PerformCARE®	Policy and Procedure

Name of Policy:	Approval/Denial Process and Notification
Policy Number:	CM-013
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Clinical Care Management Department
Related Stakeholder(s):	All Departments
Applies to:	Associates
Original Effective Date:	03/25/02
Last Revision Date:	12/03/19
Last Review Date:	10/06/20
Next Review Date:	10/01/21

Policy: PerformCare will follow Pennsylvania Department of Human Services requirements regarding approval/denial process and notifications.

Purpose: Outline procedure for sending an approval/denial notification regarding requests for authorizations.

Definitions: **HIPAA:** Healthcare Insurance Portability and Accountability Act, the federal regulations that outline confidentiality procedures for communication and management of client information.
Denial of Service: A determination made by PerformCare in response to a provider or member request for approval to provide a service of a specific amount, duration and scope which:

a. disapproves the request completely, or
b. approves provision of the requested service(s), but for a lesser amount, scope or duration than requested, or
c. approves provision of the requested service(s), but by a Network Provider, or
d. disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
e. reduces, suspends, or terminates a previously authorized service.

Acronyms: **CCM:** Clinical Care Manager
DHS: Pennsylvania Department of Human Services
EMR: Electronic Medical Record
LOC: Level of Care
MNC: Medical Necessity Criteria
PA: Physician/Psychologist Advisor

Procedure:

1. When a Member or Provider requests prior-authorization for Behavioral Health Services, a PerformCare Associate completes verification of PerformCare coverage and collects relevant demographic information, documents in the Member Electronic Medical Record and notifies the Clinical Care Manager (CCM) of the request.
2. Initial requests for a Behavioral Healthcare Services and continued stay requests for Members must meet *Pennsylvania Department of Human Services* (DHS) *HealthChoices* medical necessity as determined by application of *DHS HealthChoices Behavioral Health Program, Program Standards and Requirements, Appendix S and T HealthChoices Behavioral Health Services Guidelines for Mental Health Medical Necessity Criteria* (MNC).
3. The CCM is responsible for reviewing/responding to the request and documenting all relevant clinical information in the Member Electronic Medical Record.
4. The CCM will approve the initial or continued request if MNC is met and will generate a notification and authorization per *Appendix AA* requirements.
5. CCMs are responsible for submitting all Level of Care (LOC) requests that may not meet MNC to a PerformCare Physician/Psychologist Advisor (PA) for review and final determination of approval or denial of services.
    - 5.1 CCM are not permitted to deny a request for service, only a PerformCare PA (in accordance with *Appendix AA* requirements) may issue a denial within the scope of their licensure and practice.
    - 5.2 The Clinical Department's Documentation Audit Tool monitors compliance of the determinations per *CM-060 Denial Letter Review & Auditing Procedures*.
6. When a PA is consulted for MNC review, the PerformCare PA will document MNC determination rationale in the Electronic Medical Record.
7. A denial of a request for service must be based upon one of the following five reasons, along with an explanation for the reason, which must be explicitly stated on the notice of action:
    - 7.1 The service requested is not a covered service
    - 7.2 The service requested is a covered service but not for this particular recipient (due to age, etc.)
    - 7.3 The provider is not a Network Provider
    - 7.4 The information provided is insufficient to determine that the service is medically necessary
    - 7.5 The service requested is not medically necessary

8. All denials based on MNC must be determined by a PA in accordance with *Appendix AA*.
9. PerformCare verbally notifies the member of the decision within 2 business days.
10. Denial letters are completed using DHS *Appendix AA* templates and are mailed to the Member within two (2) business days of the decision and maintained within the Members Electronic Medical Record. PerformCare follows required time frames per *Appendix AA/Act 68/NCQA*. Refer to *Attachment 1-UM Decision Timeframes*.
11. PerformCare completes a supervisory review of denial letters prior to mailing, as well as conducts denial letter audits per *CM-060 Denial Letter Review & Auditing Procedures*.
12. PerformCare does not provide incentives to any associate who conducts utilization management activities for denying, limiting or discontinuing medically necessary services.

Related Policies: *CM-004 Physician Advisor -Psychologist Advisor Consultation*
CM-011 Clinical Care Management Decision Making
CM-015 Inter-Rater Reliability Monitoring of Medical Necessity
CM-060 Denial Letter Review & Auditing Procedures
QI-044 Grievance Policy

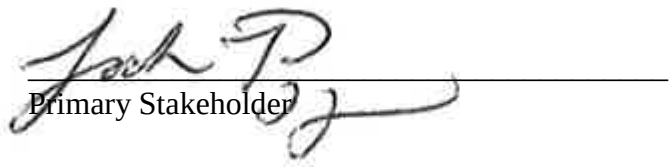
Related Reports: None

Source Documents and References: *Department of Human Services Prior Authorization Requirements for Participating Behavioral Health Managed Care Organizations in the Behavioral Health HealthChoices Program, Appendix AA*
Pennsylvania Department of Human Service HealthChoices Behavioral Health Program, Program Standards and Requirements, Appendix T
HealthChoices Behavioral Health Services Guidelines for Mental Health Medical Necessity Criteria

Superseded Policies and/or Procedures: None

Attachments: *Attachment 1 UM Decision Timeframes*

Approved by:



Primary Stakeholder

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UM DECISION TIMEFRAMES
HealthChoices, Act 68, and NCQA Comparison

TYPE OF REQUEST	HealthChoices		Act 68		NCQA	
	DECISION	NOTICE	DECISION	NOTICE	DECISION	NOTICE
Standard /Routine Non Urgent **(Pre-Service/ Prospective Utilization Review)**	At least verbally within 2 business days of receipt of request.	Written notice within 2 business days of decision.	Within 2 business days of the receipt.	Within 2 business days of communicating the decision.	Within 15 calendar days of receipt of request.	Electronic or written within 15 calendar days of request.
Standard / Routine Additional Information Extension **(Pre-Service/ Prospective Utilization Review)**	Send additional information letter within 48 hours of receipt of request & allow up to fourteen (14) Days. The decision & verbal notice must be made within 2 business days from when the information is received or due date for information, whichever is sooner. Written notification must be within 2 business days of decision. Completed decision and notice must be received by Member within 21 days of receipt of request.		Request additional information within 48 hours of the request for service.		45 calendar days to provide additional information & 15 calendar days from receipt of information for decision & notice.	

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Urgent Prior Authorization **(Pre-Service Review)**	At least verbally within 2 business days of receipt of request.	Written notice within 2 business days of decision.	Within 2 business days of the receipt.	Within 2 business days of communicating the decision.	Within 72 hours of receipt of request.	Electronic or written notification of the decision with

						72 hours of request.
Urgent Prior Authorization **(Pre-Service Review)** Additional Information Extension	If additional information is required for Urgent requests, PerformCare will notify the requestor immediately with what specific information is needed to make the decision, so that all urgent decisions are made within 24 hours of the receipt of an Urgent request. Peer-to-peer reviews when necessary are arranged and conducted so that all urgent decisions are made within 24 hours of the receipt of an Urgent request.		Request additional information within 48 hours of the request for service.		Notify member of need for additional information within 24 hours of receipt of request. Allow 48 hours to provide information. Decision within 2 calendar days of receipt of information.	
Urgent Concurrent Review	At least verbally within 2 business days of receipt of request.	Written notice within 2 business days of decision.	Within 1 business day of the receipt of all supporting information necessary to complete the review.	Written or electronic confirmation of the decision within 1 business day of communicating the decision.	Within 24 hours of receipt of request.	Electronic or written notification of the decision within 72 hours of request

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Post-service Review/ Retrospective	Within 30 calendar days of receipt of request. For PA Medicaid, post-service review only applies to 6 Criteria Dissatisfaction Complaints. A denial of payment after a service has been delivered because the service(s) was provided without authorization by a provider not enrolled in the Pennsylvania Medical Assistance Program, or a denial of payment after a service has been delivered because the service is not a covered benefit.	Within 30 days of the receipt of all supporting information reasonably necessary to complete the review. Written or electronic confirmation of its decision with 15 business days of communicating the decision.	Within 30 calendar days of receipt of request.

NOTE: Most restrictive guideline must be used for all UM decision timeframes and notifications.