or maintenance of the modification or denial status within 30 working days.
6. If the Plan's decision cannot be made within 30 working days, due to circumstances beyond its control, VCHCP will, upon knowledge by the Plan of said circumstances, immediately notify the Member and Provider describing the reasons for the delay and why the decision cannot be made by the 30th day.
7. All necessary adjustments are made if the new determination is a modification of the original decision.
 - a. Reversals of decision to modify or deny requests for service are processed within VCHCP approved time period.
 - b. Financial adjustments are made in the next regularly scheduled VCHCP check processing.
8. A summary of modifications and denials is reviewed by the UM Committee, and a summary report is sent the QA Committee.

Procedure for an Expedited Appeal

For appeals based on medical necessity or experimental/investigational services, the member may request an independent medical review (IMR) of disputed health care services. (See policy on *Independent Medical Review Process*). The IMR process allows for expedited appeals in accordance with established standards (See Policy on *Authorization Process and Timeline Standards*).

For other appeals, the member follows the Plan's grievance process which allows for expedited appeals.

A. Attachments: none

B. References: CA Health and Safety Code section 1367.01 (h)(1)(2)(3)

C. Reviewers: Utilization Management Committee; Medical Director; QA Manager; Health Services Director

Reviewed/Revised by: Lita Catapang, RN & Albert Reeves, MD

- Committee Review: UM: August 2009; QAC: August 2009

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Reviewed/No Updates by: Faustine Dela Cruz, RN, Cecilia Cabrera-Urango, RN & Albert Reeves, MD

- Committee Review: UM: February 14, 2013; QAC: February 26, 2013