MHM HealthCare, Inc.
UTILIZATION MANAGEMENT

TOPIC	**DATE: 2/2025**
Denial/Modification Process	**DATE REVISED:**
	APPROVED BY UMC: _*signature on file*_____

I Purpose

To ensure appropriate processing of Utilization Management Denials

II Policy

A. It is the policy of the medical group that UM Denials will be processed per Health Plan, CMS, and other regulatory agency standards. The process for denial or modification of a referral will in no way, jeopardize a member's health and welfare and every effort will be made to continue optimal coverage of the member's medical needs at the appropriate level of care.

B. The Medical Director or his/her physician designee, the UMC or a pharmacist will make all denial decisions including but not limited to denials of medical services or products based upon medical necessity, benefit coverage and provider network. A Board-Certified Physician, from an appropriate specialty, will be consulted for assistance in making determinations when necessary. Documentation of the date of completion of each Authorization request process will be noted on the form to assure compliance with timeframes.

C. A Denial Letter, with appropriate health plan and regulatory language, will accompany each denied or modified referral and will be sent to the PCP and/or requesting provider, the member, and the health plan in accordance with the IPA/Medical Group UM Delegation contract.

D. The IPA must notify all providers and Members of any retrospective decisions in writing, according to the regulatory requirements for Member's line of business.

E. A statement on how Members can obtain a copy of the actual benefit provision, guidelines, protocol or other similar criterion used in a decision, will be placed on the IPA's website and on the IPA's UM software alert page.

III. Procedure:

A. All service denial decisions will be made by the UM Committee, Medical Director or physician designee licensed in the State of California who is competent to evaluate specific clinical issues, deny, modify, or terminate requests for authorization of services based on medical necessity or benefit exclusions. Only a Psychiatrist, doctoral level clinical Psychologist, or certified addiction medical specialist may deny behavioral health services that are based on medical necessity.

B. All written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided should be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan

pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

C. The name and direct telephone number of the physician reviewer who made the determination to deny or modify a service/procedure is available on the IPA online portal and listed on the provider denial copy. The treating physician may contact the IPA Physician reviewer to discuss the criteria used in making the decision as well as the member's care.
D. When medically indicated, an alternative treatment plan will be identified, documented, and communicated to member/practitioner/provider. An alternative treatment plan will be communicated utilizing the Alternative Treatment Plan form.

    a. Alternatives are:

        1. Refer back to PCP
        2. Refer to alternate provider
        3. Refer back to PCP as service requested is within PCP scope of service, or
        4. Refer back to health plan for benefit coverage.

E. There will be supportive documentation substantiating that relevant clinical information was utilized in the UM decision making process.
F. Denials will indicate signature of denying physician and date denied.
G. Denials will indicate the date and time the provider was notified of the denial.
H. Reasons for denials will be clearly documented and based on medical necessity and benefits coverage in accordance with standards of optimal medical practice.
I. The group does not compensate practitioners or other individuals conducting utilization review for denials of coverage or service.
J. Written utilization review criteria used in making denial decisions is based on sound clinical evidence and is applied in an appropriate manner, based on individual patient need.
K. The medical group will send written notifications to members and practitioners/providers, which includes the reason for the denial, the criteria used in the decision, and specifically how the Member did not meet the criteria or guideline.
L. The denial letter must provide a clear and concise explanation of the IPA's decision to deny, delay, or modify.
M. The written notification shall be in easily understandable language (6^{th} grade level for Medi-Cal members), how it pertains to the member's particular case to ensure that members and practitioners understand why the decision was made and have enough information to make a decision about appealing the denial. The reason for a UM denial must be clearly documented in a permanent case record which can be either manual or automated. If the reason is for lack of clinical information, the denial must contain all factors 1-3. This includes reference to the clinical criteria that have not been met because of lack of information and must describe the information needed to render a decision in a manner specific enough for the member or members authorized representative to understand what is needed.

N. Written notification of denials shall include appeals rights including the right to submit written comments, documents, or other information relevant to the appeal and the right to an Independent Medical Review (IMR) per line of business; an explanation of the appeal process including the right of the member to representation and the time frames for deciding appeals.
O. The denial letter shall contain the notice that an external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.
P. If the denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeals process will be included in the denial letter.
Q. Denials letters will include language required by DMHC, DHS, and CMS *with* instructions on how to file an expedited or standard appeal, IMR and denial language appropriate to the member population (layman terms).
R. Medical Necessity denials will include the criteria used and clinical reason for the denial decision.
S. Non-covered benefit denials will specify the provision in the contract that excludes that coverage.
T. The denial letter will include information on how the member can obtain a copy of the actual benefit provisions, guidelines, protocol, or other similar criterion on which the denial decision was based upon request. The IPA will provide the entire copy of the criterion on which a denial or modification was issued.
U. The denial notification includes the appeal rights including:

    1. The timeframe in which the member has to file an appeal
    2. The opportunity for the member to submit written comments, documents or other information relating to the appeal
    3. The timeframe in which the organization has to make a decision on the appeal

V. Members may grant the right to be represented by anyone they choose including an Attorney at Law.
W. The IPA shall notify members of the availability of an applicable office of health insurance consumer assistance or Ombudsmen and provides the contact information.
X. All denials will be reported to the Health Plans, per the Health Plan delegated reporting schedule for each plan.
Y. The denial notification time frames are listed on the ICE Authorizations Turn-Around-Time table for each line of business.
Z. If a member who is enrolled with a health plan through an employer who is subject to ERISA, the member may, upon request, be given the identity of the expert reviewer whose advice was obtained in connection with an adverse determination. This will be provided regardless of if the advice was relied upon to make the decision."
AA. IPA must fully translate the NOA including the clinical rationale to the Member's preferred language as indicated in the Health Plan's eligibility file. The Your Rights, IMR, Nondiscrimination and Language assistance page must also be printed in the Member's preferred language.
    a. In the event the IPA speaks to the Member, and the Member indicates the language code is incorrect, the IPA will document the Member's true preferred language and send the appropriate NOA in the correct

language. The IPA will refer the Member to their health plan or social worker to update their language.

b. The IPA will utilize the certified translation vendor provided by the health plan for all non-English translations within regulation timeframes and have a mechanism for tracking translation requests to the vendor.
c. The IPA will contract directly with its own certified translation company and follow the process above ONLY if delegated to do so.

IV. RESPONSIBILITY

A. UM Staff

1. Screen all Authorization Request forms for routine referrals, hospital admissions, or continued confinement, for medical necessity based on established clinical guidelines.
2. Verify member health plan eligibility and benefits, and if non-covered, proceed with denial letter process. If the denial is based on "not a covered benefit," then resource information is offered regarding community services that may be able to assist the member. For IEHP, any non-covered benefit request should be reviewed for medical necessity and considered the best interest of the patient.
3. Route the request to the Medial Director or Physician Reviewer Queue, in the software program, for review and assessment of medical necessity.
4. Assure that the Physician Reviewer documents his/her name, decision, date, time, and rationale on the Authorization Request form, if reviewing a paper file, in the event that the IPA software system is "down".
5. Submit request for denial letter, along with other required medical documentation, to the UM staff for processing.

B. Medical Director or Physician Reviewer

1. The Medical Director will review and assess the referral request for medical necessity.
2. The Medical Director will review a request with the appropriate Board Certified Specialty Physician, based on the member's diagnosis and/or condition, to assist with the determination if necessary.
3. Contact the requesting Provider to discuss the member's case rendering a denial or alternative care decision as necessary
4. The Medical Director or Physician Reviewer is responsible for updating the request in the IPA software program, to reflect the decision and document the criteria used in making the decision. In the event that the Medical Director or Physician Reviewer is unable to access the software program at the time of decision, the UM Manager or UM Director may update the request, on behalf of the Medical Director or Physician reviewer. The Medical Director or Physician Reviewer MUST log in and countersign and document within 48 hours that they did make the determination.
5. The requesting physician shall be notified of the decision to authorize or deny care within 24 hours of the decision.- IPA online portal is "real time"; requesting providers are notified immediately upon decision via the online

portal. A courtesy fax may also be sent out same day, if requesting physician does not have access to the online portal.

6. Responsible for responding to a Peer-to-Peer request within 24 hours for urgent denials and 72 hours for routine denials. Must document in the denial the conversation and if the treating Physician agrees with the IPA decision.

C. UM Coordinator/Staff

1. The UM staff/coordinator will attempt to contact the requesting provider and/or Member, verbally to inform them of the decision and document in the authorization.
2. UM staff will upload a copy of the denial letter with regulatory inserts/attachments to the software program, so that a copy is visible to the requesting provider and PCP. A faxed copy will also be faxed out to the requesting provider, within regulatory timeframes.

V. Oversight and Monitoring

A. The IPA/MSO is responsible for reporting all peer-to-peer requests to the Utilization Manager Committee (UMC) to ensure that the Medical Director/Physician Reviewer is responding to the treating provider's requests in a timely manner and that proper documentation of the conversation is noted in the file.