COLORADO

Department of Health Care Policy & Financing

FY 2021–2022 Mental Health Parity Compliance Audit Report

June 2022

This report was produced by Health Services Advisory Group, Inc., for the Colorado Department of Health Care Policy & Financing.

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Background

In fiscal year (FY) 2019–2020, the Colorado Department of Health Care Policy & Financing (the Department) contracted with a vendor to perform a comparative analysis of policies, procedures, and organizational practices related to Colorado's seven regional accountable entities (RAEs) and two managed care organizations (MCOs) that serve Colorado's Medicaid population for compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), pursuant to 42 Code of Federal Regulations (CFR) 438 Subpart K, and Colorado's Behavioral Health Care Coverage Modernization Act, pursuant to the Colorado house bill (HB) 19-1269. This analysis included a comparison of mental health (MH) and substance use disorder (SUD) services provided by the RAEs to medical/surgical (M/S) services provided by Colorado's Medicaid MCOs as well as by Colorado's fee-for-service (FFS) providers. The analysis assessed policies, procedures, and organizational practices related to the authorization of services and provider network management as well as compliance with non-quantitative treatment limitations (NQTLs) in four categories of care: inpatient, outpatient, pharmacy, and emergency services. In FY 2020–2021, the Department contracted with Health Services Advisory Group, Inc. (HSAG), to annually review each Medicaid health plan's utilization management (UM) program and related policies and procedures, as well as a sample of prior authorization denials to determine whether the health plans followed federal and State regulations and health plan internal policies and procedures. This report contains HSAG's FY 2021–2022 findings from that audit of calendar year (CY) 2021 denial (adverse benefit determination [ABD]) records for each Medicaid health plan.

Adverse Benefit Determinations Record Review

Pursuant to Colorado's HB 19-1269, which states "The State Department shall contract with an External Quality Review Organization (EQRO) at least annually to monitor MCEs' utilization management programs and policies, including those that govern adverse determinations, to ensure compliance with the MHPAEA,"[1] the Department has requested that HSAG, Colorado's currently contracted EQRO, perform an assessment of Colorado's seven RAEs and two Medicaid MCOs—collectively referred to hereafter as "health plans"—to determine whether each health plan has implemented and followed its own written policies, procedures, and organizational processes related to UM regulations. The Department chose to meet this objective through a review of 10 inpatient and 10 outpatient ABD records for each Medicaid health plan (to the extent full samples were available). Through record reviews, HSAG has determined whether the health plans demonstrated compliance with specified federal and State managed care regulations and with each health plan's own policies and procedures.

[1] Colorado General Assembly. House Bill 19-1269 Mental Health Parity Insurance Medicaid. Available at: https://leg.colorado.gov/sites/default/files/2019a_1269_signed.pdf. Accessed on: Feb 17, 2022.

Methodology

HSAG's assessment occurred in five phases:

1. Document Request
2. Desk Review
3. Telephonic Interviews
4. Analysis
5. Reporting

1. Document Request

HSAG requested that each health plan submit documents including UM policies and procedures (as well as any related protocols, workflow diagrams, or program descriptions) and UM criteria used for the selected ABDs. In addition, HSAG requested that each health plan submit a complete list of inpatient and outpatient ABDs made between January 1, 2021, and October 31, 2021. Using a random sampling technique, HSAG selected 20 ABDs for each health plan (10 inpatient files and 10 outpatient files). The health plans then submitted to HSAG all records and pertinent documentation related to each ABD chosen. All data and file transfers were completed using HSAG's Safe Access File Exchange (SAFE) site.

2. Desk Review

HSAG performed a desk review of all submitted documentation, which included policies, procedures, and related documents; and 20 ABD files for each health plan, which may have also included UM documentation system notes, notices of adverse benefit determination (NABDs), and other pertinent member and provider communications.

3. Telephonic Interviews

HSAG collaborated with the health plans and the Department to schedule and conduct telephonic interviews with key health plan staff members to:

1. Ensure understanding of documents submitted.
2. Clarify and confirm organizational implementation of policies, procedures, and related documents.
3. Discuss the records reviewed with regard to findings, opportunities for improvement (if any), and recommendations for process improvement, if applicable.

As a result of the initial desk review and telephonic interviews, HSAG requested additional documents for review, as necessary.

4. Analysis

HSAG calculated a total compliance score for each record, an aggregate denials record review compliance score for each health plan, and an aggregate statewide denials record review compliance score.

5. Reporting

This report documents HSAG's findings related to each health plan's compliance with selected federal and State managed care regulations and each health plan's own UM policies and procedures. Appendices A through I include aggregate denials record review compliance scores for each health plan. Individually completed tools with member-specific findings will be available to the Department upon request.

Findings

HSAG evaluated each RAE and MCO (referred to collectively as health plans) based on whether the health plan followed selected regulations for making authorization determinations and for providing NABDs, as well as whether the health plan followed its own policies and procedures related to these regulations and which services require prior authorization. Each health plan has a certain amount of flexibility regarding how it structures prior authorization requirements. See Appendix J for a table that describes which services require prior authorization by health plan.

Table 1-1 presents each health plan's and the statewide aggregate percentage of compliance with elements evaluated during the review of ABD records. For health plan-specific scoring details, see Appendices A through I.

Table 1-1—Summary of Scores

Health Plan	Region	2020 Total Score	Category of Service	Compliance Score	2021 Total Score
Regional Accountable Entities (MH/SUD Services)					
Rocky Mountain Health Plans (RMHP)	1	100%	Inpatient	86%	91%∨
			Outpatient	96%	
Northeast Health Partners (NHP)	2	98%	Inpatient	100%	98%~
			Outpatient	94%	
Colorado Access (COA)	3	100%	Inpatient	100%	100%~
			Outpatient	100%	
Health Colorado, Inc. (HCI)	4	99%	Inpatient	96%	94%∨
			Outpatient	88%	

Health Plan	Region	2020 Total Score	Category of Service	Compliance Score	2021 Total Score
Colorado Access (COA)	5	98%	Inpatient	99%	99%^
			Outpatient	100%	
Colorado Community Health Alliance (CCHA)	6	84%	Inpatient	82%	86%^
			Outpatient	91%	
Colorado Community Health Alliance (CCHA)	7	83%	Inpatient	78%	81%v
			Outpatient	84%	
Managed Care Organizations (MH/SUD and M/S Services)					
Denver Health Medical Plan (DHMP)		100%	Inpatient	99%	97%v
			Outpatient	96%	
Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)		100%	Inpatient	87%	89%v
			Outpatient	91%	
Total All Health Plans		96%	Inpatient	93%	93%v
			Outpatient	94%	

v Indicates that the score declined as compared to the previous review year.

^ Indicates that the score increased as compared to the previous review year.

~ Indicates that the score remained unchanged as compared to the previous review year.

Assessment

Overall, the statewide average score for the MHP audit decreased from 96 percent in CY 2020 record reviews to 93 percent in CY 2021 record reviews. Two health plans showed consistent performance (NHP RAE 2 with 98 percent in both years and COA RAE 3 with 100 percent in both years). Two health plans improved overall performance (COA RAE 5: 98 percent to 99 percent and CCHA RAE 6: 84 percent to 86 percent). The remainder of the RAEs declined in performance as follows:

- RMHP RAE 1: 100 percent to 91 percent
- HCI RAE 4: 99 percent to 94 percent
- CCHA RAE 7: 83 percent to 81 percent
- DHMP: 100 percent to 97 percent
- RMHP Prime: 100 percent to 89 percent

Strengths

All health plans used nationally recognized utilization review (UR) criteria as follows:

- RMHP RAE 1 and RMHP Prime used Milliman Clinical Guidelines (MCG) UR criteria for all MH determinations and American Society of Addiction Medicine (ASAM) level of care criteria for all SUD determinations.
- NHP RAE 2 and HCI RAE 4 used InterQual UR criteria for all MH determinations and outpatient SUD determinations, and ASAM level of care criteria for inpatient and residential SUD determinations.
- COA RAEs 3 and 5 and DHMP used InterQual UR criteria for all MH determinations and ASAM level of care criteria for all SUD determinations.
- CCHA RAEs 6 and 7 used MCG UR criteria for all MH determinations and ASAM level of care criteria for all SUD determinations.

All health plans followed their policies and procedures regarding interrater reliability (IRR) testing and required UM staff members to participate in IRR testing annually. IRR testing ensures the consistency and quality of UM decisions. RMHP RAE 1, RMHP Prime, NHP RAE 2, and HCI RAE 4 required 80 percent for a passing score and the remainder of the health plans required a 90 percent score for passing.

Three health plans (NHP RAE 2, HCI RAE 4, and DHMP) delegated UM activities and followed policies and procedures regarding adequate monitoring and oversight of the delegated activities.

Three of nine health plans were in full compliance with the time frames for sending NABDs. The Department launched new benefits for inpatient and residential SUD services on January 1, 2021, and all health plans met the 72-hour timeliness requirement for these determinations in the first quarter, as inpatient and residential SUD benefits were initiated, and each health plan implemented the new programs.

All health plans' policies and procedures described an appropriate level of expertise required for UM staff members making denial determinations; however, record reviews demonstrated that only seven of nine health plans had consistent documentation in the files regarding the individual who made the determination.

All health plans used a Department-approved NABD template letter that included the required information and notified members of their right to an appeal; however, only five of the nine health plans consistently used the current member template for communicating NABDs to members.

Opportunities for Improvement and Recommendations

1. Three health plans did not consistently follow their own policies and procedures related to UR.
   - CCHA RAE 6: Although CCHA procedures included a process to refer cases with a noncovered diagnosis to determine if the request is valid based on a co-occurring MH diagnosis, two cases were administratively denied due to the developmental disability diagnosis, without review to determine if the request was related to a potential co-occurring mental health diagnosis. In a third case, the inpatient stay was initially approved with concurrent approvals, for a member with a diagnosis of impulse disorder. The system notes stated, "upon discovery of a noncovered diagnosis, the service is now denied." CCHA then retroactively denied the entire stay. Another case was also not referred for medical necessity review (unrelated to diagnosis) when CCHA policies required a medical necessity review.
   - CCHA RAE 7: In three cases, CCHA did not follow policies and procedures for adequately documenting criteria used for determination.
   - DHMP: In one case, the request was processed by DHMP instead of COA. This did not follow DHMP's procedures and may have impacted the member's right to receive the requested service.

2. Six health plans were out of compliance for timeliness in regard to sending NABDs, despite accurate policies and procedures. HSAG found noncompliance for NABD timeliness in:
   - One of 20 records for RMHP RAE 1:
     - This was a current review of Level 3.2 detoxification services. RMHP system notes designated this as an expedited case. Expedited cases are due within 72 hours according to §438.404, regardless of service type.
   - Two of 13 records for HCI RAE 4:
     - One record was a concurrent request for continued Level 3.7 withdrawal management (WM) services. HCI met the Department's requirement to notify the provider verbally within 72 hours but did not meet the requirement for timely written notice to the member according to §438.404.
     - One record was a new request for SUD intensive outpatient services (IOP). HCI did not meet the requirement to notify the member in writing of the denial within 10 calendar days according to 10 Code of Colorado Regulations (CCR) 2505-10 8.209.
   - One of 20 records for COA RAE 5:
     - This was a concurrent review of a mental health inpatient stay. COA did not meet the requirement for timely written notice to the member within 72 hours according to §438.404.
   - One of 20 records for CCHA RAE 6:
     - This was a new request for outpatient psychotherapy. CCHA did not meet the requirement to notify the member in writing of the denial within 10 calendar days according to 10 CCR 2505-10 8.209.

- Six of 20 records for CCHA RAE 7:
  - One request was for continued inpatient mental health services. CCHA did not send this member an NABD.
  - One new request (in October 2021) was for Level 3.5 SUD inpatient services. CCHA did not make the determination and provide notice within the Department-required 72 hours.
  - One expedited request was for continued inpatient mental health services. CCHA did not meet the requirement for notice to the member within 72 hours according to §438.404.
  - Two new requests were for mental health IOP. CCHA did not send denial notices in these two cases.
  - One request was for continued psychotherapy services. CCHA did not meet the requirement to send the notice to the member within 10 calendar days according to 10 CCR 2505-10 8.209.
- One of 20 records for DHMP:
  - One new expedited request was for inpatient mental health services. DHMP did not meet the requirement for timely written notice to the member within 72 hours according to §438.404.

HSAG recommends that the Department work with these health plans to develop and implement ongoing staff training and monitoring to ensure adherence to Colorado-specific timelines.

3. While all health plans had policies and procedures that described proactively offering peer-to-peer discussions prior to finalizing denials when making medical necessity determinations, five health plans (RMHP RAE 1, HCI RAE 4, CCHA RAE 6, CCHA RAE 7, and RMHP Prime) had instances in which the offer was not adequately documented in the electronic documentation system.

   - For RMHP RAE 1, in one of 17 records reviewed for this element, HSAG did not find any documentation indicating that the requesting provider was offered a peer-to-peer review with a medical director.
   - For HCI RAE 4, in one of 13 records reviewed for this element, HSAG did not find any evidence indicating that the requesting provider was offered a peer-to-peer review with a medical director.
   - For CCHA RAE 6, in three of 15 records reviewed for this element, HSAG did not find any evidence indicating that the requesting provider was offered a peer-to-peer review with a medical director.
   - For CCHA RAE 7, in two of 15 records reviewed for this element, HSAG did not find any evidence indicating that the requesting provider was offered a peer-to-peer review with a medical director.
   - For RMHP Prime, in one of 20 records reviewed for this element, HSAG did not find any documentation indicating that the requesting provider was offered a peer-to-peer review with a medical director.

Related to the above errors in documentation, HSAG recommended that the Department work with RMHP, HCI, and CCHA to evaluate documentation protocols and to ensure accuracy of documenting whether peer-to-peer reviews are offered.

4. While all RAEs articulated (in policy and during interviews) the intent to write NABD letters in language easy to understand for members, HSAG found that two RAEs (CCHA RAE 6 and CCHA RAE 7) sent some letters that contained abbreviations and/or complex or confusing information.
   - For CCHA, HSAG found that eight of 20 records reviewed for RAE 6 and six of 20 records reviewed for RAE 7 were out of compliance. Some letters referred the member to a page in the Health First Colorado Member Handbook which contained general benefit information and did not clearly connect the member to the reason a service would not be covered. In addition, some letters contained abbreviations or technical descriptions of all MCG criteria for approving a service, which included technical language and medical jargon but did not indicate how the information specifically related to the member's symptoms and needs. HSAG found that while CCHA had changed its template language related to the reason and rationale, CCHA staff members were not using the new templates consistently.

   Related to the above findings, HSAG recommends that the Department work with CCHA to encourage consistent use of documentation protocols.

5. With regard to the reason and rationale in NABDs, the Department determined that a best practice is to include the following:
   - The name of the criteria used
   - A brief description of the specific element of the criteria that caused the health plan to find the service not medically necessary
   - Why the health plan found the service to be not medically necessary, specific to the member's situation (e.g., what symptoms the health plan found to be present or not present, related to the criteria)
   - The right to request a copy of the criteria (in addition to other documents and records used to make the determination)

   HSAG found that:

   - RMHP RAE 1 and Prime used this best practice within their member NABD letters.
   - NHP and HCI only offered the criteria and other pertinent documents.
   - COA RAEs 3 and 5 and DHMP included all best practice information but did not specifically name the criteria (InterQual or ASAM).
   - CCHA RAEs 6 and 7 had a revised template which included all best practice information, but had not consistently implemented the revised template.

In addition, all health plans reported implementing the state-developed template language to comply with Senate Bill (SB) 21-137, which requires health plans to demonstrate in the NABD how each dimension of the ASAM criteria was considered when making the denial determination. HSAG recommends that the Department implement ongoing monitoring to assess the health plans' compliance with use of the Department's templates and best practices for communicating NABDs with members.

Appendix A. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans RAE 1

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	February 1, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Six adult records • Four children/adolescent records • Seven requests for MH services • Three requests for SUD services
Service requested/indication:		Requests for service included acute treatment unit, inpatient acute care, long-term residential treatment, ASAM 3.2-WM, ASAM 3.5-high-intensity residential, and ASAM 3.7-WM. Diagnoses included bipolar disorders, post-traumatic stress disorder, major depressive disorder (MDD), generalized anxiety disorders, schizophrenic spectrum disorders, borderline personality disorders, alcohol dependence, and cannabis dependence. Presenting symptoms included anxiety, depression, psychosis, suicidal ideation, auditory hallucinations, and disorganized thinking.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of nine expedited concurrent requests and one retrospective denial.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either requests for additional days based on the authorization ending or a post-service request and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	9	Nine denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	1	One denial was related to the member reaching the 15-day Institution for Mental Disease (IMD) benefit limitation, and all days in the month were denied.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that RMHP RAE 1 followed its policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	In all cases reviewed, the member received the provider NABD letter instead of a letter written using the member NABD template. Since this letter did notify the member in writing, this element was marked as in compliance for each record. Providers received both a phone call and an NABD on the provider template.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services	9/10	In one expedited determination, HSAG found that the notice to the member was not sent in the required time frame of 72 hours following the request for service.

Requirements	M/NM	Comments
• Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	0/10	In all cases reviewed, only the provider NABD letter went to the member and did not include the required content. Missing content included how to file a written appeal, the 60-day timeline for filing, the right to request a State fair hearing (SFH) following the adverse appeal resolution and how to do so, how to request an expedited (fast) appeal, the right to access pertinent records, and the RMHP customer service line information.
Was the denial decision made by a qualified clinician? (M/NM)*	9/9	In nine cases, a qualified clinician made the denial determination. One IMD denial did not require the decision to be made by a qualified clinician and therefore was not applicable.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	8/8	Eight denials reviewed contained evidence that the peer-to-peer review was offered. In one post-service (retrospective) request and one IMD case, a peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that the RAE based determinations on nationally recognized criteria (MCG and ASAM) and the RAE contract/benefit package.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	Although the provider NABD template was used for all member notifications, all NABDs were written at an easy-to-understand reading level. RMHP staff members reported that the previous year's MHP data file had been incorrectly pulled; therefore, the practice of not sending NABDs to members using the member template for denials of concurrent requests was not previously discovered. HSAG

Requirements	M/NM	Comments
		advised that the same letter can go to both the member and provider as long as the letter includes all required information.
Total Applicable Elements	**77**	
Total Met Elements	**66**	
Score (Number Met / Number Applicable) = %	**86%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: **
100	77	66	86%

****Total Score** = Met Elements/Total Applicable Elements

Appendix A. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans RAE 1

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	February 1, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Eight adult records • Two children/adolescent records • Six requests for MH services • Four requests for SUD services
Service requested/indication:		Requests for service included out-of-network psychotherapy evaluation, out-of-network psychotherapy (60 minutes), psychological/neurological testing, partial hospitalization program (MH), intensive outpatient program (MH), and ASAM 2.1 SUD intensive outpatient program. Diagnoses included MDD, post-traumatic stress disorder, anxiety disorder, autistic disorder, attention-deficit/hyperactivity disorder (ADHD), adjustment disorder, generalized anxiety disorder, borderline personality disorder, alcohol dependence, cannabis dependence, autism spectrum disorder (ASD), and dementia. Presenting symptoms included anxiety, depression, panic attacks, and psychosis.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	10	All 10 records demonstrated that the services requested were all subject to prior authorization requirements at the time the services were provided. This included a retrospective request for payment for services provided in CY 2020 (for psychotherapy—60 minutes). In 2020 the prior authorization requirement was applied after 12 visits. In 2021, this changed to 20 visits.

Requirements	M/NM	Comments
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of six standard requests, two standard concurrent requests, and two retrospective denials.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests, requests for additional days based on the authorization ending, or post-service requests and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	8	Eight denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	1	One denial was related to the primary diagnosis of dementia, which is not a behavioral health (BH) diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	2	Two denials were related to the requesting provider being out of network. These records were included in the count for not medically necessary services as RMHP performed a medical necessity review to determine if there was medical necessity to see an out-of-network provider. One of the out-of-network provider denials was partially approved due to the continuity of care requirement.
Other (describe): (Y/N)	5	Three denials were related to being a noncovered benefit when there are in-network providers available or when the diagnosis is a covered benefit under Medicaid FFS. Additionally, two other denials were denied due to RMHP RAE 1 not receiving enough clinical documentation to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that RMHP RAE 1 followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. In two instances, the member received the NABD on the provider template instead of the member template. Since this letter did notify the member in writing, this element was marked as in compliance for these records. Providers received both a phone call and an NABD on the provider template.

Requirements	M/NM	Comments
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All NABDs were sent within the required time frames.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	8/10	In two cases reviewed, only the provider NABD letter went to the member and did not include all the required content. Missing content included how to file a written appeal, the 60-day timeline for filing, the right to request a SFH following the adverse appeal resolution and how to do so, how to request an expedited (fast) appeal, the right to access pertinent records, and the RMHP customer service line information.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases a qualified clinician made the denial determination.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	2/2	Two requests for service were denied due to lack of adequate documentation to determine medical necessity. RMHP RAE 1 did attempt to contact each provider multiple times for additional information. There was no response.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	8/9	Eight denials reviewed contained evidence that the peer-to-peer review was offered. One denial reviewed did not show any evidence demonstrating that the peer-to-peer review was offered. Lastly, one denial was an administrative denial, for which a peer-to-peer review was not applicable.

Requirements	M/NM	Comments
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that the RAE based determinations on nationally recognized criteria (MCG and ASAM) and the RAE contract/benefit package.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	Although the provider NABD template was used for all member notifications, all NABDs were written at an easy-to-understand reading level. RMHP staff members reported that the previous year's MHP data file had been incorrectly pulled; therefore, the practice of not sending NABDs to members on the member template for denials of concurrent requests was not previously discovered. HSAG advised that the same letter can go to both the member and provider as long as the letter includes all required information.
Total Applicable Elements	**81**	
Total Met Elements	**78**	
Score (Number Met / Number Applicable) = %	**96%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
100	81	78	96%

****Total Score** = Met Elements/Total Applicable Elements

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
200	158	144	91%

*****Total Score** = Inpatient + Outpatient Met Elements/Total Inpatient + Outpatient Applicable Elements

Summary

For acute hospitalizations, RMHP allowed inpatient facilities (both MH and SUD) to admit patients and then notify RMHP of the admission. RMHP staff members reported that, during the prior review period (CY 2020), if notification had not been made within the first 24 hours of the admission, payment was authorized at the time of the notification and forward. For out-of-network facilities, consideration was given to whether the facility knew that the member was eligible for Colorado Medicaid and attributed to RMHP RAE 1. RMHP staff members reported that, during the CY 2021 review period, this practice was changed and that if the service was found to be medically necessary, RMHP authorized and paid beginning with the admit date. RMHP staff members reported that this change was driven by changes to the National Committee for Quality Assurance (NCQA) standards and guidelines.

RMHP's prior authorization list, policies, and procedures stated that the following inpatient services were subject to prior authorization and concurrent review requirements during CY 2021:

Mental Health

- Inpatient acute hospital care (including transfers between facilities)[A-1]
- Acute treatment unit
- Residential treatment (short- and long-term)

Observation and treatment in a crisis stabilization unit did not require prior authorization.

SUD Services

- Inpatient and WM (3.7) level of care
- High-intensity residential (3.5) level of care

[A-1] This represents a change from CY 2020 (transfers between facilities did not require prior authorization if the initial admission was authorized).

- Low- and medium-intensity residential (3.1 and 3.3) levels of care
- Nonmedical WM (3.2) level of care

The following outpatient services required prior authorization/concurrent review:

Mental Health

- Psychotherapy (60-minute sessions) after the 20th visit [A-2]
- Psychological/neurological testing
- Partial hospitalization program
- MH intensive outpatient program
- BH day treatment
- Out-of-network services (except emergency/crisis care and medically necessary services unavailable within the network)

SUD Services

- SUD intensive outpatient program
- Routine outpatient treatment (60-minute sessions) after the 20th visit
- Out-of-network services (except emergency/crisis care and medically necessary services unavailable within the network)

The following outpatient services did not require prior authorization/concurrent review:

- Psychotherapy (initial evaluation, 30-minute and 45-minute sessions) for MH or SUD treatment
- Psychotherapy (60-minute sessions) for the first 20 visits (MH and SUD services)
- Assertive community treatment

[A-2] This represents a change from prior authorization required following the 12th visit in CY 2020.

- Half-day psychosocial rehabilitation
- Multisystemic therapy

RMHP staff reported no quantitative benefit limitations. RMHP accepted requests for authorization electronically through an "auto-auth" online system, via fax, and by telephone. RMHP did not delegate UM activities. RMHP was in partnership with United. During the CY 2021 review period, RMHP used MCG UR criteria for all MH determinations and ASAM levels of care criteria for all SUD determinations. RMHP required its UM staff members to pass IRR testing annually with a minimum score of 80 percent.

Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, HSAG found that all files demonstrated that RMHP followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization and requirements for processing requests for services. All NABDs reviewed were written at a reading level that was easy to understand. In all cases involving a medical necessity review except one (and in some administrative denials), RMHP offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. In one outpatient file, HSAG did not find any documentation indicating that a peer-to-peer review was offered to the requesting provider. Board-certified psychiatrists reviewed all medical necessity denials. A registered nurse (RN) or master's level clinician made administrative denials. One inpatient administrative denial was due to the member reaching 15 IMD days. In one outpatient file, testing to rule out dementia were denied due to the diagnosis of dementia being a noncovered diagnosis. In denials involving requests for out-of-network care, a Doctor of Medicine (MD) reviewed for medical necessity to determine whether an equivalent service was available from an in-network provider.

In one inpatient file, HSAG found that the request was an expedited request and that the NABD was not sent to the member within the 72-hour required time frame. In two outpatient files and all 10 inpatient files, HSAG found that RMHP had sent only an NABD using the provider template to the provider, with a copy to the member. While HSAG found these letters to be written at an easy-to-understand reading level, the provider template did not include all required information. Content missing included the following:

- How to file an appeal
- The 60-day filing time frame for appeals
- The circumstances under which an expedited appeal may be requested
- The right to request a SFH following receipt of an adverse appeal resolution letter

- The right to access pertinent records and documents
- How to contact RMHP customer service for assistance

During the MHP interview, RMHP staff members reported that during CY 2021, it was standard practice to only send a provider letter (with a copy to the member) for denials determined via a concurrent review. Staff reported that regarding the prior year's (CY 2020) sample cases for the FY 2020–2021 MHP audit, the data for the sample may have been incorrectly pulled, impeding the discovery of this noncompliant practice. Staff reported that upon discovering in December 2021 that this practice caused RMHP to be out of compliance, RMHP began sending the NABD to members using the member template for all denials, whether concurrent or initial determinations. The member template included all required information.

During the MHP interview, RMHP reported several best practices related to implementation of the new SUD inpatient and residential benefit package in January 2021:

- RMHP's practice transformation team provided monthly training opportunities for providers, which included coding and claims submission procedures.
- RMHP developed provider newsletter content, podcasts, and a video series designed to assist providers in understanding the new SUD benefits.
- RMHP began using the state-developed uniform service request form for SUD services.
- RMHP reported that the SUD care coordinator is a member of the UM team to ensure that members receive the appropriate level of care when a particular level of care is denied.

HSAG found that when RMHP did send the member template, the letters demonstrated a best practice for RMHP. The reason and rationale RMHP added to the letters included:

- The name of the criteria used.
- A brief description of the specific element of the criteria that caused RMHP to find the service not medically necessary.
- Why RMHP found the service to be not medically necessary, specific to the member's situation (e.g., what symptoms RMHP found to be present or not present, related to the criteria).
- The right to request a copy of the criteria (in addition to other documents and records used to make the determination).

Appendix B. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Northeast Health Partners RAE 2

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	January 31, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Four adult records • Six children/adolescent records • Six requests for MH services • Four requests for SUD services
Service requested/indication:		Requests for service included ASAM 3.2 WM, ASAM 3.7 WM, acute treatment unit, inpatient hospitalization, and residential treatment (MH). Diagnoses included SUD, opioid dependence, alcohol use disorder, generalized anxiety disorders, post-traumatic stress disorder, MDD, bipolar disorders, impulse control disorder, conduct disorder, neurodevelopmental disorder, and ADHD. (The member with a neurodevelopmental disorder was involved with the intensive care management program.) Presenting symptoms included anxiety, depression, behavioral issues, suicidal ideations, and aggression.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of three standard requests, four standard concurrent requests, and three expedited concurrent requests.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that NHP followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a copy of the NABD. Providers received both a phone call and a copy of the NABD.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	In all cases reviewed, the NABD was sent within the required time frame.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also addressed the reason for the denial.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	10/10	All records contained evidence that the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that the RAE based determinations on nationally recognized criteria (InterQual or ASAM).
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs were written at an easy-to-understand reading level.
Total Applicable Elements	**80**	
Total Met Elements	**80**	
Score (Number Met / Number Applicable) = %	**100%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: **
100	80	80	100%

****Total Score** = Met Elements/Total Applicable Elements

Appendix B. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Northeast Health Partners RAE 2

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	January 31, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The four outpatient records HSAG reviewed consisted of: • Three adult records • One adolescent (14 years old) • Two requests for MH services • Two requests for SUD services
Service requested/indication:		Requests for service included intensive outpatient program (SUD and MH), ASAM 2.1 chemical dependency intensive outpatient program, and electroconvulsive therapy. Diagnoses included panic disorder, stimulant use disorders, alcohol use disorders, schizoaffective disorder, MDD, generalized anxiety disorders, and post-traumatic stress disorder. Presenting symptoms included anxiety, depression, panic attacks, visual and auditory hallucinations, and lethargy.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All four records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of four standard requests. Two of the standard requests were concurrent.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending.

Requirements	M/NM	Comments
Reason for the denial:		
Medical necessity? (Y/N)	4	All denials were related to not meeting medical necessity. One denial did not meet medical necessity for the level of care requested because the requested service was too low (ASAM 2.1) and the records provided met medical necessity for a higher level of care (ASAM 3.5 residential treatment).
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	4/4	In all cases, HSAG found that NHP followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	4/4	Members received a copy of the NABD. Providers received both a phone call and a copy of the NABD.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	4/4	In all cases reviewed, the NABD was sent within the required time frame.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	4/4	All NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also addressed the reason for the denial.
Was the denial decision made by a qualified clinician? (M/NM)*	4/4	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	4/4	All records contained evidence that the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	2/4	Only two records contained evidence that the RAE based determinations on nationally recognized criteria (InterQual or ASAM) and the criteria used to make the decision were properly documented in the system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	4/4	All NABDs were written at an easy-to-understand reading level.
Total Applicable Elements	**32**	
Total Met Elements	**30**	
Score (Number Met / Number Applicable) = %	**94%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
40	32	30	94%

****Total Score** = Met Elements/Total Applicable Elements

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
140	112	110	98%

*****Total Score** = Met Inpatient + Outpatient Elements/Total Inpatient + Outpatient Applicable Elements

Summary

For acute hospitalizations, NHP required authorization for acute MH inpatient hospitalization, SUD WM, and SUD residential treatment. For emergency hospitalizations, NHP allowed 24 hours for notification of the admission. The first 24 hours of the admission were honored for payment if the admission met medical necessity criteria. For contracted facilities, if notification was not made within the first 24 hours of the admission, payment was authorized at the time of the notification and forward. For out-of-network facilities, consideration was given to whether it was known that the member was eligible for Colorado Medicaid. For SUD inpatient and residential treatment, NHP did not impose a penalty for lack of notification within the first four days; however, all days were subject to medical necessity review.

NHP delegated UM activities to Beacon Health Options (Beacon). During the review period (CY 2021), Beacon used InterQual UR criteria for all MH UR determinations and outpatient SUD determinations. NHP used ASAM level of care criteria for inpatient and residential SUD determinations. Beacon required its UM staff members to pass IRR testing annually with a minimum score of 80 percent. Beacon's prior authorization list, policies, and procedures stated that the following inpatient services are subject to prior authorization and/or concurrent review requirements:

Mental Health

- Inpatient acute hospital care
- Acute treatment unit
- Residential treatment center

- Crisis stabilization unit (after the fifth visit per episode of care)
- Observation

SUD Services

- Inpatient and WM (3.7) level of care
- High-intensity residential (3.5) level of care
- Low- and medium-intensity residential (3.1 and 3.3) levels of care
- Nonmedical WM (3.2) level of care

The following outpatient services required prior authorization/concurrent review during the review period:

Mental Health

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) after the 25th visit
- Assertive community treatment
- Partial hospitalization program
- Intensive outpatient program for MH
- BH day treatment
- Out-of-network services (except emergency/crisis care)
- Half-day psychosocial rehabilitation
- Multisystemic therapy

SUD Services

- SUD intensive outpatient program
- Out-of-network services (except emergency/crisis care and medically necessary services unavailable within the network)

The following outpatient services did not require prior authorization/concurrent review:

- Routine psychotherapy initial evaluations and psychotherapy services (30-minute, 45-minute, and 60-minute sessions) for the first 25 visits
- Psychological/neurological testing

Beacon, on behalf of NHP, accepted requests for authorization electronically through a website, via fax, and by telephone. The website allowed the upload of medical record documentation but was not an automated review/approval system. Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, the records reviewed for NHP RAE 2 demonstrated that Beacon used nationally recognized UR criteria (InterQual and ASAM), although the criteria used for the determination were not properly documented in two outpatient files. HSAG also found that Beacon followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider in all cases reviewed.

NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all of the required information. In all cases involving a medical necessity review, NHP offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. Board-certified psychiatrists reviewed all medical necessity denials for 24-hour level of care. A psychiatrist or Doctor of Philosophy (PhD)-level psychologist reviewed medical necessity denials for outpatient care. Administrative denials were also reviewed by a physician or psychologist. Although HSAG found that the reason and rationale added to the NABD templates were minimally compliant, these simply stated, “we believe your symptoms can be managed in another level of care.” HSAG recommends that NHP add additional information to the reason and rationale for the denial so that members may better understand the circumstances surrounding the denial of services. The Department has determined that the best practice for describing the reason and rationale for the denial is to include the following:

- The name of the criteria used (e.g., InterQual, ASAM)
- A brief description of the specific element of the criteria that caused the RAE to find the service to be not medically necessary
- Why the RAE found the service to be not medically necessary, specific to the member’s situation (e.g., what symptoms the RAE found to be present or not present, related to the criteria)
- The right to request a copy of the criteria (in addition to the other documents and records used to make the determination)

During the MHP interview, Beacon staff reported that when a particular level of care is denied and a lower level of care is recommended, Beacon expects the provider to coordinate with the attributed community mental health center (CMHC) to arrange for services. Beacon reported that a referral to care coordination is not typically made and that the NHP care coordination department is not copied on or notified of the denial. The NHP executive director was unaware of this practice and requested that NHP's care coordination department receive copies of NABDs. HSAG recommends that NHP and Beacon collaborate to develop a process for making care coordination referrals when needed to ensure appropriate services are arranged when services needed differ from services requested and denied.

During the MHP interview, NHP reported several best practices related to implementation of the new SUD inpatient and residential benefit package in January 2021:

- Beacon held monthly and quarterly provider forums as well as individualized training for providers as needed to ensure understanding of the new benefits and RAE requirements.
- Beacon developed provider newsletter content regarding new codes or changes to coding requirements.
- Beacon reported no longer declining to accept provider applications based on network sufficiency in a particular area.
- Beacon began using the state-developed uniform service request form for SUD services.

Appendix C. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Colorado Access RAE 3

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	January 27, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Seven adult records • Three children/adolescent records • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for services included inpatient acute care, inpatient hospitalization, acute treatment unit, ASAM 3.5 clinically managed high-intensity residential treatment, ASAM 3.7 WM, and long-term residential treatment. Diagnoses included reactive attachment disorder, disruptive mood dysregulation disorder, bipolar affective disorders, MDD, unspecified mood disorders, adjustment disorder, borderline personality disorder, ADHD, generalized anxiety disorder, social anxiety disorder, post-traumatic stress disorder, methamphetamine use disorder, other stimulant dependence, opioid use disorder, opioid dependence, alcohol dependence, developmental disability, and intellectual disability. In addition, one member was five months postpartum. Presenting symptoms included anxiety, suicidal ideations, depression, out of character behaviors, agitation, restlessness, sleep disturbances, and aggression toward others.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.

Requirements	M/NM	Comments
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of nine expedited concurrent requests and one expedited preservice request.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice request or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that COA followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. Providers received a copy of the NABD and, in most cases, a phone call as well.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	In all cases reviewed, the NABD was sent within the required time frame.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request a SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also addressed the reason for the denial.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	10/10	All records reviewed contained evidence that the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that COA based determinations on nationally recognized criteria (InterQual and ASAM).
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs were written at an easy-to-understand reading level.
Total Applicable Elements	**80**	
Total Met Elements	**80**	
Score (Number Met / Number Applicable) = %	**100%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: **
100	80	80	100%

****Total Score** = Met Elements/Total Applicable Elements

Appendix C. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Colorado Access RAE 3

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	January 27, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Seven adult records • Three children/adolescent records • Eight requests for MH services • Two requests for SUD services
Service requested/indication:		Requests for service included partial hospitalization program, ASAM 2.1 SUD intensive outpatient program, MH intensive outpatient program, psychological testing, and out-of-network psychotherapy (60 minutes). Covered diagnoses included borderline personality disorders, post-traumatic stress disorder, ADHD, SUD, alcohol dependence, MDD, general anxiety disorders, oppositional defiant disorder, disruptive mood dysregulation disorder, adjustment disorder, mild intellectual disability, and enuresis. Presenting symptoms included anxiety, depression, auditory and visual hallucinations, and psychosis.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of seven standard requests and three retrospective denials.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or post-service requests (retrospective) for payment of services that had not yet been reviewed for medical necessity.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	1	One denial was related to the requesting provider being an out-of-network provider. The denial was also "not medically necessary" as there were in-network providers that could provide the service requested.
Other (describe): (Y/N)	3	Two denials had lack of information/documentation to determine medical necessity. One denial had out-of-network provider notes that did not demonstrate medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that COA followed policies and procedures related to which services require prior authorization, and followed nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. Providers received a copy of the NABD and, in most cases, a phone call as well.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services	10/10	In all cases reviewed, the NABD was sent within the required time frame.

Requirements	M/NM	Comments
• Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing, and access to pertinent records.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	2/2	Two requests for service were denied due to lack of adequate information to determine medical necessity. COA made multiple attempts to contact the providers for additional information. There was no response from either provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	8/8	All applicable records contained evidence that the peer-to-peer review was offered. There were two instances where peer-to-peer was not applicable. One case was an administrative denial, and in one case the member had already been discharged from care.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that COA based determinations on nationally recognized criteria (InterQual and ASAM) and the Colorado contract/benefit package.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs were written at an easy-to-understand reading level.
Total Applicable Elements	**80**	
Total Met Elements	**80**	
Score (Number Met / Number Applicable) = %	**100%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
100	80	80	100%

****Total Score** = Met Elements/Total Applicable Elements

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
200	160	160	100%

*****Total Score** = Met Inpatient + Outpatient Elements/Total Inpatient + Outpatient Applicable Elements

Summary

For acute hospitalizations, COA required prior authorization for acute inpatient hospitalization. For emergency hospitalizations, COA allowed 24 hours for notification of the admission. The first 24 hours of the admission were honored for payment if the admission met medical necessity criteria. For contracted facilities, if notification was not made within the first 24 hours of the admission, payment was authorized at the time of the notification and forward. For out-of-network facilities, consideration was given to whether it was known that the member was eligible for Colorado Medicaid.

COA did not delegate UM activities. During the review period (CY 2021), COA used InterQual UR criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. COA required its UM staff members to pass IRR testing annually with a minimum score of 90 percent. COA's prior authorization list, policies, and procedures stated that the following inpatient services are subject to authorization and concurrent review requirements:

Mental Health

- Inpatient acute hospital care
- Acute treatment unit
- Residential treatment center

Care in a Crisis Stabilization Unit and observation services did not require prior authorization/concurrent review.

SUD Services

- Inpatient and WM (3.7) level of care
- High-intensity residential (3.5) level of care
- Low- and medium-intensity residential (3.1 and 3.3) levels of care

The following outpatient services required prior authorization/concurrent review during the review period:

Mental Health

- Psychological/neurological testing
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment
- Out-of-network services (except emergency/crisis care)

SUD Services

- SUD intensive outpatient program
- Out-of-network services (except emergency/crisis care)

COA did not require prior authorization/concurrent review for the following outpatient services:

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) for MH or SUD treatment
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

COA reported no quantitative benefit limitations. COA accepted requests for authorization via fax and by telephone. COA did not use an electronic authorization system. Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, COA RAE 3 demonstrated that COA consistently used nationally recognized UR criteria (InterQual) and followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider.

NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all of the required information. In all cases involving a medical necessity review, COA offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. Board-certified psychiatrists reviewed all medical necessity denials. Administrative denials were reviewed by an RN or master's level clinician, except requests for out-of-network providers, which were reviewed for medical necessity by a physician to ensure that equivalent services were available in the network.

COA RAE 3 achieved a 100 percent score for all inpatient and outpatient records reviewed. HSAG found that COA used several best practices overall, which were specifically related to implementing the new SUD benefits:

- COA reported that all bed-based care is processed as an expedited request with a goal of making the determination within 24 hours. HSAG found that in most cases, files reviewed demonstrated this 24-hour turnaround time.
- COA reported regular meetings between care coordination and UM staff to review collaboration on particular cases and referral processes.
- New provider newsletter content and provider tip sheets were developed to include coding and authorization information related to the new SUD benefits.
- COA began using the state-developed uniform service request form for SUD services.
- COA's NABD letters included the reason and rationale at an easy-to-understand reading level and gave clear information about the criteria used including:
  - A brief description of the specific element of the criteria that caused the RAE to find the service to be not medically necessary.
  - Why the RAE found the service to be not medically necessary, specific to the member's situation (e.g., what symptoms the RAE found to be present or not present, related to the criteria).
  - The right to request a copy of the criteria (in addition to the other documents and records used to make the determination).

Based on the Department's consideration of best practices, HSAG recommends that COA also include in these letters the specific name of the criteria used (InterQual, ASAM, etc.).

Appendix D. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Health Colorado, Inc. RAE 4

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	January 31, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Five adult records • Five children/adolescent records • One request for MH services • Two requests for SUD services
Service requested/indication:		Requests for service included inpatient hospitalization, acute treatment unit, residential treatment, ASAM 3.1 low-intensity treatment services, ASAM 3.5 high-intensity treatment services, and ASAM 3.7 WM. Diagnoses included SUD, alcohol dependence, alcohol use disorder, opioid use disorders, depressive disorder, anxiety disorder, post-traumatic stress disorder, and MDD. Presenting symptoms included depression, anxiety, suicidal ideations, behavioral outbursts, and hallucinations.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	10/10	Most records demonstrated that the services requested were subject to prior authorization requirements according to the RAE's prior authorization list. Two records requested ASAM 3.7 WM, which does not require prior authorization; however, medical necessity review is permitted, and if medical necessity review informs Beacon staff that medical necessity criteria are not met, Beacon will deny the entire stay.

Requirements	M/NM	Comments
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of one standard request, three standard concurrent requests, and six expedited concurrent requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either a preservice request or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that HCI followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. Providers received a copy of the NABD, and in most cases, a phone call as well.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	9/10	Nine records reviewed demonstrated the NABD was sent within the required time frame. One record met the SUD service time frame requirement for verbal notification to the provider; however, it did not meet the 42 CFR §438 regulation requirement for written notice to the member within 72 hours.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also addressed the reason for the denial.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	9/10	Nine of 10 records reviewed contained evidence that the peer-to-peer review was offered. In one record, the document submitted was a corrupted file, and no other documentation was submitted after informing Beacon of the corrupted file. The noncorrupted clinical notes did not show any evidence that the peer-to-peer review was offered to the provider.
Was the decision based on established authorization criteria? (M/NM)*	9/10	In one record reviewed, the clinical notes indicated which established criteria were used; however, the notes did not clearly justify which criteria were not met.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs were written at an easy-to-understand reading level.
Total Applicable Elements	**80**	
Total Met Elements	**77**	
Score (Number Met / Number Applicable) = %	**96%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: **
100	80	77	96%

****Total Score** = Met Elements/Total Applicable Elements

Appendix D. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Health Colorado, Inc. RAE 4

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	January 31, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The three outpatient records HSAG reviewed consisted of: • Three adult records • One request for MH services • Two requests for SUD services
Service requested/indication:		Requests for service included ASAM 2.1 intensive outpatient program and intensive outpatient program (MH). Diagnoses included SUD, cannabis use disorder, MDD, and post-traumatic stress disorder. Presenting symptoms included mood swings, obsessive thoughts, and poor concentration.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All three records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of three standard requests. Two of the standard requests were concurrent.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either a preservice request or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	3	All denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.

Requirements	M/NM	Comments
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	1	One denial was related to lack of updated clinical documentation to determine continued medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	3/3	In all three records reviewed, HSAG found that HCI followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	3/3	Members received a copy of the NABD. Providers received both a phone call and a copy of the NABD.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	2/3	Two records reviewed demonstrated the NABD was sent within the required time frame. One record was sent 12 calendar days following the request for service.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended. Beacon staff did report they should have considered an extension notification regarding the request for service which needed updated clinical documentation from the requesting provider.
Did the NABD include the required content? (M/NM)*	3/3	All NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE

Requirements	M/NM	Comments
		in filing, and access to pertinent records; the template also addressed the reason for the denial.
Was the denial decision made by a qualified clinician? (M/NM)*	3/3	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	1/1	One request for service was denied due to lack of adequate documentation to determine medical necessity. RAE 4 did attempt to contact the provider for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	3/3	All records reviewed contained evidence that the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	1/3	Although it was clear which criteria were used, in two records reviewed, HCI did not clearly document in the system notes which established criteria were used.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	3/3	All NABDs were written at an easy-to-understand reading level.
Total Applicable Elements	**25**	
Total Met Elements	**22**	
Score (Number Met / Number Applicable) = %	**88%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
30	25	22	88%

****Total Score** = Met Elements/Total Applicable Elements

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
130	105	99	94%

***Total Score = Met Inpatient + Outpatient Elements/Total Inpatient + Outpatient Applicable Elements

Summary

For acute hospitalizations, HCI required authorization for acute MH inpatient hospitalization, SUD WM, and SUD residential treatment. For emergency hospitalizations, HCI allowed 24 hours for notification of the admission. The first 24 hours of the admission were honored for payment if the admission met medical necessity criteria. For contracted facilities, if notification was not made within the first 24 hours of the admission, payment was authorized at the time of the notification and forward. For out-of-network facilities, consideration was given to whether it was known that the member was eligible for Colorado Medicaid. For SUD inpatient and residential treatment, HCI did not impose a penalty for lack of notification within the first four days; however, all days were subject to medical necessity review.

HCI delegated UM activities to Beacon Health Options (Beacon). During the review period (CY 2021), Beacon used InterQual UR criteria for all MH UR determinations and outpatient SUD determinations. HCI used ASAM level of care criteria for inpatient and residential SUD determinations. Beacon required its UM staff members to pass IRR testing annually with a minimum score of 80 percent. Beacon's prior authorization list, policies, and procedures stated that the following inpatient services are subject to prior authorization and/or concurrent review requirements:

Mental Health

- Inpatient acute hospital care
- Acute treatment unit
- Residential treatment center
- Crisis stabilization unit (after the fifth visit per episode of care)
- Observation

SUD Services

- Inpatient and WM (3.7) level of care
- High-intensity residential (3.5) level of care
- Low- and medium-intensity residential (3.1 and 3.3) levels of care
- Nonmedical WM (3.2) level of care

The following outpatient services required prior authorization/concurrent review during the review period:

Mental Health

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) after the 25th visit
- Assertive community treatment
- Partial hospitalization program
- Intensive outpatient program for MH
- BH day treatment
- Out-of-network services (except emergency/crisis care)
- Half-day psychosocial rehabilitation
- Multisystemic therapy

SUD Services

- SUD intensive outpatient program
- Out-of-network services (except emergency/crisis care and medically necessary services unavailable within the network)

The following outpatient services did not require prior authorization/concurrent review:

- Routine psychotherapy initial evaluations and psychotherapy services (30-minute, 45-minute, and 60-minute sessions) for the first 25 visits
- Psychological/neurological testing

Beacon, on behalf of HCI, accepted requests for authorization electronically through a website, via fax, and by telephone. The website allowed the upload of medical record documentation but was not an automated review/approval system. Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, the records reviewed for HCI RAE 4 demonstrated that Beacon used nationally recognized UR criteria (InterQual and ASAM) in most cases. The criteria used for the determination were not properly documented in two outpatient files. Additionally, in one inpatient file, the system notes did not clearly document which criteria were not met to result in the determination of not medically necessary. HSAG also found that Beacon followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider in all cases reviewed.

NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all of the required information. In all cases involving a medical necessity review (except one inpatient file), HCI offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. Board-certified psychiatrists reviewed all medical necessity denials for 24-hour level of care. A psychiatrist or Doctor of Philosophy (PhD)-level psychologist reviewed medical necessity denials for outpatient care. Administrative denials were also reviewed by a physician or psychologist. Although HSAG found that the reason and rationale added to the NABD templates were minimally compliant, these simply stated, “we believe your symptoms can be managed in another level of care.” HSAG recommends that HCI add additional information to the reason and rationale for the denial so that members may better understand the circumstances surrounding the denial of services. The Department has determined that the best practice for describing the reason and rationale for the denial is to include the following:

- The name of the criteria used (e.g., InterQual, ASAM)
- A brief description of the specific element of the criteria that caused the RAE to find the service to be not medically necessary
- Why the RAE found the service to be not medically necessary, specific to the member’s situation (e.g., what symptoms the RAE found to be present or not present, related to the criteria)
- The right to request a copy of the criteria (in addition to the other documents and records used to make the determination)

During the MHP interview, Beacon staff reported that when a particular level of care is denied and a lower level of care is recommended, Beacon expects the provider to coordinate with the attributed CMHC to arrange for services. Beacon reported that a referral to care coordination is not typically made and that the NHP care coordination department is not copied on or notified of the denial. HSAG recommends that HCI and Beacon collaborate to develop a process for making care coordination referrals when needed to ensure appropriate services are arranged when services needed differ from services requested and denied.

In addition, when discussing how the RAE ensures that members receive the recommended level of care, Beacon staff reported that the UM workflow is such that members/families are required to request MH residential treatment level of care and Beacon does not respond to provider referrals for MH residential treatment level of care. Given the previous discussion that denials do not routinely result in referral to care coordination, HSAG noted that this practice could result in some care gaps and recommends that Beacon evaluate this practice and assess any resultant care gaps.

During the MHP interview, HCI reported several best practices related to implementation of the new SUD inpatient and residential benefit package in January 2021:

- Beacon held monthly and quarterly provider forums as well as individualized training for providers as needed to ensure understanding of the new benefits and RAE requirements.
- Beacon developed provider newsletter content regarding new codes or changes to coding requirements.
- Beacon reported no longer declining to accept provider applications based on network sufficiency in a particular area.
- Beacon began using the state-developed uniform service request form for SUD services.

Appendix E. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Colorado Access RAE 5

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	January 27, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Eight adult records • Two children/adolescent records • Seven requests for MH services • Three requests for SUD services
Service requested/indication:		Requests for services included inpatient acute care, inpatient hospitalization, acute treatment unit, long-term residential treatment, ASAM 3.1 low-intensity residential treatment, ASAM 3.5 high-intensity residential treatment, and ASAM 3.7 WM. Diagnoses included MDD, alcohol use disorder, schizoaffective disorder, bipolar disorder, unspecified schizophrenia disorder, unspecified depressive disorder, alcohol dependence, cannabis dependence, unspecified mental disorder, and SUD. Presenting symptoms included aggression, suicidal ideation, depression, anxiety, insomnia, and behavioral issues.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of five expedited concurrent requests, two expedited preservice requests, two standard preservice requests, and one retrospective denial.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either requests for additional days based on the authorization ending, preservice requests, or a post-service request for payment for a service that had not yet been reviewed for medical necessity (retrospective review).
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	1	One denial was related to the requesting provider being an out-of-network provider. The denial was also "not medically necessary" as there were providers in network that could provide the service requested.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that COA followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. Providers received a copy of the NABD and, in most cases, a phone call as well.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services	9/10	In one expedited determination, HSAG found that notice to the member was sent after the required time frame had expired. During the interview, COA staff members informed HSAG that due to the holiday weekend, the case waited until Monday for medical director review and should have been forwarded to the after-hours medical director.

Requirements	M/NM	Comments
• Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request a SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also addressed the reason for the denial.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied due to lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	9/9	In one instance, peer-to-peer review was not applicable for the retrospective denial. COA followed its peer review policy for all records reviewed.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that COA based determination on nationally recognized criteria (InterQual and ASAM) and the Colorado contract/benefit package.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs were written at an easy-to-understand reading level.
Total Applicable Elements	**79**	
Total Met Elements	**78**	
Score (Number Met / Number Applicable) = %	**99%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: **
100	79	78	99%

****Total Score** = Met Elements/Total Applicable Elements

Appendix E. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Colorado Access RAE 5

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	January 27, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Seven adult records • Three children/adolescent records • Seven requests for MH services • Three requests for SUD services
Service requested/indication:		Requests for service included partial hospitalization program, ASAM 2.1 SUD intensive outpatient, MH intensive outpatient program, and psychological/neurological testing. Diagnoses included MDD, post-traumatic stress disorder, generalized anxiety disorders, alcohol dependence, other stimulant dependence, opioid dependence, cocaine abuse disorder, ADHD, bipolar disorder, unspecified depressive disorder, anxiety disorder, eating disorder, and ASD. Presenting symptoms included anxiety, auditory visual hallucinations, behavioral issues, depression, restlessness, agitation, gender dysphoria, and suicidal ideations.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of nine standard requests and one retrospective denial. Two requests were concurrent, including one standard request for payment and subsequent retrospective denial.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or a post-service request for coverage (retrospective).
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	2	Two denials not meeting medical necessity were also denied for other reasons. One denial was not a covered benefit due to the request to treat an SUD with MH intensive outpatient treatment. For the second denial, the requested service was denied because a lower level of care was requested (SUD intensive outpatient), and medical records showed that medical necessity for a higher level of care (residential treatment) was met.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that COA followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. Providers received a copy of the NABD and, in most cases, a phone call as well.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services	10/10	In all cases reviewed, the NABD was sent within the required time frame.

Requirements	M/NM	Comments
• Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing, and access to pertinent records; the template also addressed the reason for the denial.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/9	All applicable records contained evidence that the peer-to-peer review was offered. There was one instance where peer-to-peer review was not offered because the member was already discharged from care.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that COA based determinations on nationally recognized criteria (InterQual and ASAM) and the Colorado contract/benefit package.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs were written at an easy-to-understand reading level.
Total Applicable Elements	**79**	
Total Met Elements	**79**	
Score (Number Met / Number Applicable) = %	**100%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
100	79	79	100%

****Total Score** = Met Elements/Total Applicable Elements

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
200	158	157	99%

*****Total Score** = Met Inpatient + Outpatient Elements/Total Inpatient + Outpatient Applicable Elements

Summary

For acute hospitalizations, COA required prior authorization for acute inpatient hospitalization. For emergency hospitalizations, COA allowed 24 hours for notification of the admission. The first 24 hours of the admission were honored for payment if the admission met medical necessity criteria. For contracted facilities, if notification was not made within the first 24 hours of the admission, payment was authorized at the time of the notification and forward. For out-of-network facilities, consideration was given to whether it was known that the member was eligible for Colorado Medicaid.

COA did not delegate UM activities. During the review period (CY 2021), COA used InterQual UR criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. COA required its UM staff members to pass IRR testing annually with a minimum score of 90 percent. COA's prior authorization list, policies, and procedures stated that the following inpatient services are subject to authorization and concurrent review requirements:

Mental Health

- Inpatient acute hospital care
- Acute treatment unit
- Residential treatment center

Care in a Crisis Stabilization Unit and observation services did not require prior authorization/concurrent review.

SUD Services

- Inpatient and WM (3.7) level of care
- High-intensity residential (3.5) level of care
- Low- and medium-intensity residential (3.1 and 3.3) levels of care

The following outpatient services required prior authorization/concurrent review during the review period:

Mental Health

- Psychological/neurological testing
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment
- Out-of-network services (except emergency/crisis care)

SUD Services

- SUD intensive outpatient program
- Out-of-network services (except emergency/crisis care)

COA did not require prior authorization/concurrent review for the following outpatient services:

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) for MH or SUD treatment
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

COA reported no quantitative benefit limitations. COA accepted requests for authorization via fax and by telephone. COA did not use an electronic authorization system. Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, COA RAE 5 demonstrated that COA consistently used nationally recognized UR criteria (InterQual) and followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider.

NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all of the required information. In all cases involving a medical necessity review, COA offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. Board-certified psychiatrists reviewed all medical necessity denials. Administrative denials were reviewed by an RN or master's level clinician, except requests for out-of-network providers, which were reviewed for medical necessity by a physician to ensure that equivalent services were available in the network. COA provided most NABDs to members well within the required time frame. HSAG found that in one inpatient expedited determination, the NABD was not sent within the 72-hour time frame. During the interview, COA staff agreed that the case should have been referred to after-hours medical personnel due to the holiday weekend.

COA RAE 3 achieved a 100 percent score for all inpatient records reviewed and a 99 percent aggregate score for outpatient records reviewed. HSAG found that COA used several best practices overall, which were specifically related to implementing the new SUD benefits:

- COA reported that all bed-based care is processed as an expedited request with a goal of making the determination within 24 hours. HSAG found that in most cases, files reviewed demonstrated this 24-hour turnaround time.
- COA reported regular meetings between care coordination and UM staff to review collaboration on particular cases and referral processes.
- New provider newsletter content and provider tip sheets were developed to include coding and authorization information related to the new SUD benefits.
- COA began using the state-developed uniform service request form for SUD services.
- COA's NABD letters included the reason and rationale at an easy-to-understand reading level and gave clear information about the criteria used including:
  - A brief description of the specific element of the criteria that caused the RAE to find the service to be not medically necessary.

- Why the RAE found the service to be not medically necessary, specific to the member's situation (e.g., what symptoms the RAE found to be present or not present, related to the criteria).
- The right to request a copy of the criteria (in addition to the other documents and records used to make the determination).

Based on the Department's consideration of best practices, HSAG recommends that COA also include in these letters the specific name of the criteria used (InterQual, ASAM, etc.).

Appendix F. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Colorado Community Health Alliance RAE 6

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	February 4, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Seven adult records • Three children/adolescent records • Six requests for MH services • Four requests for SUD services
Service requested/indication:		Requests for service included inpatient acute care, residential treatment, acute treatment unit, ASAM 3.5 residential treatment, and ASAM 3.7 residential treatment. Diagnoses included MDD, bipolar disorder, impulsive disorder, schizophrenia spectrum disorders, stimulant use disorder, alcohol dependence, other stimulant dependence, alcohol use disorder, ASD, and intellectual disability. Presenting symptoms included anxiety, depression, paranoia, delusional thinking, suicidal ideation, psychosis, and aggressive/ assaultive behavior.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of one standard preservice request, one expedited preservice request, and eight expedited concurrent requests.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	6	Six denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	2	Two denials were related to the primary diagnosis being a noncovered diagnosis, including ASD and an intellectual disability. Neither denial contained evidence for requesting or reviewing more clinical documentation to determine if a MH diagnosis exists.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	2	The two noncovered diagnosis denials were related to the primary diagnosis of ASD or an intellectual disability.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	2	Two denials were due to reaching the 15-day IMD benefit limitation.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	8/10	In eight cases, HSAG found that CCHA RAE 6 followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria. Although CCHA procedures included a process to refer cases with a noncovered diagnosis to determine if the request is valid based on a co-occurring MH diagnosis, two cases were administratively denied due to the development diagnosis. In one case, the inpatient stay was initially approved with a diagnosis of impulse disorder. The system notes stated, "upon discovery of a noncovered diagnosis, the service is now denied." CCHA then retroactively denied the entire stay.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. Providers received a copy of the NABD and, in most cases, a fax as well.

Requirements	M/NM	Comments
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All records reviewed demonstrated that the NABD was sent within the required time frame.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	9/10	NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request a SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also addressed the reason for the denial. The reason for the denial was found unclear at times in some of the records reviewed. These issues were scored and addressed related to the requirement that the reason be easily understood by the member. In one record, the NABD did not accurately or clearly describe which service had been requested and was being denied.
Was the denial decision made by a qualified clinician? (M/NM)*	6/8	In six cases, a qualified clinician made the denial determination. Two IMD denials did not need a qualified clinician to make the decision and therefore were not applicable.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the requesting provider.

Requirements	M/NM	Comments
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	5/8	Three denials reviewed did not contain evidence that the peer-to-peer review was offered. In two IMD cases, peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	8/10	Eight records contained evidence that CCHA based determinations on nationally recognized criteria (MCG and ASAM) and the RAE contract/benefit package.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	6/10	The reason for the denial was not easily understood and confusing in four of the NABDs reviewed. HSAG found that in some cases when the denial was related to a noncovered diagnosis, the member was not told specific information related to the reason for the denial or why the diagnosis was not covered, and was referred to page 24 of the Health First Colorado Member Handbook. These instructions likely confused members. One IMD denial was unclear about requested dates and which specific months were being denied.
Total Applicable Elements	**76**	
Total Met Elements	**62**	
Score (Number Met / Number Applicable) = %	**82%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: **
100	76	62	82%

****Total Score** = Met Elements/Total Applicable Elements

Appendix F. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Colorado Community Health Alliance RAE 6

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	February 4, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Six adults • Four children/adolescents • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for service included psychotherapy (60 minutes), psychological/neuropsychological evaluation and testing, partial hospitalization program, intensive outpatient program (MH), and ASAM 2.1 chemical dependence intensive outpatient program. Diagnoses included alcohol dependence, MDD, post-traumatic stress disorder, ADHD, generalized anxiety disorder, and ASD. Presenting symptoms included anxiety, depression, and insomnia.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list. This included the request for psychotherapy (60 minutes) during CCHA's prior authorization requirement for psychotherapy after 20 sessions from March 2021 to August 2021.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of six standard requests and four standard concurrent requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending.

Requirements	M/NM	Comments
Reason for the denial:		
Medical necessity? (Y/N)	6	Six denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	1	One denial was related to the MH diagnosis of MDD. CCHA stated that MDD is not a covered diagnosis to request a SUD benefit (ASAM 2.1).
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	1	One denial was related to the requesting provider being out of network.
Other (describe): (Y/N)	5	Three denials were related to ASD testing not being a covered benefit when it is covered by Medicaid FFS; this included the out-of-network provider request. One noncovered benefit denial was related to the MH diagnosis not covered to request ASAM 2.1 services. Additionally, one denial was related to CCHA not receiving additional clinical documentation to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	9/10	In nine cases, HSAG found that CCHA RAE 6 followed policies and procedures related to which services require prior authorization and followed nationally recognized UM criteria. In the case wherein the provider requested SUD services for a member with a MH diagnosis, regarding referral for medical necessity review, CCHA did not follow its stated process of reaching out to the requesting provider.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. Providers received a copy of the NABD and, in most cases, a fax as well.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services	9/10	Nine records reviewed demonstrated that the NABD was sent within the required time frame. One record was sent 14 calendar days following the request for service.

Requirements	M/NM	Comments
• Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period= 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also addressed the reason for the denial. The reason for the denial was unclear at times in some of the records reviewed. These issues were scored and addressed related to the requirement that the reason be easily understood by the member.
Was the denial decision made by a qualified clinician? (M/NM)*	9/10	In nine cases, a qualified clinician made the denial determination. In the case wherein the provider requested SUD services for a member with a MH diagnosis, regarding medical necessity review, CCHA did not follow its stated process of reaching out to the requesting provider.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	1/1	One request for service was denied due to lack of adequate documentation to determine medical necessity. CCHA did attempt to contact the provider for additional information but did not receive a response.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	7/7	Seven denials reviewed contained evidence that the peer-to-peer review was offered. Three denials were administrative denials, and peer-to-peer reviews were not applicable.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that CCHA based determinations on nationally recognized criteria (MCG and ASAM) and the RAE contract/benefit package.

Requirements	M/NM	Comments
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	6/10	Three denials due to a "not a covered benefit" offered little to no explanation about why the request for service is not a covered benefit or referred the member to page 24 of the Health First Colorado Member Handbook with no other explanation. The NABDs also used abbreviations without defining them. In one denial related to lack of medical necessity, CCHA copied the full description of the MCG criteria in the letter and did not adequately describe the specific member situation that did not meet medical necessity. The NABD was cumbersome and difficult to follow.
Total Applicable Elements	**78**	
Total Met Elements	**71**	
Score (Number Met / Number Applicable) = %	**91%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
100	78	71	91%

****Total Score** = Met Elements/Total Applicable Elements

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
200	154	133	86%

*****Total Score** = Met Inpatient + Outpatient Elements/Total Inpatient + Outpatient Applicable Elements

Summary

For acute hospitalizations, CCHA required prior authorization for acute inpatient hospitalization. For emergency hospitalizations, CCHA allowed 24 hours for notification of the admission. The first 24 hours of the admission were honored for payment if the admission met medical necessity criteria. For contracted facilities, if notification was not made within the first 24 hours of the admission, payment was authorized at the time of the notification and forward. For out-of-network facilities, consideration was given to whether it was known that the member was eligible for Colorado Medicaid.

CCHA's prior authorization list, policies, and procedures stated that the following inpatient services are subject to prior authorization and concurrent review requirements:

Mental Health

- Inpatient acute hospital care
- Acute treatment unit
- Residential treatment center

Observation level of care did not require prior authorization but was subject to medical necessity review. Treatment in a crisis stabilization unit did not require prior authorization.

SUD Services

- Inpatient (3.7) level of care
- High-intensity residential (3.5) level of care
- Low- and medium-intensity residential (3.1 and 3.3) levels of care

The following outpatient services required prior authorization/concurrent review:

Mental Health

- Routine psychotherapy services (initial evaluation, 30-minute, 45-minute, and 60-minute sessions), only from March through August 2021
- Psychological/neurological testing
- Assertive community treatment
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy
- Out-of-network services (except emergency/crisis care)

SUD Services

- SUD intensive outpatient program
- Out-of-network services (except emergency/crisis care)

The following outpatient services did not require prior authorization/concurrent review:

- Routine psychotherapy services (for MH or SUD)—except from March through August 2021.
- WM (3.7) level of care
- Nonmedical WM (3.2) level of care

CCHA reported no quantitative benefit limitations. CCHA accepted requests for authorization electronically through an automated online system, via fax, and by telephone. CCHA did not delegate UM activities. CCHA was in partnership with

Anthem. CCHA staff members reported that CCHA UM staff members are Anthem employees. During the review period (CY 2021), CCHA used MCG UR criteria for all MH UR determinations and ASAM level of care criteria for all SUD determinations. CCHA required its UM staff members to pass IRR testing annually with a minimum score of 90 percent.

Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, the records reviewed for CCHA RAE 6 demonstrated that CCHA used nationally recognized UR criteria; however, two inpatient files did not document which criteria were used for determinations. HSAG found that CCHA did not consistently follow its policies and procedures. In two inpatient cases, HSAG found documentation of service denial solely for the reason of the presence of a developmental disability. Neither case contained documentation that the presence of a co-occurring MH diagnosis was assessed for or given consideration. In one file, the determination notes and the letter to the member stated, "Upon discovery of the presence of a noncovered diagnosis, the service is now denied." CCHA then retroactively denied the entire stay. These services had been approved initially and upon concurrent review for the diagnosis of impulse disorder. CCHA described the process of ensuring medical necessity review for noncovered diagnoses; however, both of these cases were administratively denied, and medical director consideration of a possible MH diagnosis was not documented.

In addition, CCHA described processes for referring specific denials to care coordination; however, applicable files did not contain documentation that provided evidence of implementing the stated procedures. In one case, SUD services were requested for a member whose records only included a MH diagnosis. CCHA denied the services based on the statement that SUD services are not appropriate to treat a MH diagnosis. Although CCHA staff members described a process for reaching out to the provider to clarify the diagnosis and/or the request, this process was not documented in the file. The NABD in this case simply stated the service was not a covered benefit with no explanation, which likely confused the member.

Requesting providers were offered a peer-to-peer review with a medical director for medical necessity denials in most cases. In three inpatient files, HSAG found no evidence that a peer-to-peer review was offered.

The CCHA RAE 6 total score of 86 percent was largely driven by not following stated procedures. For example, although CCHA revised the NABD template following the FY 2020–2021 MHP audit findings, in several instances the previous template was used, which included several typographical errors and reasons and rationales that were awkward and difficult to understand. In addition, for several inpatient and outpatient records, the NABD was not sent to the member, which CCHA reported was related to the switch to a new documentation system which required manual processes that did not occur.

HSAG noted that several cases indicated incorrect reason codes in the data file, and CCHA also reported that staff used the incorrect field to pull the data. Both of these dynamics caused cases to be removed from the sample and replaced with oversample cases. Additionally, HSAG noted that CCHA sent NABDs to members for provider procedural issues and stated that staff were unaware that members should not receive these notices. Although CMS recently reiterated and clarified this requirement, this interpretation has been used since the Balanced Budget Act (BBA) of 1997 was enacted.

HSAG recommends that CCHA evaluate processes and develop training on procedures, Colorado-required processes, and the Medicaid managed care regulations to ensure consistency of process, documentation, and compliance with regulations.

Appendix G. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Colorado Community Health Alliance RAE 7

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	February 4, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Six adult records • Four children/adolescent records • Six requests for MH services • Four records for SUD services
Service requested/indication:		Requests for services included inpatient acute care, residential treatment, ASAM 3.2/3.7 WM, and ASAM 3.5 high-intensity residential. Diagnoses included MDD, ADHD, post-traumatic stress disorder, reactive attachment disorder, psychotic disorder, conduct disorder, SUD, opioid use disorder, stimulant use disorders, other stimulant dependence, and alcohol abuse. Presenting symptoms included anxiety, depression, audio hallucinations, suicidal ideations, and homicidal ideations toward others.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of one standard preservice request, one expedited preservice request, seven expedited concurrent requests, and one retrospective denial.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		Nine requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending. One retrospective denial was a claim request.
Reason for the denial:		
Medical necessity? (Y/N)	7	Seven denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	3	One denial was due to reaching the 15-day IMD benefit limitation. Two denials were because of a noncovered benefit, one of which was due to the member being treated for a SUD at an inappropriate level of care (MH inpatient), and the other was due to the member receiving services past the prior authorization date without concurrent approval.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	7/10	In seven cases, HSAG found that CCHA followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria. During the interview, CCHA staff described the process for documentation; however, three denials showed no evidence that CCHA followed its own process for clearly documenting criteria used for authorization decision making.
Were both the provider and member notified (member in writing)? (M/NM)*	9/10	Nine members received a written NABD. Providers received a copy of the NABD and, in most cases, a phone call or fax. One file did not contain evidence that an NABD was sent. Staff responded in agreement that the member did not receive a letter.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services	7/10	Seven cases reviewed demonstrated that the NABD was sent within the required time frame. Three cases demonstrated that the NABD was either not sent within the required time frame or not sent at all.

Requirements	M/NM	Comments
• Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	7/10	NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also addressed the reason for the denial. In three files, the letter either was not sent, or the reason noted in the letter was inaccurate.
Was the denial decision made by a qualified clinician? (M/NM)*	7/8	In seven cases, a qualified clinician made the denial determination. Two denials were administrative denials not requiring medical director review (one IMD and one retrospective determination) and therefore were not applicable for this element.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM)*	0/1	One request for service was denied due to lack of documentation to support the request. CCHA described its process of reaching out to the provider for requesting additional documentation or submitting a new request for a more appropriate service. However, the record did not provide evidence that this process was followed.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	6/8	Six denials reviewed contained evidence that the peer-to-peer review was offered, while two files contained no evidence that the peer-to-peer process was offered. For two denials reviewed, an IMD and retrospective denial, peer-to-peer review was not applicable.

Requirements	M/NM	Comments
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that CCHA RAE 7 based determinations on nationally recognized criteria (MCG and ASAM) and the RAE contract/benefit package.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	7/10	Seven NABDs reviewed contained correspondence that was easy to understand. Two "not a covered benefit" denials had inaccurate information and did not specifically describe the member's situation, making the NABD difficult to understand. One denial had no NABD in the file and was found out of compliance for this element.
Total Applicable Elements	**77**	
Total Met Elements	**60**	
Score (Number Met / Number Applicable) = %	**78%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: **
100	77	60	78%

****Total Score** = Met Elements/Total Applicable Elements

Appendix G. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Colorado Community Health Alliance RAE 7

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	February 9, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Five adult records • Five children/adolescent records • Seven requests for MH services • Three requests for SUD services
Service requested/indication:		Requests for service included psychological/neurological evaluation and testing, psychotherapy (60 minutes), partial hospitalization program, intensive outpatient program (MH), and chemical dependence intensive outpatient program. Diagnoses included MDD, disruptive mood dysregulation disorder, adjustment disorder, post-traumatic stress disorder, other stimulant dependence, alcohol abuse, and ASD. Presenting symptoms included anxiety, depression, paranoia, visual hallucinations, and panic attacks.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list. This included the prior authorization requirement for psychotherapy (60 minutes) services from March 2021 to August 2021.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of seven standard preservice requests and three standard concurrent requests.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	7	Seven denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	2	Two denials were related to a noncovered diagnosis. CCHA staff reported that if there is only a developmental diagnosis on the request for service, they do not reach out to the requesting provider/facility to clarify whether a MH diagnosis exists.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network. One denial was requested by an out-of-network provider; however, this was not the reason for denial.
Other (describe): (Y/N)	6	Two denials were denied due to lack of updated clinical information to support medical necessity. One denial was incorrectly labeled as "investigational"; this was a data entry mistake, and the correct reason for denial was due to not meeting medical necessity. Three denials were related to requests for noncovered benefits, including two that were noncovered diagnoses.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that CCHA followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	8/10	Eight members received a written NABD. Providers were notified about the denial determination by letter or fax. CCHA staff informed HSAG that CCHA had a new documentation system in place which caused some members to not receive an NABD.

Requirements	M/NM	Comments
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	7/10	Seven cases demonstrated that the NABD was sent within the required time frame. Three cases demonstrated that the NABD was not sent within the required time frame, the previous NABD from a prior request was attached, or the NABD was not sent at all.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	7/10	NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request a SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also addressed the reason for the denial. The reason for the denial was found unclear or inaccurate in one of the records reviewed. In two cases, members did not receive an NABD.
Was the denial decision made by a qualified clinician? (M/NM)*	9/10	In nine cases reviewed, a qualified clinician made the denial determination. During an administrative denial (not a covered benefit and diagnosis) file review, CCHA described its process of reaching out to the provider to request additional documentation or submitting a new request for a more appropriate service. However, there was no documentation in the record to support that this process was followed.

Requirements	M/NM	Comments
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	2/2	Two requests for service were denied due to lack of documentation to support the request. CCHA reached out to the providers multiple times requesting additional clinical documentation. Each attempt was unsuccessful.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	7/7	Seven denials reviewed contained evidence that the peer-to-peer review was offered. In three denials reviewed, peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	9/10	Most records contained evidence that CCHA RAE 7 based determinations on nationally recognized criteria (MCG and ASAM) and the RAE contract/benefit package. One record, an administrative denial, did not contain any documentation about the decision-making process or how the denial was determined. The NABD letter did not explain why the requested service was denied due to the diagnosis provided.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	7/10	Seven NABDs reviewed contained correspondence that was easy to understand. One denial that was "not a covered benefit due to noncovered diagnosis" contained inaccurate information and did not specifically state the member's situation, which caused the NABD to be confusing. CCHA did not send out an NABD to two members and therefore were found out of compliance for this element.
Total Applicable Elements	**79**	
Total Met Elements	**66**	
Score (Number Met / Number Applicable) = %	**84%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
100	79	66	84%

****Total Score** = Met Elements/Total Applicable Elements

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
200	156	126	81%

***Total Score = Met Inpatient + Outpatient Elements/Total Inpatient + Outpatient Applicable Elements

Summary

For acute hospitalizations, CCHA required prior authorization for acute inpatient hospitalization. For emergency hospitalizations, CCHA allowed 24 hours for notification of the admission. The first 24 hours of the admission were honored for payment if the admission met medical necessity criteria. For contracted facilities, if notification was not made within the first 24 hours of the admission, payment was authorized at the time of the notification and forward. For out-of-network facilities, consideration was given to whether it was known that the member was eligible for Colorado Medicaid.

CCHA's prior authorization list, policies, and procedures stated that the following inpatient services are subject to prior authorization and concurrent review requirements:

Mental Health

- Inpatient acute hospital care
- Acute treatment unit
- Residential treatment center

Observation level of care did not require prior authorization but was subject to medical necessity review. Treatment in a crisis stabilization unit did not require prior authorization.

SUD Services

- Inpatient (3.7) level of care
- High-intensity residential (3.5) level of care
- Low- and medium-intensity residential (3.1 and 3.3) levels of care

The following outpatient services required prior authorization/concurrent review:

Mental Health

- Routine psychotherapy services (initial evaluation, 30-minute, 45-minute, and 60-minute sessions), only from March through August 2021
- Psychological/neurological testing
- Assertive community treatment
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy
- Out-of-network services (except emergency/crisis care)

SUD Services

- SUD intensive outpatient program
- Out-of-network services (except emergency/crisis care)

The following outpatient services did not require prior authorization/concurrent review:

- Routine psychotherapy services (for MH or SUD), except from March through August 2021.
- WM (3.7) level of care
- Nonmedical WM (3.2) level of care

CCHA reported no quantitative benefit limitations. CCHA accepted requests for authorization electronically through an automated online system, via fax, and by telephone. CCHA did not delegate UM activities. CCHA was in partnership with Anthem. CCHA staff members reported that CCHA UM staff members are Anthem employees. During the review period (CY 2021), CCHA used MCG UR criteria for all MH UR determinations and ASAM level of care criteria for all SUD determinations. CCHA required its UM staff members to pass IRR testing annually with a minimum score of 90 percent.

Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, the records reviewed for CCHA RAE 7 demonstrated that CCHA used nationally recognized UR criteria; however, one outpatient file did not document which criteria were used for determinations. HSAG found that CCHA did not consistently follow its policies and procedures. In three inpatient cases, HSAG did not find any documentation of stated procedures for medical necessity review or referral. CCHA described processes for referring specific denials to care coordination; however, applicable files did not contain documentation that provided evidence of implementing stated procedures. CCHA denied the services based on the statement that SUD services are not appropriate to treat a MH diagnosis. Although CCHA staff members described a process for reaching out to the provider to clarify the diagnosis and/or the request, this process was not documented in the files.

Requesting providers were offered a peer-to-peer review with a medical director for medical necessity denials in most cases. In two inpatient files, HSAG found no evidence that a peer-to-peer review was offered.

The CCHA RAE 7 total score of 81 percent was largely driven by not following stated procedures. For example, although CCHA revised the NABD template following the FY 2020–2021 MHP audit findings, in several instances the previous template was used, which included several typographical errors and reasons and rationales that were awkward and difficult to understand. In addition, for several inpatient and outpatient records, the NABD was not sent to the member, which CCHA reported was related to the switch to a new documentation system which required manual processes that did not occur.

HSAG noted that several cases indicated incorrect reason codes in the data file, and CCHA also reported that staff used the incorrect field to pull the data. Both of these dynamics caused cases to be removed from the sample and replaced with oversample cases. Additionally, HSAG noted that CCHA sent NABDs to members for provider procedural issues and stated that staff were unaware that members should not receive these notices. Although CMS recently reiterated and clarified this requirement, this interpretation has been used since the BBA of 1997 was enacted.

- HSAG recommends that CCHA evaluate processes and develop training on procedures, Colorado-required processes, and the Medicaid managed care regulations to ensure consistency of process, documentation, and compliance with regulations.

Appendix H. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Denver Health Medical Plan MCO

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	January 25, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Eight adult records • Two children/adolescent records • Eight requests for MH services • Two requests for SUD services
Service requested/indication:		Requests for service included residential treatment (short- and long-term), acute treatment unit, inpatient hospitalization, ASAM 3.1 low-intensity residential, and ASAM 3.7 WM. Diagnoses included MDD, alcohol dependence, stimulant dependence, alcohol use disorders, SUD, methamphetamine use disorder, generalized anxiety disorders, bipolar disorder, post-traumatic stress disorder, schizophrenia, unspecific neurodevelopmental disorder, and ADHD. Presenting symptoms included anxiety, anxious distress, psychosis, depression, and psychotic episodes.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the MCO's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of two standard requests and eight expedited requests. Seven of the eight expedited requests were concurrent.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests; seven were requests for additional days and three were preservice requests.

Requirements	M/NM	Comments
Reason for the denial:		
Medical necessity? (Y/N)	10	All 10 denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that COA (DHMP's delegate), on behalf of DHMP, followed policies and procedures related to which services require prior authorization; and used nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. Providers received a copy of the NABD, and in most cases, a phone call as well.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	9/10	Nine records reviewed demonstrated that the NABD was sent within the required time frame. One record was sent 16 calendar days following the request for service.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.

Requirements	M/NM	Comments
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request a SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing, and access to pertinent records; the template also addressed the reason for the denial.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all records reviewed, a qualified clinician made the denial determination.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation received from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	10/10	All records reviewed contained evidence that the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that COA based determinations on nationally recognized criteria (InterQual and ASAM).
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs were written at an easy-to-understand reading level.
Total Applicable Elements	**80**	
Total Met Elements	**79**	
Score (Number Met / Number Applicable) = %	**99%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: **
100	80	79	99%

****Total Score** = Met Elements/Total Applicable Elements

Appendix H. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Denver Health Medical Plan MCO

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	January 25, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Nine adult records • One child record (8 years old) • Eight requests for MH services • Two requests for SUD services
Service requested/indication:		Requests for service included intensive outpatient program, out-of-network psychotherapy (60 minutes), partial hospitalization program, psychological/neuropsychological testing, and ASAM 2.1 SUD intensive outpatient program. Diagnoses included bipolar disorder, MDD, anorexia nervosa, post-traumatic stress disorder, generalized anxiety disorders, unspecified depressive disorder, antisocial personality disorder, borderline personality disorder, panic disorder, ADHD, alcohol dependence, alcohol use disorder, and a neurocognitive disorder. Presenting symptoms included mania, depression, auditory visual hallucinations, and episodes of disassociation.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to the MCO's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of seven standard requests and three retrospective denials.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or new requests for payment resulting in a post-service (retrospective) review.
Reason for the denial:		
Medical necessity? (Y/N)	9	Nine denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	1	The "not a covered diagnosis" reason category was related to the diagnosis of a neurocognitive disorder.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	1	One denial was related to a neurocognitive diagnosis.
Out-of-network provider? (Y/N)	2	Two denials were denied due to the request being from an out-of-network provider when in-network providers were available. The reason categories for these denials were also "not medically necessary" or "not a covered benefit."
Other (describe): (Y/N)	2	Two "not a covered benefit" denials to see an out-of-network provider were denied because there were in-network providers available or when the benefit was covered by Medicaid FFS.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	9/10	In all cases except one, HSAG found that COA (DHMP's delegate), on behalf of DHMP, followed policies and procedures related to which services require prior authorization, and used nationally recognized UM criteria. In the one instance, the request did not follow procedures and was processed by DHMP instead of COA.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. Providers received a copy of the NABD and, in most cases, a phone call as well.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services	10/10	In all cases reviewed, the NABD was sent within the required time frame.

Requirements	M/NM	Comments
• Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided on a Department-approved template letter which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing, and access to pertinent records; the template also addressed the reason for the denial.
Was the denial decision made by a qualified clinician? (M/NM)*	9/10	In nine cases reviewed, a qualified clinician made the denial determination. In one case reviewed, the denial was processed by DHMP UM. Stated procedures were not followed including the required medical necessity review by a qualified clinician for out-of-network requests.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/9	Nine records contained evidence that the peer-to-peer review was offered. One was an administrative denial; therefore, a peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	9/10	All records except one contained evidence that COA based determinations on nationally recognized criteria (InterQual and ASAM) and the Colorado contract/benefit package.

Requirements	M/NM	Comments
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs were written at an easy-to-understand reading level.
Total Applicable Elements	**79**	
Total Met Elements	**76**	
Score (Number Met / Number Applicable) = %	**96%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
100	79	76	96%

****Total Score** = Met Elements/Total Applicable Elements

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
200	159	155	97%

*****Total Score** = Met Inpatient + Outpatient Elements/Total Inpatient + Outpatient Applicable Elements

Summary

DHMP delegated UM for BH services to Colorado Access (COA). For acute hospitalizations, COA (on behalf of DHMP) required prior authorization for acute inpatient hospitalization. For emergency hospitalizations, COA allowed 24 hours for notification of the admission. The first 24 hours of the admission were honored for payment if the admission met medical necessity criteria. For contracted facilities, if notification was not made within the first 24 hours of the admission, payment was authorized at the time of the notification and forward. For out-of-network facilities, consideration was given to whether it was known that the member was eligible for Colorado Medicaid.

During the review period (CY 2021), COA used InterQual UR criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. COA required its UM staff members to pass IRR testing annually with a minimum score of 90 percent. COA's prior authorization list, policies, and procedures stated that the following inpatient services are subject to authorization and concurrent review requirements:

Mental Health

- Inpatient acute hospital care
- Acute treatment unit
- Residential treatment center

Care in a Crisis Stabilization Unit and observation services did not require prior authorization/concurrent review.

SUD Services

- Inpatient and WM (3.7) level of care
- High-intensity residential (3.5) level of care
- Low- and medium-intensity residential (3.1 and 3.3) levels of care

The following outpatient services required prior authorization/concurrent review during the review period:

Mental Health

- Psychological/neurological testing
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment
- Out-of-network services (except emergency/crisis care)

SUD Services

- SUD intensive outpatient program
- Out-of-network services (except emergency/crisis care)

DHMP did not require prior authorization/concurrent review for the following outpatient services:

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) for MH or SUD treatment
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

DHMP reported no quantitative benefit limitations. COA accepted requests for authorization via fax and by telephone. COA did not use an electronic authorization system. Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, DHMP demonstrated that in most cases it used nationally recognized UR criteria (InterQual) and followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider. In one outpatient file, HSAG found that DHMP's UM department processed a request for services and administratively denied the request because it was made by an out-of-network provider. DHMP's agreement with COA states that all requests for BH services are sent to COA for determination. As the COA provider network uses independently contracted providers outside of

the DHMP clinic system, this request may have been inappropriately denied. Documentation within this file also did not contain evidence of which criteria were used for determination. Additionally, in this case, DHMP did not follow COA's processes for medical necessity review of out-of-network requests. HSAG recommends periodic refresher training for DHMP UM staff to ensure BH requests are routed to COA.

NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all of the required information. In all cases involving a medical necessity review, COA offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. Board-certified psychiatrists reviewed all medical necessity denials. Administrative denials were reviewed by an RN or master's level clinician, except requests for out-of-network providers, which were reviewed for medical necessity by a physician to ensure that equivalent services were available in the network. COA provided most NABDs to members well within the required time frame. HSAG found that in one inpatient expedited determination, the NABD was not sent within the 72-hour time frame. During the interview, COA staff agreed that the case should have been referred to after-hours medical personnel for review.

DHMP, through COA's processes, demonstrated several best practices overall, which were specifically related to implementing the new SUD benefits:

- COA reported that all bed-based care is processed as an expedited request with a goal of making the determination within 24 hours. HSAG found that in most cases, files reviewed demonstrated this 24-hour turnaround time.
- COA reported regular meetings between care coordination and UM staff to review collaboration on particular cases and referral processes.
- New provider newsletter content and provider tip sheets were developed to include coding and authorization information related to the new SUD benefits.
- COA began using the state-developed uniform service request form for SUD services.
- COA's NABD letters included the reason and rationale at an easy-to-understand reading level and gave clear information about the criteria used including:
  - A brief description of the specific element of the criteria that caused the MCO to find the service to be not medically necessary.

- Why the MCO found the service to be not medically necessary, specific to the member's situation (e.g., what symptoms the MCO found to be present or not present, related to the criteria).
- The right to request a copy of the criteria (in addition to the other documents and records used to make the determination).

Based on the Department's consideration of best practices, HSAG recommends that COA also include in these letters the specific name of the criteria used (e.g., InterQual, ASAM).

In addition, HSAG noted that DHMP BH NABDs are on COA letterhead and start with the sentence, "Colorado Access is your Regional Accountable Entity." HSAG recommends that DHMP and COA collaborate to determine if DHMP letterhead should be used or if the letter should explain the delegation to COA.

Appendix I. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans Medicaid Prime

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	February 1, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Ten adult records • Six requests for MH services • Four requests for SUD services
Service requested/indication:		Requests for service included acute treatment unit, inpatient acute care, ASAM 3.5 high-intensity residential, and ASAM 3.7 WM. Covered diagnoses included schizoaffective disorder, schizophrenic spectrum disorders, MDD, anorexia, alcohol dependence, other stimulant dependence, and cannabis abuse. Presenting symptoms included anxiety, depression, paranoia, delusions, verbal aggression to others, visual hallucinations, and homicidal ideations.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to RMHP's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of seven expedited concurrent requests, one expedited preservice request, and two retrospective reviews.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests, requests for additional days based on the authorization ending, or post-service requests for payment and subsequent retrospective review.

Requirements	M/NM	Comments
Reason for the denial:		
Medical necessity? (Y/N)	8	Eight denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	3	Two denials were due to reaching the 15-day IMD benefit limitation, and all hospitalization days were denied. One request was denied due to lack of clinical documentation provided to RMHP to show medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	10/10	In all cases, HSAG found that RMHP Prime followed policies and procedures related to which services require prior authorization, and followed nationally recognized UM criteria.
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. In nine cases reviewed, the member received the provider NABD letter instead of a letter written using the member NABD template. Since this letter did notify the member in writing, this element was marked as in compliance for each record. Providers received both a phone call and an NABD on the provider template.
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services	10/10	All NABDs were sent within the required time frames.

Requirements	M/NM	Comments
• Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	1/1	RMHP Prime extended one determination to obtain additional clinical documentation. An extension letter was sent to the member within the required time frame and included the required content.
Did the NABD include the required content? (M/NM)*	1/10	In nine cases reviewed, only the provider NABD letter went to the member and did not include all the required content. Missing content included how to file a written appeal, the 60-day timeline for filing, the right to request a SFH following the adverse appeal resolution and how to do so, how to request an expedited (fast) appeal, reminder of the grievance process, the right to access pertinent records, and the RMHP customer service line information.
Was the denial decision made by a qualified clinician? (M/NM)*	8/8	In eight cases, a qualified clinician made the denial determination. In the two IMD cases, a peer-to-peer review was not applicable.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	1/1	One request for service was denied due to lack of adequate documentation to determine medical necessity. RMHP did attempt to contact the provider for additional information but received no response.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	5/6	One denial reviewed did not contain evidence that the peer-to-peer review was offered. In two post-service (retrospective) requests and two IMD cases, a peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that RMHP based determinations on nationally recognized criteria (MCG and ASAM) and the RMHP contract/benefit package.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	Although the provider NABD template was used for all member notifications, all NABDs were written at an easy-to-understand reading level.

Requirements	M/NM	Comments
		RMHP staff members reported that the previous year's MHP data file had been incorrectly pulled; therefore, the practice of not sending NABDs to members on the member template for denials of concurrent requests was not previously discovered. HSAG advised that the same letter can go to both the member and provider as long as the letter includes all required information.
Total Applicable Elements	**76**	
Total Met Elements	**66**	
Score (Number Met / Number Applicable) = %	**87%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: **
100	76	66	87%

****Total Score** = Met Elements/Total Applicable Elements

Appendix I. Colorado Department of Health Care Policy & Financing
CY 2021 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans Medicaid Prime

Review Period:	January 1, 2021–October 31, 2021
Date of Review:	February 1, 2022
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Nine adult records • One child (12 years old) record • Seven requests for MH services • Three requests for SUD services
Service requested/indication:		Requests for service included in-network and out-of-network psychotherapy (60 minutes), psychological/neuropsychological evaluation and testing, out-of-network outpatient office visits, office visits for ketamine injections, and requests for ASAM 2.1 SUD intensive outpatient programs. Diagnoses included post-traumatic stress disorder, generalized anxiety disorders, ADHD, MDD, personality disorders, sedative use disorder, alcohol dependence, and cannabis dependence. Presenting symptoms included anxiety, depression, and difficulty concentrating and focusing.
Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requested were all subject to prior authorization requirements according to RMHP's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of 10 standard requests; four requests were concurrent.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	5	Five denials were related to not meeting medical necessity.
Not a covered diagnosis? (Y/N)	0	No denials were related to a noncovered diagnosis.
Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N)	0	No denials were related to the primary diagnosis of intellectual or neurocognitive disorders, or traumatic brain injury.
Out-of-network provider? (Y/N)	4	Four denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	6	Three denials relating to the requesting provider being out of network were also denied because seeing an out-of-network provider when an in-network provider is available is considered a noncovered benefit. The fourth out-of-network denial was also denied due to the requesting service being an experimental treatment (ketamine injections), which is not U.S. Food and Drug Administration (FDA)-approved to treat depression. Two denials were due to lack of clinical documentation provided to RMHP Prime to support medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/N)*	6/10	In four files reviewed, the provider previously worked for an in-network group practice, applied to contract with RMHP independently, but was not yet enrolled with Medicaid. RMHP reported that these four cases should have been approved for continuity of care reasons, but they were administratively denied. (42 CFR §438 allows contracting for a period of 120 calendar days while a provider finalizes Medicaid enrollment.)
Were both the provider and member notified (member in writing)? (M/NM)*	10/10	Members received a written NABD. In three instances, the member received the provider NABD letter instead of a letter written using the member NABD template. Since this letter did notify the member in writing, this element was marked as in compliance for each record. Providers received both a phone call and an NABD using the provider template.

Requirements	M/NM	Comments
Date notice of adverse benefit determination (NABD) sent:		
Was the notice sent within required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All NABDs were sent within the required time frames.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determinations were extended.
Did the NABD include the required content? (M/NM)*	7/10	In three cases reviewed, only the provider NABD letter went to the member and did not include all the required content. Missing content included how to file a written appeal, the 60-day timeline for filing, the right to request a SFH following the adverse appeal resolution and how to do so, how to request an expedited (fast) appeal, reminder of the grievance process, the right to access pertinent records, and the RMHP customer service line information.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases, a qualified clinician made the denial determination.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	2/2	Two requests for service were denied due to lack of adequate documentation to determine medical necessity. RMHP did attempt to contact each provider multiple times for additional information but did not receive any response.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM)*	6/6	Six denials reviewed contained evidence that the peer-to-peer review was offered. Four denials were administrative denials, and peer-to-peer reviews were not applicable.

Requirements	M/NM	Comments
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that the MCO based determinations on nationally recognized criteria (MCG and ASAM) and the MCO contract/benefit package.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	Although the provider NABD template was used for all member notifications, all NABDs were written at an easy-to-understand reading level. RMHP staff members reported that the previous year's MHP data file had been incorrectly pulled; therefore, the practice of not sending NABDs to members using the member template for denials of concurrent requests was not previously discovered. HSAG advised that the same letter can go to both the member and provider as long as the letter contains all required information.
Total Applicable Elements	**78**	
Total Met Elements	**71**	
Score (Number Met / Number Applicable) = %	**91%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)

Y = Yes, **N** = No (**Not Scored, For Information Only**)

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
100	78	71	91%

****Total Score** = Met Elements/Total Applicable Elements

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
200	154	137	89%

*****Total Score =** Met Inpatient + Outpatient Elements/Total Inpatient + Outpatient Applicable Elements

Summary

For acute hospitalizations, RMHP Prime allowed inpatient facilities (both MH and SUD) to admit patients and then notify RMHP of the admission. RMHP staff members reported that, during the prior review period (CY 2020), if notification had not been made within the first 24 hours of the admission, payment was authorized at the time of the notification and forward. For out-of-network facilities, consideration was given to whether the facility knew that the member was eligible for Colorado Medicaid and attributed to RMHP Prime. RMHP staff members reported that, during the CY 2021 review period, this practice was changed and that if the service was found to be medically necessary, RMHP authorized and paid beginning with the admit date. RMHP staff members reported that this change was driven by changes to the NCQA standards and guidelines.

RMHP's prior authorization list, policies, and procedures stated that the following inpatient services were subject to prior authorization and concurrent review requirements during the CY 2021:

Mental Health

- Inpatient acute hospital care (including transfers between facilities)[I-1]
- Acute treatment unit
- Residential treatment (short and long term)

Observation and treatment in a crisis stabilization unit did not require prior authorization.

SUD Services

- Inpatient and WM (3.7) level of care
- High-intensity residential (3.5) level of care
- Low- and medium-intensity residential (3.1 and 3.3) levels of care
- Nonmedical WM (3.2) level of care

[I-1] This represents a change from CY 2020 (transfers between facilities did not require prior authorization if the initial admission was authorized).

The following outpatient services required prior authorization/concurrent review:

Mental Health

- Psychotherapy (60-minute sessions) after the 20th visit [I-2]
- Psychological/neurological testing
- Partial hospitalization program
- MH intensive outpatient program
- BH day treatment
- Out-of-network services (except emergency/crisis care and medically necessary services unavailable within the network)

SUD Services

- SUD intensive outpatient program
- Routine outpatient treatment (60-minute sessions) after the 20th visit
- Out-of-network services (except emergency/crisis care and medically necessary services unavailable within the network)

The following outpatient services did not require prior authorization/concurrent review:

- Psychotherapy (initial evaluation, 30-minute and 45-minute sessions) for MH or SUD treatment
- Psychotherapy (60-minute sessions) for the first 20 visits (MH and SUD services)
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

[I-2] This represents a change from prior authorization required following the 12th visit in CY 2020.

RMHP staff reported no quantitative benefit limitations. RMHP Prime accepted requests for authorization electronically through an "auto-auth" online system, via fax, and by telephone. RMHP Prime did not delegate UM activities. RMHP Prime was in partnership with United. During the CY 2021 review period, RMHP Prime used MCG UR criteria for MH determinations and ASAM levels of care criteria for all SUD determinations. RMHP Prime required its UM staff to pass IRR testing annually with a minimum score of 80 percent.

Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, HSAG found that most files demonstrated that RMHP Prime followed its prior authorization list and UM policies and procedures with regard to which services are subject to prior authorization and requirements for processing requests for services. In four outpatient files reviewed, the provider previously worked for an in-network group practice, applied to contract with RMHP independently, but was not yet enrolled with Medicaid. RMHP reported that these four cases should have been approved for continuity of care reasons, but they were administratively denied. (42 CFR §438 allows contracting for a period of 120 calendar days while a provider finalizes Medicaid enrollment.) All NABDs were written at a reading level that was easy to understand. In all cases except one involving a medical necessity review, RMHP Prime offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. In one inpatient file, HSAG did not find any documentation that a peer-to-peer review was offered to the requesting provider. Board-certified psychiatrists reviewed all medical necessity denials. An RN or master's level clinician made administrative denials. Two inpatient administrative denials were due to the member reaching the 15-day IMD limitation. In denials involving requests for out-of-network care, an MD reviewed for medical necessity to ensure that an equivalent service was available from an in-network provider.

All files demonstrated that RMHP Prime sent the NABD within the required time frames; however, in nine inpatient and three outpatient files, HSAG found that RMHP had sent only an NABD on a provider template to the provider, with a copy to the member. While HSAG found these letters to be written at an easy-to-understand reading level, the provider template did not include all the required information. Missing content included the following:

- How to file an appeal
- The 60-day filing time frame for appeals
- The circumstances under which an expedited appeal may be requested
- The right to request a SFH following receipt of an adverse appeal resolution letter
- The right to access pertinent records and documents
- How to contact RMHP Prime customer service for assistance.

During the MHP interview, RMHP staff members reported that during CY 2021, it was standard practice to only send a provider letter (with a copy to the member) for denials determined via a concurrent review. Staff reported that regarding the prior year's (CY 2020) sample cases for the FY 2020–2021 MHP audit, the data for the sample may have been incorrectly pulled, impeding the discovery of this noncompliant practice. Staff reported that upon discovering in December 2021 that this practice caused RMHP to be out of compliance, RMHP began sending the NABD to members using the member template for all denials, whether concurrent or initial determinations. The member template included all required information.

During the MHP interview, RMHP reported several best practices related to implementation of the new SUD inpatient and residential benefit package in January 2021:

- RMHP's practice transformation team provided monthly training opportunities for providers, which included coding and claims submission procedures.
- RMHP developed provider newsletter content, podcasts, and a video series designed to assist providers in understanding the new SUD benefits.
- RMHP began using the state-developed uniform service request form for SUD services.
- RMHP reported that the SUD care coordinator is a member of the UM team to ensure that members receive the appropriate level of care when a particular level of care is denied.

HSAG found that when RMHP did send the member template, the letters demonstrated a best practice for RMHP. The reason and rationale RMHP added to the letters included:

- The name of the criteria used.
- A brief description of the specific element of the criteria that caused RMHP to find the service not medically necessary.
- Why RMHP found the service to be not medically necessary, specific to the member's situation (e.g., what symptoms RMHP found to be present or not present, related to the criteria).
- The right to request a copy of the criteria (in addition to other documents and records used to make the determination).

Appendix J. Colorado Department of Health Care Policy & Financing Services Requiring Prior Authorization and Policies, by Health Plan

Table J-1 shows the services requiring prior authorization and selected UM policy details through December 31, 2020. The table represents categories of service and may not include all Current Procedural Terminology (CPT) code types.

Table J-1—Services Requiring Prior Authorization and Policies, by Health Plan*

Service Type/Code	RMHP RAE 1	NHP RAE 2	COA RAE 3	HCI RAE 4	COA RAE 5	CCHA RAE 6	CCHA RAE 7	DHMP	RMHP Prime
Inpatient Services (Mental Health)									
Acute Hospitalization	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emergency Admissions	24-hour notifi-cation	24-hour notifi-cation	24-hour notifi-cation	24-hour notifi-cation	24-hour notifi-cation	24-hour notifi-cation	24-hour notifi-cation	24-hour notifi-cation	24-hour notifi-cation
Observation	No	Yes**	No	Yes**	No	No, but subject to Med Nec review	No, but subject to Med Nec review	No	No
Acute Treatment Unit (ATU)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Residential Treatment (RTC) (Long and Short Term) (MH)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Crisis Stabilization Unit (CSU)	No	After the 5th visit per episode of care	No	After the 5th visit per episode of care	No	No	No	No	No

Service Type/Code	RMHP RAE 1	NHP RAE 2	COA RAE 3	HCI RAE 4	COA RAE 5	CCHA RAE 6	CCHA RAE 7	DHMP	RMHP Prime
SUD Services*									
Inpatient (3.7 WM)	No Notifi-cation at some point	No	Yes	No	Yes	Yes (No for 3.7 WM)	Yes (No for 3.7 WM)	Yes	No Notifi-cation at some point
	If not authorized—Subject to medical necessity review								
High-Intensity Residential (3.5)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Non-Medical Detoxification (3.2)	No	No	No	No	No	No	No	No	No
	If not authorized—Subject to medical necessity review								
Low- and Medium-Intensity Residential (3.1/3.3)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Intensive Outpatient (IOP)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Routine Outpatient Tx	60 min. After the 20th visit** 30 and 45 min. No	No	No	No	No	No	No	No	60 min. After the 20th visit** 30 and 45 min. No

Appendix J. Colorado Department of Health Care Policy & Financing Services Requiring Prior Authorization and Policies, by Health Plan

Service Type/Code	RMHP RAE 1	NHP RAE 2	COA RAE 3	HCI RAE 4	COA RAE 5	CCHA RAE 6	CCHA RAE 7	DHMP	RMHP Prime
Outpatient Services									
Psychotherapy (P-Tx) (Initial evaluation)	No	No	No	No	No	No	No	No	No
P-Tx (60 minutes)	After the 20th visit**	After the 25th visit	No**	After the 25th visit	No**	No***	No***	No**	After the 20th visit**
P-Tx (30 or 45 minutes)	No	After the 25th visit	No**	After the 25th visit	No**	No***	No***	No**	No
Psychological/ Neurological Testing	Yes	No**	Yes	No**	Yes	Yes	Yes	Yes	Yes
Assertive Community Treatment (ACT)	No	Yes	No	Yes	No	Yes	Yes	No	No
Partial Hospitalization Program (PHP)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Intensive Outpatient Program—MH (IOP)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
BH Day Treatment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Half-Day Psychosocial Rehab	No	Yes	No	Yes	No	Yes	Yes	No	No
Multisystemic Therapy (MST)	No	Yes	No	Yes	No	Yes	Yes	No	No

Service Type/Code	RMHP RAE 1	NHP RAE 2	COA RAE 3	HCI RAE 4	COA RAE 5	CCHA RAE 6	CCHA RAE 7	DHMP	RMHP Prime
Benefit limitations applied?	No	No	No	No	No	No	No	No	No
Services by Out of Network (OON) Provider	All Services by OON (except emergency/crisis) (cover only if in-network unavailable)								

Acronyms/abbreviations used in this table: ASAM, American Society of Addiction Medicine; MCG, Milliman Clinical Guidelines; Med Nec, medical necessity; MD/DO, Doctor of Medicine/Doctor of Osteopathic Medicine; PCP, primary care provider; PhD, Doctor of Philosophy; RN, registered nurse; WM, withdrawal management.

*SUD inpatient and residential services became a managed care covered benefit as of January 1, 2021.

**Represents a change in policy from the previous review period.

***CCHA reported requiring prior authorization after 20 sessions only from March through August 2021.

Table J-2 shows the UM criteria used by each MCE and policy components.

Table J-2—Criteria Used and Policy Components, by MCE

Criteria/Policies	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	DHMP	Prime
Criteria Used	MH-MCG ASAM (All SUD)	MH-IQ OP SUD-IQ IP/Res SUD-ASAM	MH–IQ ASAM (All SUD)	MH-IQ OP SUD-IQ IP/Res SUD-ASAM	MH–IQ ASAM (All SUD)	MH-MCG ASAM (All SUD)	MH-MCG ASAM (All SUD)	MH–IQ ASAM (All SUD)	MH-MCG ASAM (All SUD)
Peer-to-Peer Review	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
IRR Testing/Passing Score	80%	80%	90%	80%	90%	90%	90%	90%	80%
Delegation of UM	No	Yes to Beacon	No	No Beacon/ Partner	No	No Anthem/ Partner	No Anthem/ Partner	Yes to COA	No
Level of Reviewer for Medical Necessity Denial Determinations	MD/DO All Services Pharm-D or PhD BH for specified services	MD/DO All Services PhD for non-24-hour level of care	MD/DO All Services	MD/DO All Services PhD for non-24-hour level of care	MD/DO All Services	MD/DO All Services	MD/DO All Services	MD/DO All Services	MD/DO All Services Pharm-D or PhD BH for specified services

Appendix J. Colorado Department of Health Care Policy & Financing Services Requiring Prior Authorization and Policies, by Health Plan

Criteria/Policies	RAE 1	RAE 2	RAE 3	RAE 4	RAE 5	RAE 6	RAE 7	DHMP	Prime
Level of Reviewer for Administrative Denials (Admin)	RN or clinician All Admin	MD/DO All Services PhD for non-24-hour level of care	MD/DO for non-covered Services Non-clinical for Other Admin	MD/DO All Services PhD for non-24-hour level of care	MD/DO for non-covered Services Non-clinical for Other Admin	RN or clinician All Admin		MD/DO for non-covered Services Non-clinical for Other Admin	RN or clinician All Admin

IQ = InterQual