COLORADO
Department of Health Care Policy & Financing

FY 2023–2024 Mental Health Parity Compliance Audit Report

March 2024

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

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose of This Report

Pursuant to Colorado's House Bill (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,"[1-1] the Colorado Department of Health Care Policy & Financing (the Department) has requested that Health Services Advisory Group, Inc. (HSAG), Colorado's EQRO, perform an assessment of Colorado's seven Regional Accountable Entities (RAEs) and two Medicaid managed care organizations (MCOs)—collectively referred to hereafter as "health plans" or "managed care entities (MCEs)"—to determine whether each MCE has implemented and followed its own written policies, procedures, and organizational processes related to utilization management (UM) regulations. The Department chose to meet this objective through a review of 10 inpatient and 10 outpatient adverse benefit determination (ABD) records for each Medicaid MCE (to the extent full samples were available). Through record reviews, HSAG has determined whether each MCE demonstrated compliance with specified federal and State managed care regulations as well as its own policies and procedures. For additional information regarding the background of this project and the methodology used, please refer to Section 3—Background and Methodology.

Overview of Results

Overall, the MCE average score for the mental health parity (MHP) audit decreased slightly from 96 percent in the calendar year (CY) 2022 record reviews to 95 percent in CY 2023 record reviews.[1-2] In both CY 2022 and 2023, scores for the MCEs ranged from 91 percent to 100 percent, which demonstrated strong adherence to their prior authorization policies and procedures. Two MCEs showed consistent performance with total scores of 91 percent and 100 percent in both years. Three MCEs demonstrated improved overall performance in CY 2023 as compared to CY 2022; however, the remaining four MCEs' total scores demonstrated a decline in performance. The decline for the four MCEs was minimal, with a decrease of three-percentage points or less in CY 2023 compared to CY 2022. For additional information about the MCE findings, assessment, opportunities for improvement, and recommendations, please refer to Section 2—Findings and Assessment. For individual MCE findings, opportunities for improvement, and recommendations, please refer to Appendix A through Appendix I.

[1-1] 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: August 1, 2023.

[1-2] Comparison of results from year to year and applicability of results to each health plan's general population should be considered with caution, as sample sizes were not statistically significant.

2. Findings and Assessment

Findings

HSAG evaluated each MCEs based on whether the MCE followed selected regulations for making authorization determinations and for providing notices of adverse benefit determination (NABDs), as well as whether the MCE followed its own policies and procedures related to these regulations and which services require prior authorization. While all MCEs must follow the State and federal regulations, each MCE 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 MCE.

Table 2-1 presents each MCE's and the statewide aggregate percentage of compliance with elements evaluated during the review of ABD records. For individual MCE scoring details, see Appendix A through Appendix I.

Table 2-1—Summary of Scores

MCE		2022 Total Score	Category of Service	Compliance Score	2023 Total Score
RAEs—Mental Health (MH)/Substance Use Disorder (SUD) Services					
Region 1	Rocky Mountain Health Plans (RMHP)	99%	Inpatient	96%	97%v
			Outpatient	99%	
Region 2	Northeast Health Partners (NHP)	91%	Inpatient	89%	91%~
			Outpatient	93%	
Region 3	Colorado Access (COA)	96%	Inpatient	95%	95%v
			Outpatient	95%	
Region 4	Health Colorado, Inc. (HCI)	92%	Inpatient	97%	96%^
			Outpatient	95%	
Region 5	Colorado Access (COA)	94%	Inpatient	93%	95%^
			Outpatient	98%	
Region 6	Colorado Community Health Alliance (CCHA)	97%	Inpatient	95%	96%v
			Outpatient	96%	
Region 7	Colorado Community Health Alliance (CCHA)	92%	Inpatient	94%	95%^
			Outpatient	96%	

MCE	2022 Total Score	Category of Service	Compliance Score	2023 Total Score
MCOs—MH/SUD and Medical/Surgical (M/S) Services				
Denver Health Medical Plan (DHMP)	97%	Inpatient	94%	94%∨
		Outpatient	95%	
Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)	100%	Inpatient	100%	100%~
		Outpatient	100%	
Total All MCEs	**96%**	**Inpatient**	**95%**	**95%∨**
		Outpatient	**96%**	

∨ Indicates that the score decreased compared to the previous review year.

∧ Indicates that the score increased compared to the previous review year.

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

Assessment

Overall, the statewide average score for the MHP audit decreased from 96 percent in the CY 2022 record reviews to 95 percent in the CY 2023 record reviews. Two MCEs showed consistent performance (NHP RAE 2 and RMHP Prime, with a 91 percent and a 100 percent total score in both years, respectively). Three MCEs improved overall performance (HCI RAE 4: 92 percent to 96 percent, COA RAE 5: 94 percent to 95 percent, and CCHA RAE 7: 92 percent to 95 percent). The remainder of the MCEs' total scores declined in performance as follows:

- RMHP RAE 1: 99 percent to 97 percent
- COA RAE 3: 96 percent to 95 percent
- CCHA RAE 6: 97 percent to 96 percent
- DHMP: 97 percent to 94 percent

Strengths

All MCEs used nationally recognized utilization review criteria as follows:

- RMHP RAE 1 and Prime used Milliman Clinical Guidelines (MCG) utilization review 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 utilization review criteria for MH determinations and ASAM level of care criteria for all SUD determinations.
- COA RAEs 3 and 5 and DHMP used InterQual utilization review criteria for MH determinations and ASAM level of care criteria for all SUD determinations.

- CCHA RAEs 6 and 7 used MCG utilization review criteria for MH determinations and ASAM level of care for all SUD determinations.

All MCEs 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 and RMHP Prime required an 80 percent IRR passing score, and NHP RAE 2, COAs RAE 3 and 5, HCI RAE 4, CCHA RAEs 6 and 7, and DHMP required an IRR passing score of 90 percent.

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

All MCE policies and procedures described an appropriate level of expertise for determining medical necessity determinations. All record reviews demonstrated that all MCEs consistently documented the individual who made the adverse benefit determination. The documentation in the files demonstrated that in all cases, the individual who made the determination possessed the required credentials and expertise to do so.

Five of the nine MCEs were fully compliant in notifying the provider of the determination within the required time frame. Providers were notified of the denial determination by telephone, secure email, fax, and/or a copy of the member's notice of adverse benefit determination (NABD).

Six of the nine MCEs demonstrated consistency between the reason for the denial determination stated in the NABDs sent to members and the reason for the determination that was documented in the UM system.

All MCEs used a Department-approved NABD letter template, which included the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the MCE in filing, access to pertinent records, and the reason for the denial. Additionally, five of the nine MCEs consistently listed all required ASAM dimensions for SUD inpatient and residential denials and how the dimensions were considered when making the denial determinations.

Overview of Analysis

1. Eight of the nine MCEs were out of compliance for not sending the NABD to the member within the required time frame, despite having accurate policies and procedures. HSAG found noncompliance in:
   - One of 20 records for RMHP RAE 1:
     - One record demonstrated that RMHP RAE 1 did not send the member an NABD, and the member was only copied on the provider notification letter.

- Five of 20 records for NHP RAE 2:
  - Two inpatient SUD records did not meet the Department's requirement for timely written notice to the member within 72 hours.
  - Two inpatient records and one outpatient record demonstrated that NHP RAE 2 did not send the member an NABD after the denial determination.
- Two of 20 records for COA RAE 3:
  - One SUD inpatient record and one MH inpatient record did not meet the Department's required 72-hour time frame and 10-calendar-day time frame, respectively, for notice to the member.
- Three of 20 records for HCI RAE 4:
  - Two inpatient records demonstrated that HCI did not send the members, who were Special Connections members, an NABD within the 24-hour time frame required by the Department.
  - In one outpatient record, HSAG found that HCI did not send notice of the denial within 10 calendar days as required by 10 Code of Colorado Regulations (CCR) 2505-10 §8.209.
- Four of 20 records for COA RAE 5:
  - Two concurrent SUD inpatient records did not meet the requirement for timely written notice to the member within 72 hours of the request for service as required by 42 CFR §438.404. Additionally, two inpatient records demonstrated that COA did not send the members, who were Special Connections member, an NABD within the 24-hour time frame required by the Department.
- Two of 20 records for CCHA RAE 6:
  - Two MH inpatient records demonstrated that CCHA did not send the member timely written notice of the NABD within the required time frame.
- Two of 20 records for CCHA RAE 7:
  - One SUD inpatient record did not meet the Department's requirement for timely notice to the member within 72 hours of the request for service.
  - One MH outpatient record did not meet the requirement to send notice of the denial within 10 calendar days as required by 10 CCR 2505-10 §8.209.
- One of 20 records for DHMP:
  - One inpatient SUD record did not comply with the Department's required 72-hour time frame for written notice to the member following a request for service.

2. Four of the nine MCEs did not consistently include all required ASAM dimensions in the NABD to demonstrate to the member how each of the dimensions were used when making the denial determination. HSAG found:
   - One inpatient SUD NABD for COA RAE 3 did not include the required ASAM dimensions.
   - One inpatient SUD NABD for CCHA RAE 6 only listed the ASAM dimensions that were not met.
   - Two inpatient SUD NABDs for CCHA RAE 7 only listed the ASAM dimensions that were not met.

- One inpatient SUD NABD for DHMP only listed three of the six required ASAM dimensions.

3. Six of the nine MCEs did not follow outlined policies and procedures for offering a peer-to-peer review to the requesting provider before issuing a medical necessity denial determination.
   - One outpatient record for NHP RAE 2, COA RAE 3, and DHMP, and two outpatient records for COA RAE 5, did not contain evidence that a peer-to-peer review was offered to the requesting provider.
   - One inpatient record and three outpatient records for CCHA RAE 6 indicated that a peer-to-peer review was offered to the requesting provider, but occurred after the medical necessity determination and issuance of the NABD to the member.
   - One inpatient record for CCHA RAE 7 did not demonstrate that a peer-to-peer review was offered. Additionally, one outpatient record indicated that a peer-to-peer review was offered to the requesting provider, but after the medical necessity determination and issuance of the NABD to the member.

4. Six of the nine MCEs (RMHP RAE 1, NHP RAE 2, COA RAE 3, HCI RAE 4, CCHA RAE 7, and DHMP) did not consistently demonstrate outreach to the requesting provider to request additional information before issuing a denial related to a lack of adequate documentation to determine medical necessity.

5. During the denial record review, HSAG noted common findings across multiple MCEs regarding member communication standards, which included:
   - Use of medical jargon and terminology without plain language explanations to further simplify the NABD for the member.
   - Minor typos and use of acronyms without spelling the acronym out in its entirety the first time it is used in the NABD (e.g., Intensive Outpatient Program [IOP]).
   - Not stating member-specific information to provide background information to the member (e.g., what symptoms were found to be present or not present) or as best practice, referencing in the NABD the MCE criteria being used (i.e., InterQual) in making the denial determination.

Opportunities for Improvement and Recommendations

HSAG recommends that the Department:

1. Work with the MCEs to develop and implement ongoing staff training and monitoring to ensure adherence to sending the member an NABD within the required time frames.
2. Monitor the MCEs' compliance with using all the required ASAM dimensions in the NABDs to ensure clear and consistent communication with the members regarding an SUD inpatient or residential denial determination and to comply with Colorado Senate Bill (SB) 21-137.
3. Follow-up with the six MCEs that did not adhere to their internal peer-to-peer review procedures before issuing a medical necessity denial determination to the member or did not thoroughly document in the record whether a peer-to-peer review was offered. Additionally, HSAG

recommends that the Department review individual findings for trends and evidence of ongoing issues and consider corrective action plans, when appropriate.

4. Work with the MCEs to increase outreach and consultation with the requesting provider to obtain additional information when there is lack of adequate documentation to determine medical necessity.
5. Monitor the MCEs' implementation of member communication best practices in the NABD template by including member-specific information and references to the clinical criteria (InterQual or ASAM) used. For example, what symptoms the MCE found to be present or not present related to the criteria. Additionally, the MCEs should enhance oversight procedures to ensure that a plain language explanation is included next to any medical jargon or terminology in the NABD to better align with the *Health First Colorado Member Communications Standards* and perform a spell-check of the NABD.

3. Background and Methodology

Background

In fiscal year (FY) 2019–2020, the Department contracted with a vendor to perform a comparative analysis of policies, procedures, and organizational practices related to Colorado's seven RAEs and two MCOs that serve Colorado's Medicaid population for compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), pursuant to Title 42 of the Code of Federal Regulations (42 CFR) 438 Subpart K, and Colorado's Behavioral Health Care Coverage Modernization Act, pursuant to Colorado HB 19-1269. This analysis included a comparison of MH and SUD services provided by the RAEs to 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 began contracting with HSAG to annually review each Medicaid health plan's[3-1] 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 2023–2024 findings from that audit of calendar year (CY) 2023 denial records for each Medicaid health plan.

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 MCE submit documents including UM policies and procedures (as well as any related protocols, workflow diagrams, or program descriptions) and UM criteria used for the

[3-1] The definition of health plan is any of the following: managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management entity (PCCM-E). Colorado's RAEs hold a contract with the Department as both a PIHP and a PCCM-E. For the purposes of this report, health plan refers to Medicaid MCOs and Colorado's RAEs.

selected ABDs. In addition, HSAG requested that each MCE submit a complete list of inpatient and outpatient ABDs made between January 1, 2023, and October 31, 2023. Using a random sampling technique, HSAG selected 20 ABDs for each MCE (10 inpatient files and 10 outpatient files). The MCEs then submitted to HSAG all records and pertinent documentation related to each ABD chosen. All data and file transfers were completed using HSAG's Secure 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 MCE, which may have also included UM documentation system notes, NABDs, and other pertinent member and provider communications.

3. Telephonic Interviews

HSAG collaborated with the MCEs and the Department to schedule and conduct telephonic interviews with key MCE 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 MCE, and an aggregate statewide denials record review compliance score.

5. Reporting

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

Appendix A. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 1—Rocky Mountain Health Plans

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 16, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 • Five requests for MH services • Five requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, acute treatment unit, psychiatric residential treatment facility, qualified residential treatment program, ASAM 3.5 clinically managed high-intensity residential, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM [withdrawal management] medically monitored withdrawal management. Diagnoses included major depressive disorder, post-traumatic stress disorder, attention-deficit hyperactivity disorder, stimulant dependence, other stimulant dependence, cannabis dependence, alcohol dependence, opioid dependence, unspecified psychosis (not due to a substance or known physiological condition), generalized anxiety disorder, other psychoactive substance abuse, bipolar disorder, and oppositional defiant disorder. Presenting symptoms included anxiety, auditory and visual hallucinations, insomnia, agitation, depression, restlessness, chronic pain, body aches, hopelessness, cravings, elevated pulse rate, racing thoughts, anhedonia, impaired concentration, memory

Requirements	M/NM	Comments
		problems, irritability, emotional numbness, headaches, mood swings, body sweats, impaired insight and judgement, suicidal ideation, impulsive behaviors, and binge-eating behaviors.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 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 acute treatment unit, psychiatric residential treatment facility, and qualified residential treatment program through August 31, 2023. Two records requested ASAM 3.7 WM level of care, which do not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of six standard requests, three standard concurrent requests, and one retrospective denial.
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 authorization ending, or a new request for payment resulting in a post-service (retrospective) review.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
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/NM)*	10/10	In all cases, HSAG found that RMHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, and/or copy of the NABD within the required time frame.

Requirements	M/NM	Comments
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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 demonstrated that the NABD was sent within the required time frame. In one record reviewed, the member was only copied on the provider notice letter.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	9/10	The NABDs provided used a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, and access to pertinent records. The NABDs provided also included the reason for denial, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable. In one record reviewed, the member was only copied on the provider notice letter, and it did not include all the required content that is in an NABD.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases, 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)*	8/8	Eight denials reviewed contained evidence that a peer-to-peer review was offered. For two denials, peer-to-peer was not applicable due to the parent/guardian requesting a residential

Requirements	M/NM	Comments
		treatment center for the member or due to a post-service (retrospective) request.
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 or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	9/10	Nine NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**78**	
Total Met Elements	**75**	
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**)

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 16, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for services included partial hospitalization program, electroconvulsive therapy, MH intensive outpatient program, SUD intensive outpatient program, out-of-network psychotherapy (60-minute), and BH day treatment. Diagnoses included major depressive disorder, post-traumatic stress disorder, cannabis use disorder, bipolar disorder, bipolar II disorder, alcohol use disorder, borderline personality disorder, generalized anxiety disorder, alcohol dependence, attention-deficit hyperactivity disorder, obsessive compulsive disorder, and other stimulant dependence. Presenting symptoms included anxiety, depression, hopelessness, helplessness, anhedonia, insomnia, stress, obsession/compulsion, intrusive thoughts, poor self-esteem/image, passive suicidal ideation, eating behavior issues, tremors, hypersensitivity, difficulty concentrating, and restlessness.

Requirements	M/NM	Comments
Is prior authorization required according to 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 prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of two standard requests and eight 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.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	1	One denial was related to a request for an out-of-network provider when there were in-network providers available.
Other (describe): (Y/N)	1	One denial had limited submitted clinical information to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that RMHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, and/or copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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 records demonstrated that 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 determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, and access to pertinent records. The NABDs provided also included the reason for denial, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determination 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)*	0/1	One request for service was denied due to lack of documentation to determine medical necessity. The record contained no evidence of RMHP reaching out to the provider for additional information, and during the interview, RMHP staff members confirmed additional outreach did not occur.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All records contained evidence that a peer-to-peer review was offered.
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 or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**81**	
Total Met Elements	**80**	
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	78	75	96%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
100	81	80	99%

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

Summary

RMHP did not report any quantitative benefit limitations. RMHP accepted requests for authorization by fax, secure email, and telephone. RMHP did not delegate UM activities. RMHP was in partnership with United Healthcare.

Inpatient Services

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 2023:

MH Services

- Acute hospitalization
- Acute treatment unit (prior authorization no longer required after August 31, 2023)

- Residential treatment center (short- and long-term)
  - Effective August 31, 2023, RMHP no longer requires prior authorization for acute treatment unit, qualified residential treatment programs (QRTP), and psychiatric residential treatment facilities (PRTF), with the exception of treatment for an eating disorder.

For emergency admission, RMHP allowed 24 hours for notification of the admission. Observation did not require prior authorization, but RMHP did request a call from the admitting facility. Crisis stabilization unit services did not require prior authorization.

SUD Services

- Inpatient medically monitored (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

Non-medical detoxification (3.2 WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

The following outpatient services required prior authorization/concurrent review:

MH Services

- Electroconvulsive therapy
- Partial hospitalization program
- Intensive outpatient program
- Behavioral health (BH) day treatment
- Out-of-network services (except emergency/crisis care)

SUD Services

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

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)
- Psychological/neurological testing
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

Strengths

RMHP demonstrated an overall score of 97 percent. During the CY 2023 review period, RMHP used MCG utilization review criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. RMHP required its UM staff to pass IRR testing annually with a minimum score of 80 percent. During the MHP interview, RMHP staff members reported the last IRR testing was conducted in November 2023 and all participants passed with a minimum score of 80 percent or better.

Based on the review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, 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 requirements for processing requests for services. RMHP staff members noted during the interview an increase in average length of stay for SUD low-intensity residential (3.1) and high-intensity residential (3.5) levels of care, and in an effort to decrease provider administrative burden and improve member care, RMHP extended initial authorization from 14 days to 30 days beginning in April 2023. RMHP used nationally recognized utilization review criteria (MCG or ASAM) for all records reviewed. HSAG found that RMHP made the denial determinations within the required time frame and providers were notified of the denial determinations by telephone, secure email, and/or a copy of the NABD for all

records reviewed. Additionally, all records except one demonstrated that the member was sent the NABD within the required time frame.

In all cases reviewed, the denial determination was made by a qualified clinician and contained evidence that a peer-to-peer review was offered to the requesting provider, if applicable. All records demonstrated that the NABD reason for the denial that was consistent with the reason documented in the UM system. RMHP's NABDs included the required content such as the member's appeal rights, rights to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, and access to pertinent records. Additionally, the NABDs included member-specific information and contact information for providers in the area for alternative treatments/services, if applicable.

During the MHP interview, RMHP reported working one-on-one with providers and continuing provider training on submission of the proper documentation for MH and SUD review requests. RMHP indicated a positive provider response to these trainings. RMHP additionally reported enhancing documentation of outreach to the member after discharge from ASAM level of care treatments/services so that case managers could better serve the member. Staff members also reported conducting case management meetings while members were in residential/inpatient treatment level of care to increase engagement in case management services. Additionally, RMHP staff members also reported having dedicated SUD case managers and peer support specialists who follow up with the member post-discharge.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Implementing ongoing staff member training to ensure the member is issued an NABD, including when issuing a retrospective medical necessity denial.
- Enhancing monitoring procedures to ensure that additional outreach to the requesting provider occurs when adequate documentation is not received.
- As a best practice, including a plain language explanation next to any medical terminology, as two NABDs contained medical jargon/terminology.

Appendix B. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 2—Northeast Health Partners

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 19, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 • Three requests for MH services • Seven requests for SUD services
Service requested/indication:		Requests for service included inpatient hospitalization, MH residential treatment center, acute treatment unit, ASAM 3.1 clinically managed low-intensity residential, ASAM 3.2 WM clinically managed residential withdrawal management, ASAM 3.5 clinically managed high-intensity residential, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored inpatient withdrawal management. Diagnoses included major depressive disorder, alcohol use disorder, cannabis dependence, generalized anxiety disorder, panic disorder, cannabis use disorder, bipolar disorder, disruptive mood dysregulation disorder, conduct disorder, post-traumatic stress disorder, stimulant use disorder, and opioid use disorder. Presenting symptoms included anxiety, depression, auditory and visual hallucinations, agitation, cold sweats, cravings, headaches, body aches, pessimistic thoughts, memory issues, restlessness, sensitivity, poor judgement, dysphoria, ambivalence, lack of engagement, nightmares, intrusive memories, oppositional and

Requirements	M/NM	Comments
		defiant behaviors, aggression, impulsivity, insomnia, poor appetite, and suicidal ideations.
Is prior authorization required according to 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. Two records requested ASAM 3.2 WM, and one record requested ASAM 3.7 WM, neither of which require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of four standard requests, five standard concurrent requests, and one retrospective request.
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 a post-service request (retrospective) for payment of services not yet reviewed for medical necessity.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
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 adequate information to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that Carelon (NHP's delegate) followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, and/or copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/NM)*	6/10	Six records demonstrated that the NABD was sent within the required time frame. Two records did not meet the SUD service

Requirements	M/NM	Comments
• 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		time frame requirement for written notice to the member within 72 hours, and two records demonstrated the member was not sent an NABD after the denial determination.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	8/10	The NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, the reason for the denial, and a recommended alternative level of care, if applicable. In two records, an NABD was not sent to the member.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases, 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)*	0/1	One request for service was denied due to lack of adequate documentation to determine medical necessity. Carelon did not reach out to the requesting provider for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	8/8	Eight records contained evidence that a peer-to-peer review was offered. For two denials, peer-to-peer was not applicable due to the parent/guardian requesting a residential treatment center for the member or due to a post-service (retrospective) request.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that the RAE based the determinations on nationally recognized criteria (InterQual and ASAM).

Requirements	M/NM	Comments
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	8/10	Eight NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**79**	
Total Met Elements	**70**	
Score (Number Met / Number Applicable) = %	**89%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)
Y = Yes, **N** = No (**Not Scored, For Information Only**)

Appendix B. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 2—Northeast Health Partners

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 19, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for service included electroconvulsive therapy, MH intensive outpatient program, SUD intensive outpatient program, partial hospitalization program, out-of-network psychotherapy (60-minute), and partial hospitalization program. Diagnoses included major depressive disorder, post-traumatic stress disorder, generalized anxiety disorder, conduct disorder, trauma and stressor related disorder, attention-deficit hyperactivity disorder, eating disorder, autism spectrum disorder, opioid use disorder, bipolar I disorder, and mixed obsessional thoughts and acts disorder. Presenting symptoms included depression, suicidal ideation, functional impairment, sadness, anxiety, concentration issues, out-of-control behavior, excessive worry, separation fears, hyperventilation, irritability, mood reactivity, poor self-care, conduct issues, difficulty expressing emotions, low appetite, cravings, mood swings, thoughts of harming others, self-harming behaviors, low self-esteem, eating issues, weight loss, auditory and visual hallucinations, insomnia, and low motivation.

Requirements	M/NM	Comments
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 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 and seven 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.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	1	One denial was related to the request for an out-of-network provider when there were in-network providers available.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	9/10	In nine cases reviewed, HSAG found that Carelon (NHP's delegate) followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, and/or a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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	Nine records demonstrated that the NABD was sent within the required time frame. In one record, Carelon did not send an NABD to the member.

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 determination time frames were extended.
Did the NABD include the required content? (M/NM)*	9/10	The NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, the reason for the denial, and a recommended alternative level of care, if applicable. In one record, an NABD was not sent to the member.
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)*	9/10	Nine records contained evidence that a peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	9/10	Most records contained evidence that the RAE based determinations on nationally recognized criteria (InterQual or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	9/10	Nine NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**80**	
Total Met Elements	**74**	
Score (Number Met / Number Applicable) = %	**93%**	

***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	70	89%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
100	80	74	93%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	159	144	91%

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

Summary

NHP delegated UM activities to Carelon (formerly Beacon Health Options). Carelon staff members reported no quantitative benefit limitations. Carelon, on behalf of NHP, accepted requests for authorization electronically through Provider Connect (an online platform used primarily by inpatient and SUD providers) and via fax, email, and telephone.

Inpatient Services

Carelon's prior authorization list, policies, and procedures stated that the following inpatient services were subject to prior authorization and/or concurrent review requirements during CY 2023:

MH Services

- Acute hospitalization
- Observation
- Acute treatment unit
- Residential treatment center (short- and long-term)
  - Includes qualified residential treatment program (QRTP) and psychiatric residential treatment facility (PRTF)
- Crisis stabilization unit (after the fifth visit per episode of care)

For acute hospitalizations, NHP required authorization. For emergency admissions, NHP allowed 24 hours for notification of the admission.

SUD Services

- Inpatient medically monitored (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

Non-medical detoxification (3.2 WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

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

MH Services

- Electroconvulsive therapy
- Assertive community treatment
- Partial hospitalization program
- Intensive outpatient program
- BH day treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy
- Out-of-network services (except emergency/crisis care)

SUD Services

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

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, 60-minute sessions)
- Psychological/neuropsychological testing

Strengths

NHP demonstrated an overall score of 91 percent. During the CY 2023 review period, Carelon used InterQual utilization review criteria for all MH utilization review determinations and ASAM level of care criteria for all SUD determinations. Carelon required its UM staff members to pass IRR testing annually with a minimum score of 90 percent, which was a 10 percent increase in the minimum score compared to the last review period (CY 2022). Carelon reported that the last IRR testing occurred in summer 2023 and not all UM staff members passed, but after additional training and testing, all UM staff members passed with scores of 90 percent or better.

Based on the review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, NHP demonstrated that Carelon used nationally recognized utilization review criteria (InterQual or ASAM) and documented which criteria were used for all determinations except in one outpatient record. In all cases reviewed except one, HSAG also found that Carelon followed its policies and procedures related to which services require prior authorization and used nationally recognized UM criteria. HSAG found that Carelon notified providers of the denial determinations by telephone, secure email, and/or a copy of the NABD within the required time frame for all records reviewed. Most records demonstrated that the member was sent the NABD within the required time frame; however, two records demonstrated the NABD was not sent within 72-hour time frame requirement. Additionally, three members did not receive an NABD after the denial determination. Carelon did not use an extension in any of the records reviewed.

HSAG found that in all cases reviewed, the denial determination was made by a qualified clinician. In all applicable cases, except one outpatient case, Carelon provided evidence that a peer-to-peer review was offered to the requesting provider.

One inpatient record was denied due to lack of adequate documentation to determine medical necessity and did not include documentation of outreach to the requesting provider for additional information. Carelon staff members confirmed during the MHP interview that additional outreach did not occur. In all cases except three, the records demonstrated that the NABD reason

for the denial was consistent with the reason documented in the UM system. The NABDs contained the required information, such as the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, the reason for the denial, and a recommended alternative level of care, if applicable. Inpatient SUD NABDs also included the required language regarding how each ASAM dimension was considered when determining medical necessity.

During the NHP interview, Carelon made HSAG aware of recent changes, which included hiring a new staff member to lead the process for reviewing Independent Assessments (IAs) for qualified residential treatment program placements. The new role would provide additional support and assistance to UM and care management staff members, including working with the parent/guardian and obtaining additional information. Additionally, Carelon brought on a dedicated medical doctor (MD) for the Colorado contract for utilization review who specifically understands Colorado regulations and standards. During the interview, NHP shared that SUD entities within one county collaborated to better streamline services, offer various services to members needing different levels of care, increase effort to improve access to care, and support a full continuum of care for members.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Enhancing Carelon's monitoring mechanisms to ensure that the member is issued an NABD within the required time frame.
- Following established policies and procedures to ensure that requesting providers are consistently offered a peer-to-peer review.
- Ensuring all denial determinations due to medical necessity use established utilization review criteria (InterQual or ASAM) and that staff members document in the UM system the criteria that was used.
- Enhancing monitoring procedures to ensure that additional outreach occurs with the requesting provider when adequate documentation is not received.

Appendix C. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 3—Colorado Access

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 18, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 • Four requests for MH services • Six requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, acute treatment unit, psychiatric residential treatment facility, ASAM 3.1 clinically managed low-intensity residential, ASAM 3.5 clinically managed high-intensity residential, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored withdrawal management. Diagnoses included generalized anxiety disorder, major depressive disorder, post-traumatic stress disorder, alcohol use disorder, attention-deficit disorder, attention-deficit hyperactivity disorder, schizoaffective disorder, obsessive compulsive disorder, alcohol dependence, other stimulant dependence, bipolar disorder, unspecified personality disorder, stimulant use disorder, and polysubstance dependence. Presenting symptoms included depression, suicidal ideation, anxiety, labile mood, decreased sleep, ambivalent attitude, impaired insight and judgement, nightmares, flashbacks, hypervigilance, insomnia, fatigue, low energy, irritability, hopelessness, anhedonia, concentrations issues, intermittent

Requirements	M/NM	Comments
		cravings and urges, aggression towards others, anger, repetitive thoughts, mood changes, hyperactivity, panic attacks, and phobias.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All records demonstrated that the services requested were all 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 and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of two standard requests, six 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 authorization ending, or post-service requests for payment and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
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 adequate documentation to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, HSAG found that COA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	9/10	Providers received a phone call, secure email, and/or copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/NM)*	8/10	Eight records demonstrated that the NABD was sent within the required time frame. One record did not meet the SUD service time

Requirements	M/NM	Comments
• 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		frame requirement for written notice to the member within 72 hours and a second record did not meet the standard residential MH service time frame of 10 calendar days including the additional 14 calendar day extension.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	1/1	COA extended one denial determination to obtain additional information. An extension letter was sent to the member within the requested time frame and included the required content.
Did the NABD include the required content? (M/NM)*	9/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a brief area to address the reason for denial. However, in one ASAM SUD denial, the NABD did not list each of the required ASAM dimensions considered in making the determination.
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)*	1/1	One request was denied due to lack of adequate documentation to determine medical necessity. COA did attempt to reach the provider to obtain the additional documentation.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	7/7	Seven cases reviewed contained evidence that a peer-to-peer was offered. In two retrospective denials, peer-to-peer was not applicable and in one denial, the member had already been discharged.
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).

Requirements	M/NM	Comments
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**79**	
Total Met Elements	**75**	
Score (Number Met / Number Applicable) = %	**95%**	

***Scored Elements**

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

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

Appendix C. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 3—Colorado Access

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 18, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request:		The 10 outpatient records HSAG reviewed consisted of: • Nine adult records • One child/adolescent record • 10 requests for MH services
Service requested/indication:		Requests for services included psychological/neuropsychological testing, partial hospitalization program, MH intensive outpatient program, out-of-network psychological evaluation and psychotherapy (60-minute), and BH day treatment. Diagnoses included major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder, attention-deficit hyperactivity disorder, borderline personality disorder, bipolar disorder, bipolar II disorder, dyslexia, alcohol use disorder, unspecified psychosis not due to a substance or know physiological condition, stimulant use disorder, chronic post-traumatic stress disorder, other stimulant abuse, and cannabis use disorder. Presenting symptoms included depression, anxiety, labile mood, inattention, issues with comprehension and auditory processing, fatigue, struggle to function, insomnia, concentration issues, mania, interrupted sleep, nightmares, agitation, poor impulse control, unwanted thoughts, jitters, anhedonia, sleep disturbances, panic attacks, decreased appetite, anger, paranoia, difficulty controlling emotional, self-harming behaviors, alcohol use, and acting out behaviors.

Requirements	M/NM	Comments
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services required 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 eight standard requests and two 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 authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	1	One denial was related to the request for an out-of-network provider when there were in-network providers available.
Other (describe): (Y/N)	1	One denial was related to lack of adequate documentation to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	9/10	In nine cases reviewed, HSAG found that COA followed policies and procedures related to which services require prior authorization and used nationally recognized criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, and/or copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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 records demonstrated that 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 determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a brief area to address the reason for 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)*	0/1	One request was denied due to lack of adequate documentation to determine medical necessity and there was no additional outreach to the requesting provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/10	Nine records reviewed contained evidence that a peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	9/10	Nine records contained evidence that COA based determinations on nationally recognized criteria (InterQual).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**81**	
Total Met Elements	**77**	
Score (Number Met / Number Applicable) = %	**95%**	

***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	75	95%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
100	81	77	95%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	160	152	95%

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

Summary

COA did not report any quantitative benefit limitations and did not delegate UM activities. COA accepted requests for authorization through an online portal and via fax, telephone, and secure email.

Inpatient Services

COA's prior authorization list, policies, and procedures stated that the following inpatient services were subject to authorization and concurrent review requirements during CY 2023:

MH Services

- Acute hospitalization
- Acute treatment unit
- Residential treatment center (short- and long-term)
  - Includes qualified residential treatment programs (QRTP) and psychiatric residential treatment facilities (PRTF)

For acute hospitalizations, COA required prior authorization. For emergency admissions, COA allowed 24 hours for notification of the admission. Crisis stabilization unit and observation services 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

Non-medical detoxification (3.2 WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

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

MH Services

- Psychological/neuropsychological testing
- Electroconvulsive therapy
- Partial hospitalization program
- Intensive outpatient program
- BH day treatment
- Out-of-network services (except emergency/crisis care)

SUD Services

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

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

Strengths

COA RAE 3 demonstrated an overall score of 95 percent. During the CY 2023 review period, COA used InterQual utilization review 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 or better. During the MHP interview, COA staff members stated that the last IRR testing was conducted in September 2023 and two staff members did not pass, but after additional training and testing, the two staff members passed with the minimum score.

Based on the review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, HSAG found that all files except one demonstrated that COA followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization requirements for processing requests for services. In all files except one, COA used nationally recognized utilization review criteria (InterQual or ASAM). Additionally, COA utilized the *ASAM Criteria Navigator* by InterQual for ASAM determinations, and HSAG determined this to be a best practice. HSAG found that COA made the denial determinations within the required time frame, and providers were notified of the denial determinations in all cases except one. Providers were notified by telephone, secure email, and/or a copy of the NABD. All records except one inpatient record demonstrated that the member was sent the NABD within the required time frame. COA utilized an extension in one inpatient record to obtain additional documentation. HSAG found that the extension letter was sent to the member within the required time frame and included the required content.

In all cases reviewed, the denial determination was made by a qualified clinician. In all applicable cases except one, the records contained evidence that a peer-to-peer review was offered to the requesting provider.

One inpatient record and one outpatient record were denied due to lack of adequate documentation to determine medical necessity; however, one record did not include documentation of outreach to the requesting provider for additional information. COA staff members confirmed during the MHP interview that additional outreach did not occur. All records demonstrated that the NABD reason for the denial was consistent with the reason documented in the UM system. All NABDs included the required content, such as the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a brief reason for the denial. In one out-of-network outpatient NABD, COA listed in-network providers and contact information for the member, and HSAG determined that this is a best practice. However, in one ASAM SUD denial, the NABD did not list each of the required ASAM dimensions considered in making the determination.

During the MHP interview, COA staff members stated that recent upgrades to their software system enhance oversight capabilities, allowing for additional monitoring of how staff members interact and follow up with care management. Additionally, when communicating with providers regarding UM changes or updates, staff members stated that there are organizational efforts to communicate with providers through the provider-facing website, newsletters, and direct fax blasts.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Enhancing monitoring mechanisms to ensure that the provider is notified of the denial and that the member is sent the NABD within the required time frame.
- Following established policies and procedures to ensure that requesting providers are consistently offered peer-to-peer review and that staff members are documenting when the requesting providers are offered peer-to-peer review.
- Providing continuous staff member training to ensure that staff members document and save utilization review criteria (InterQual or ASAM) in the UM system and that all denial determinations due to medical necessity use established criteria.
- Enhancing monitoring procedures to ensure that COA reaches out to the requesting provider for additional documentation, when needed, particularly for ASAM levels of care.
- Including each of the required ASAM dimensions in the inpatient SUD NABDs and conducting periodic chart audits to ensure consistency.

- As a best practice, including in the NABDS (other than the SUD NABDs, which mostly included the required ASAM dimensions) reference to the MCE's criteria (i.e., InterQual) used in making the determination and including more member-specific information regarding the reason for the denial (e.g., what symptoms COA found to be present or not present related to the criteria).

Appendix D. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 4—Health Colorado, Inc.

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 17, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 • Four requests for MH services • Six requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, acute treatment unit, qualified residential treatment program, ASAM 3.1 clinically managed low-intensity residential, ASAM 3.2 WM clinically managed withdrawal management, ASAM 3.5 clinically managed high-intensity residential, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored withdrawal management. Diagnoses included generalized anxiety disorder, major depressive disorder, post-traumatic stress disorder, opioid use disorders, stimulant use disorders, schizoaffective disorders, alcohol use disorder, cannabis dependence, and amphetamine use disorder. Presenting symptoms included depression, anxiety, auditory hallucinations, cravings, suicidal ideation, insomnia, poor insight and judgement, anhedonia, psychosis, irritability, agitation, behavioral issues, and aggression.
Is prior authorization required according to 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. Two records requested at WM level of care,

Requirements	M/NM	Comments
		one for ASAM 3.2 WM and one for 3.7 WM, which do not require prior authorization; however, medical necessity review and concurrent review for continued authorization is permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of one standard request, eight standard concurrent requests, and one retrospective denial.
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 authorization ending, or a post-service request (retrospective) for payment of services not yet reviewed for medical necessity.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
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/NM)*	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.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, a secure email, and/or a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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	8/10	Eight records demonstrated that the NABD was sent within the required time frame. Two records did not meet the Special Connections member requirement for written notice to the member within 24 hours.

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 determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	The NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, the reason for the denial, and a recommended alternative level of care, if applicable.
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/NA)*	8/8	All applicable records demonstrated that peer-to-peer review was offered. In two instances, peer-to-peer was not applicable due to the parent/guardian requesting residential treatment center for the member or due to a post-service (retrospective) request.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that HCI based determinations on nationally recognized criteria (InterQual or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**78**	
Total Met Elements	**76**	
Score (Number Met / Number Applicable) = %	**97%**	

***Scored Elements**
M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)
Y = Yes, **N** = No (**Not Scored, For Information Only**)

Appendix D. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 4—Health Colorado, Inc.

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 17, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for service included electroconvulsive therapy, SUD intensive outpatient program, MN intensive outpatient program, and partial hospitalization program. Diagnoses included major depressive disorder, bipolar I disorder, bipolar II disorder, post-traumatic stress disorder, alcohol use disorder, alcohol dependence, cannabis dependence, undifferentiated somatoform disorder, generalized anxiety disorder, stimulant use disorder, cannabis use disorder, and panic disorder. Presenting symptoms included anxiety, depression, suicidal ideation, paranoia, racing thoughts, impulsive behaviors, labile mood, difficulty concentrating, cravings, insomnia, emotional volatility, decreased/poor appetite, agitation, irritability, altered mental status, hopelessness, helplessness, anhedonia, self-harming behaviors, panic attacks, mood swings, low energy, sleep disturbances, and fatigue.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	The 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 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 authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
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 adequate information to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	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.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	9/10	Providers received a phone call or secure email and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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 demonstrated that the NABD was sent within the required time frame. One record did not meet the standard outpatient MH service time frame requirement of 10 calendar days.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	The NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, the reason for the denial, and a recommended alternative level of care, if applicable
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)*	0/1	One request for service was denied due to lack of adequate documentation to determine medical necessity. HCI did not attempt to reach out to the requesting provider for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All records contained evidence that a peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that determinations were based on nationally recognized criteria (InterQual or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	9/10	Nine NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**81**	
Total Met Elements	**77**	
Score (Number Met / Number Applicable) = %	**95%**	

***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	78	76	97%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
100	81	77	95%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	159	153	96%

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

Summary

HCI delegated UM activities to Carelon (formerly Beacon Health Options). Carelon staff members reported no quantitative benefit limitations. Carelon, on behalf of HCI, accepted requests for authorization electronically through Provider Connect (an online platform used primarily by inpatient and SUD providers), and via fax, email, and telephone.

Inpatient Services

Carelon's prior authorization list, policies, and procedures stated that the following inpatient services were subject to prior authorization and/or concurrent review requirements during CY 2023:

MH Services

- Acute hospitalization
- Observation
- Acute treatment unit
- Residential treatment center (short- and long-term)
  - Includes qualified residential treatment programs (QRTP) and psychiatric residential treatment facilities (PRTF)

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

For acute hospitalizations, HCI required authorization. For emergency admissions, HCI allowed 24 hours for notification of the admission.

SUD Services

- Inpatient medically monitored (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

Non-medical detoxification (3.2 WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

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

MH Services

- Electroconvulsive therapy
- Assertive community treatment
- Partial hospitalization program
- Intensive outpatient program
- BH day treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy
- Out-of-network services (except emergency/crisis care)

SUD Services

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

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)
- Psychological/neuropsychological testing

Strengths

HCI demonstrated an overall score of 96 percent. During the CY 2023 review period, Carelon used InterQual utilization review criteria for all MH utilization review determinations and ASAM level of care criteria for all SUD determinations. Carelon required its UM staff members to pass IRR testing annually with a minimum score of 90 percent, which was a 10 percent increase in the minimum score compared to the last review period (CY 2022). Carelon reported that the last IRR testing occurred in summer 2023 and not all UM staff members passed, but after additional training and testing, all UM staff members passed with scores of 90 percent or better.

Based on the review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, the records reviewed for HCI demonstrated that Carelon used nationally recognized utilization review criteria (InterQual or ASAM) and documented which criteria were used for all determinations. In all cases reviewed, HSAG also found that Carelon followed its policies and procedures related to which services require prior authorization. HSAG found that Carelon notified providers of the denial determinations by telephone or secure email and provided a copy of the NABD within the required time frame for all records reviewed, except one outpatient record. Most records demonstrated that the member was sent the NABD within the required time frame; however, two inpatient records and one outpatient record demonstrated that the NABD was not sent within the 24-hour Special Connections member time frame requirement or the standard MH outpatient 10-calendar-day time frame requirement. Carelon did not use an extension in any of the records reviewed.

HSAG found that in all cases reviewed, the denial determination was made by a qualified clinician. In all applicable cases, the records contained evidence that a peer-to-peer review was offered to the requesting provider.

One outpatient record was denied due to lack of adequate documentation to determine medical necessity and did not include documentation of outreach to the requesting provider for additional information. Carelon staff members confirmed during the MHP interview that additional outreach did not occur. In all cases except one, the records demonstrated that the NABD reason for the denial was consistent with the reason documented in the UM system. In the one record, the UM system notes indicated additional SUD concerns and needing to be treated for the SUD concerns before continuing with the MH service request; however, this information was not documented in the NABD. The NABDs contained the required information, such as the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, the reason for the denial, and a recommended alternative level of care, if applicable. Inpatient SUD NABDs also included the required language regarding how each ASAM dimension was considered when determining medical necessity.

During the HCI interview, Carelon made HSAG aware of recent changes, which included hiring a new staff member to lead the process for reviewing Independent Assessments (IAs) for qualified residential treatment program placements. The new role would provide additional support and assistance to UM and care management staff members, including working with the parent/guardian and obtaining additional information. Additionally, Carelon brought on a dedicated MD for the Colorado contract for utilization review who will specifically understand Colorado regulations and standards. HCI staff members stated during the interview that the use of consultants across the region helps to better understand gaps in care, build the provider network, and expand services. Additionally, a facility in the region began providing a WM level of care and this has added more accessibility for members needing this type of service.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Enhancing Carelon's monitoring mechanisms to ensure that the provider is notified of the denial and that the member is sent the NABD within the required time frame.

- Providing continuous and regular staff member training to ensure that the reason for the denial in the UM system is consistent with the reason the member was provided in the NABD.
- Enhancing monitoring procedures to ensure that additional outreach occurs with the requesting provider when adequate documentation is not received.

Appendix E. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 5—Colorado Access

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 18, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Nine adult records • One child/adolescent record • Four requests for MH services • Six requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, acute treatment unit, psychiatric residential treatment facility, ASAM 3.1 clinically managed low-intensity residential, ASAM 3.5 clinically managed high-intensity residential, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored withdrawal management. Diagnoses included major depressive disorder, cannabis use disorder, generalized anxiety disorder, post-traumatic stress disorder, schizoaffective disorder, bipolar disorder, cocaine use disorder, methamphetamine use disorder, alcohol use disorder, stimulant use disorders, disruptive mood dysregulation disorder, and opioid use disorder. Presenting symptoms included anxiety, depression, tiredness, limited/poor insight and judgement, emotional dysregulation, restlessness, poor impulse control, agitation, anger, disruptive behaviors, reactivity, insomnia, and night terrors.

Requirements	M/NM	Comments
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list. One record requested ASAM 3.7 WM, which does not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of two standard requests, seven standard concurrent requests, and one retrospective denial.
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 authorization ending, or post-service requests for payment and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
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 adequate documentation to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	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.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	8/10	Providers received a phone call, a secure email, and/or a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		

Requirements	M/NM	Comments
Was the member notice sent within the required time frame? (M/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	6/10	Six records demonstrated that the NABD was sent within the required time frame. Two records did not meet the SUD service time frame requirement for written notice to the member within 72 hours and two records did not meet the Special Connections member requirement for written notice to the member within 24 hours.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	1/1	COA extended one determination and 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)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a brief area to address the reason for denial.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases, 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 was denied due to lack of adequate documentation to determine medical necessity. COA did attempt to make contact multiple times to obtain the additional documentation.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/9	Nine records contained evidence that a peer-to-peer review was offered. In one post-service (retrospective) request, 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 COA based determinations on nationally recognized criteria (InterQual or ASAM).

Requirements	M/NM	Comments
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**81**	
Total Met Elements	**75**	
Score (Number Met / Number Applicable) = %	**93%**	

***Scored Elements**

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

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

Appendix E. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 5—Colorado Access

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 18, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Six adult records • Four children/adolescent records • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for services included psychological/neuropsychological testing, MH intensive outpatient program, out-of-network SUD intensive outpatient program, electroconvulsive therapy, and partial hospitalization program. Diagnoses included generalized anxiety disorder, bipolar disorder, post-traumatic stress disorder, disruptive mood dysregulation disorder, panic disorder, attention-deficit hyperactivity disorder, major depressive disorder, other stimulant abuse, autism spectrum disorders, opioid dependence, mood disorder, alcohol use disorder, cocaine use disorder, and amphetamine-type use disorder. Presenting symptoms included depression, anxiety, mixed obsessional thoughts and acts, low/decreased motivation, lack of decisiveness, mood swings, irritability, social isolation, insomnia, worrying thoughts, aggression, destructive and out of control behaviors, suicidal thoughts, nightmares, agitation, restlessness, body chills, guarded behaviors, disengaged, and emotional dysregulation.

Requirements	M/NM	Comments
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 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 standard concurrent request.
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 authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	1	One denial was related to the requesting provider being out-of-network when there were in-network providers available.
Other (describe): (Y/N)	1	One denial was related to lack of adequate documentation to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	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.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, a secure email, and/or a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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 records demonstrated that 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)*	1/1	COA extended one determination to obtain additional clinical information. 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)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a brief area to address the reason for denial.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases, 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. COA did attempt to contact the provider for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	8/10	Eight records contained evidence that a 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 or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**82**	
Total Met Elements	**80**	
Score (Number Met / Number Applicable) = %	**98%**	

***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	81	75	93%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
100	82	80	98%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	163	155	95%

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

Summary

COA did not report any quantitative benefit limitations and did not delegate UM activities. COA accepted requests for authorization through an online portal and via fax, telephone, and secure email.

Inpatient Services

COA's prior authorization list, policies, and procedures stated that the following inpatient services were subject to authorization and concurrent review requirements during CY 2023:

MH Services

- Acute hospitalization
- Acute treatment unit
- Residential treatment center (short- and long-term)
  - Includes qualified residential treatment programs (QRTP) and psychiatric residential treatment facilities (PRTF)

For acute hospitalizations, COA required prior authorization. For emergency admissions, COA allowed 24 hours for notification of the admission. Crisis stabilization unit and observation services 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

Non-medical detoxification (3.2 WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

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

MH Services

- Psychological/neuropsychological testing
- Electroconvulsive therapy
- Partial hospitalization program
- Intensive outpatient program
- BH day treatment
- Out-of-network services (except emergency/crisis care)

SUD Services

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

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

Strengths

COA RAE 5 demonstrated an overall score of 95 percent. During the CY 2023 review period, COA used InterQual utilization review 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 or better. During the MHP interview, COA staff members stated that the last IRR testing was conducted in September 2023 and two staff members did not pass, but after additional training and testing, the two staff members passed with the minimum score.

Based on the review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, HSAG found that all files demonstrated that COA followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization requirements for processing requests for services. COA used nationally recognized utilization review criteria (InterQual or ASAM) for all records reviewed. Additionally, COA utilized the *ASAM Criteria Navigator* by InterQual for ASAM determinations, and HSAG determined this to be a best practice. HSAG found that COA made the denial determinations and providers were notified of the denial determinations within the required time frame for all records except two. Providers were notified by telephone, secure email, and/or a copy of the NABD. All records except four inpatient records, which included two Special Connections members, demonstrated that the member was sent the NABD within the required time frame. COA utilized an extension in one inpatient and one outpatient record to obtain additional documentation. HSAG found that the extension letters were sent to the member within the required time frame and included the required content.

In all cases reviewed, the denial determination was made by a qualified clinician. In all applicable cases except two, the records contained evidence that a peer-to-peer review was offered to the requesting provider.

One inpatient record and one outpatient record were denied due to lack of adequate documentation to determine medical necessity. Both records demonstrated that COA reached out to the requesting provider for additional information. All records demonstrated that the NABD reason for the denial was consistent with the reason documented in the UM system. All NABDs included the required content, such as the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a brief reason for the denial. Additionally, in one out-of-network outpatient NABD, COA listed in-network providers and contact information for the member, and HSAG determined that this is a best practice.

During the MHP interview, COA staff members stated that recent upgrades to their software system enhance oversight capabilities, allowing for additional monitoring regarding how staff members interact and follow up with care management. Additionally, when communicating with providers regarding UM changes or updates, staff members stated that there were organizational efforts to communicate with providers through the provider-facing website, newsletters, and direct fax blasts.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Enhancing monitoring mechanisms to ensure that the provider is notified of the denial and that the member is sent the NABD within the required time frame. Additionally, ensure that staff members are documenting the method of communication to the requesting provider in the UM system.
- Following established policies and procedures to ensure that requesting providers are consistently offered peer-to-peer review and that staff members are documenting when the requesting providers are offered peer-to-peer review.
- As a best practice, including in the NABDs (other than the SUD NABDs, which included the required ASAM dimensions) reference to the MCE's criteria (i.e., InterQual) used in making the determination and including more member-specific information regarding the reason for the denial (e.g., what symptoms COA found to be present or not present related to the criteria).

Appendix F. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 6—Colorado Community Health Alliance

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 24, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 requests for SUD services
Service requested/indication:		Requests for service included inpatient hospitalization, psychiatric residential treatment facility, ASAM 3.1 clinically managed low-intensity residential, ASAM 3.2 WM clinically managed residential withdrawal management, ASAM 3.5 clinically managed high-intensity residential treatment, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored inpatient withdrawal management. Diagnoses included major depressive disorder, alcohol use disorder, cannabis use disorder, post-traumatic stress disorder, alcohol dependence, opioid dependence, other stimulant dependence, unspecified mood disorder, cannabis dependence, generalized anxiety disorder, bipolar disorder, attention-deficit hyperactivity disorder, and panic disorder. Presenting symptoms included anxiety, depression, agitation, tremors, sweats, restlessness, nausea, irritability, body aches, poor impulse control, guarded behaviors, aggression, cravings, and poor insight.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list. Three records requested at WM level of

Requirements	M/NM	Comments
		care, one for ASAM 3.2 WM and two for 3.7 WM, which do not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of four standard requests and six standard concurrent requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests were new requests—either preservice requests or requests for additional days based on authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
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 clinical information to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	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.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, a secure email, fax, and/or a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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	8/10	Eight cases demonstrated that the NABD was sent within the required time frame. Two cases demonstrated that the NABD was not within standard inpatient or residential MH time frame requirement of 10 calendar days.

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 determination time frames were extended.
Did the NABD include the required content? (M/NM)*	9/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a reason for the denial. However, in one ASAM SUD denial, the NABD did not list each of the required ASAM dimensions considered in making the determination.
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)*	1/1	One request for service was denied due to lack of clinical information to determine medical necessity. CCHA did attempt to contact the provider for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/10	Nine denials reviewed contained evidence that a peer-to-peer review was offered. In one record review, peer-to-peer was offered, but it was after the NABD was issued to the member.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that CCHA based determination on nationally recognized criteria (MCG or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**81**	
Total Met Elements	**77**	
Score (Number Met / Number Applicable) = %	**95%**	

***Scored Elements**

M = Met, **NM** = Not Met, **NA** = Not Applicable (**Scored Elements**)
Y = Yes, **N** = No (**Not Scored, For Information Only**)

Appendix F. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 6—Colorado Community Health Alliance

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 24, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for service included psychological/neuropsychological testing, MH intensive outpatient program, SUD intensive outpatient program, partial hospitalization program, and out-of-network psychotherapy (60-minutes). Diagnoses included major depressive disorder, social anxiety disorder, attention-deficit hyperactivity disorder, bipolar disorder, post-traumatic stress disorder, generalized anxiety disorder, stimulant use disorder, alcohol use disorder, cannabis use disorder, other disorders of psychological development, adjustment disorder, disruptive mood dysregulation disorder, and oppositional defiant disorder. Presenting symptoms included depression, anxiety, impulsive behaviors, easily distracted, excessive fidgety movements, sensory sensitivity, social difficulties, inattention, disorganized, labile mood, poor attention span, impulsivity, overwhelming and racing thoughts, acting out behaviors, irritability, low frustration tolerance, speech and language delays, aggression, limited

Requirements	M/NM	Comments
		engagement with peers, delays social development, defiance, hallucinations, suicidal ideation, anger, and temper outbursts.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All 10 records demonstrated that the services requests 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 standard concurrent request.
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 authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	1	One denial was related to the requesting provider being out-of-network.
Other (describe): (Y/N)	1	One denial was related to lack of clinical information to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	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.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, fax, and/or copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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	All records demonstrated that 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 determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a 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)*	1/1	One request for service was denied due to lack of adequate documentation to determine medical necessity. CCHA did attempt to contact the request provider for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	7/10	Seven denials reviewed contained evidence that a peer-to-peer was offered. In three denial records reviewed, peer-to-peer was offered, but it was after the NABD was issued to the member.
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 or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
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 Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
100	81	77	95%

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

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	162	155	96%

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

Summary

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

Inpatient Services

CCHA's prior authorization list, policies, and procedures stated that the following inpatient services were subject to prior authorization and concurrent review requirements during CY 2023:

MH Services

- Inpatient acute hospitalization
- Acute treatment unit
- Residential treatment center (short- and long-term)
  - Includes qualified residential treatment program (QRTP) and psychiatric residential treatment facilities (PRTF)

For acute hospitalization, CCHA required prior authorization. For emergency admissions, CCHA did not require notification of the admission. 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 medically monitored (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

Non-medical detoxification (3.2 WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

The following outpatient services required prior authorization/concurrent review:

MH Services

- Psychological/neuropsychological testing
- Assertive community treatment
- Partial hospitalization program
- Intensive outpatient program
- BH day treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy
- Out-of-network services (except emergency/crisis care)

SUD Services

- Intensive outpatient program

- Out-of-network services (except emergency/crisis care)

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)
- Electroconvulsive therapy

Strengths

CCHA RAE 6 demonstrated an overall score of 96 percent. During the CY 2023 review period, CCHA used MCG utilization review criteria for all MH utilization review 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. During the MHP interview, CCHA reported that the last IRR testing occurring in June 2023 and five UM staff members did not pass, but after additional coaching and training, all staff members passed.

Based on the review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, the records review demonstrated that CCHA used nationally recognized utilization review criteria and documented which criteria were used for determinations. HSAG found that CCHA made the denial determinations within the required time frame and providers were notified of the denial determinations by telephone, secure email, fax, and/or a copy of the NABD within the required time frame. However, two inpatient records demonstrated that the NABD was not sent to the member within the standard inpatient or residential MH time frame requirement of 10 calendar days. This included one of the NABDs being issued three months after the denial determination. During the MHP interview, CCHA staff members indicated that the record was accidently removed from the queue, and once staff members were made aware of the issue, they sent the NABD to the member. CCHA did not use an extension within any of the records reviewed.

In all cases reviewed, the denial determination was made by a qualified clinician and requesting providers were offered a peer-to-peer review. Although all requesting providers were offered a peer-to-peer review, in four cases peer-to-peer occurred after the NABD was issued to the member.

In one inpatient and one outpatient record that were denied due to lack of adequate documentation to determine medical necessity, CCHA demonstrated it followed its policies and procedures in attempting to reach out to the requesting provider for additional information. All records demonstrated that the NABD reason for the denial was consistent with the reason documented in CCHA's UM system. The NABDs were provided using a Department-approved template letter, which included the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal an appeal, the availability of assistance from the RAE in filing, access to pertinent records, and a reason for the denial. However, one inpatient ASAM SUD denial, the NABD did not include the complete list of the required ASAM dimensions and how they were considered when determining medical necessity.

During the MHP interview, CCHA discussed the ongoing collaboration and communication between the UM and care coordination departments. Within the past year, CCHA had communicated with their Member Advisory Committee about trying to help each member better understand the UM process, the care being provided, and the quality of care, regardless of whether the member receives care from the physical health (PH) side or the BH side. A UM staff member also conducted a "UM 101" presentation that was member-friendly and explained what UM does and the background process so that members could understand CCHA's process when there is a request for service(s). Additionally, during the committee meeting, CCHA brought in their grievance and appeal department to help the members further understand the grievance process.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Enhancing monitoring mechanisms to ensure that the member is sent the NABD within the required time frame or utilize extensions, if needed, to meet compliance.
- Providing further training and oversight to ensure that the NABDs include each of the required ASAM dimensions in the inpatient SUD NABDs.
- Continuing to follow established policies and procedures and enhance monitoring procedures to ensure that requesting providers are offered peer-to-peer review prior to the issuance of the member NABD.

Appendix G. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 7—Colorado Community Health Alliance

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 24, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 • Four requests for MH services • Six requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, acute treatment unit, psychiatric residential treatment facility, ASAM 3.1 clinically managed low-intensity residential, ASAM 3.5 clinically managed high-intensity residential, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored withdrawal management. Diagnoses included alcohol use disorder, major depressive disorder, schizoaffective disorder, unspecified psychosis, stimulant use disorder, bipolar disorder, post-traumatic stress disorder, attention-deficit hyperactivity disorder, alcohol dependence, hallucinogen dependence, opioid dependence, other stimulant dependence, and cannabis dependence. Presenting symptoms included anxiety, insomnia, hyperactivity, restlessness, depression, easily distracted, restlessness, nightmares, flashbacks, aggression, impulsivity, defiant behaviors, poor impulse control, poor appetite, body aches, and body chills.

Requirements	M/NM	Comments
Is prior authorization required according to 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. Two records requested ASAM 3.7 WM, which do not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of three standard requests, six standard concurrent requests, and one retrospective denial.
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 authorization ending, or post-service request and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
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 adequate documentation to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	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.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	9/10	Providers received a phone call, secure email, fax, and/or copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services	9/10	Nine cases demonstrated that the NABD was sent within the required time frame. One case demonstrated that the NABD was not sent within the required 72-hour time frame.

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)*	1/1	CCHA extended one determination and 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)*	8/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a reason for the denial. However, in two ASAM SUD denials, the NADB did not list each of the required ASAM dimensions considered in making the determination.
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)*	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.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	8/9	Peer-to-peer review was not applicable for the retrospective denial. In one record, there was no evidence that peer-to-peer was offered. During the interview, CCHA confirmed that peer-to-peer was not offered.
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 or ASAM).

Requirements	M/NM	Comments
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**81**	
Total Met Elements	**76**	
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**)

Appendix G. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for RAE 7—Colorado Community Health Alliance

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 24, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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/adolescent record • Nine requests for MH services • One request for SUD service
Service requested/indication:		Requests for services included psychological/neuropsychological testing, MH intensive outpatient program, SUD intensive outpatient program, partial hospitalization program, and out-of-network psychotherapy (60-minutes). Diagnoses included post-traumatic stress disorder, major depressive disorder, attention-deficit hyperactivity disorder, borderline personality disorder, generalized anxiety disorder, disruptive mood dysregulation disorder, schizoaffective disorder, and opioid dependence. Presenting symptoms included anxiety, depression, easily distracted, impulsivity, irritability, labile mood, low frustration tolerance, aggressive, destructive behaviors, insomnia, poor impulse control, disassociation, poor appetite, suicidal ideation, racing thoughts, mood swings, auditory hallucinations, and inattention.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	The 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 standard requests and one retrospective denial.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or a new request for payment resulting in a post-service (retrospective review).
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	1	One denial was related to the requesting provider being out-of-network when there were in-network providers available.
Other (describe): (Y/N)	2	Two denials were related to lack of adequate documentation to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	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.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, fax, and/or a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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 demonstrated that the NABD was sent within the required time frame. One NABD was sent to the member six months after the denial determination. CCHA staff members clarified during the interview that once staff members were aware of the mistake, an NABD was sent to the member.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a 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)*	1/2	Two requests for services were denied due to lack of adequate documentation to determine medical necessity. CCHA did attempt to contact one of the requesting providers for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	8/9	Peer-to-peer review was not applicable for the retrospective denial. Eight denials contained evidence that a peer-to-peer review was offered. During the interview, CCHA confirmed that in one case, peer-to-peer review occurred after the denial determination and NABD was issued.
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 or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
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 Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
100	81	76	94%

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

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	162	154	95%

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

Summary

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

Inpatient Services

CCHA's prior authorization list, policies, and procedures stated that the following inpatient services were subject to prior authorization and concurrent review requirements during CY 2023:

MH Services

- Inpatient acute hospitalization
- Acute treatment unit
- Residential treatment center (short- and long-term)
  - Includes qualified residential treatment programs (QRTP) and psychiatric residential treatment facilities (PRTF)

For acute hospitalization, CCHA required prior authorization. For emergency admissions, CCHA did not require notification of the admission. Observation level of care did not require prior authorization but was subject to medical necessity review. Treatment in crisis stabilization unit did not require prior authorization.

SUD Services

- Inpatient medically monitored (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

Non-medical detoxification (3.2 WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

The following outpatient services required prior authorization/concurrent review:

MH Services

- Psychological/neuropsychological testing
- Assertive community treatment
- Partial hospitalization program
- Intensive outpatient program
- BH day treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy
- Out-of-network services (except emergency/crisis care)

SUD Services

- Intensive outpatient program

- Out-of-network services (except emergency and crisis care)

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)
- Electroconvulsive therapy

Strengths

CCHA RAE 7 demonstrated an overall score of 95 percent. During the CY 2023 review period, CCHA used MCG utilization review criteria for all MH utilization review 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. During the MHP interview, CCHA reported that the last IRR testing occurring in June 2023, and five UM staff members did not pass, but after additional coaching and training, all staff members passed.

Based on the review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, the records review demonstrated that CCHA used nationally recognized utilization review criteria and documented which criteria were used for determinations. HSAG found that CCHA made the denial determinations within the required time frame and providers were notified of the denial determinations by telephone, secure email, fax, and/or received a copy of the NABD within the required time frame in all records reviewed except one inpatient record. However, one inpatient record and one outpatient record demonstrated that the NABD was not sent within the required time frame. This included one of the NABDs being issued six months after the denial determination. During the MHP interview, CCHA staff members indicated that the record was accidently removed from the queue, and once staff members were made aware of the issue, they sent the NABD to the member. CCHA used an extension in one inpatient record and HSAG found that the extension letter was sent to the member within the required time frame and included the required content.

In all cases reviewed, the denial determination was made by a qualified clinician. In all applicable cases except one, the records contained evidence that a peer-to-peer review was offered to requesting providers. Additionally, in one case peer-to-peer occurred after the denial determination and issuance of the NABD to the member.

In one inpatient record and two outpatient records that were denied due to lack of adequate documentation to determine medical necessity, only two records demonstrated that CCHA followed its policies and procedures in attempting to reach out to the requesting provider for additional information. All records demonstrated that the NABD reason for the denial was consistent with the reason documented in CCHA's UM system. The NABDs were provided using a Department-approved template letter, which included the member's appeal rights, the right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing an appeal, access to pertinent records, and a reason for the denial. However, two inpatient ASAM SUD denials, the NABD did not include the complete list of the required ASAM dimensions and how they were considered when determining medical necessity.

During the MHP interview, CCHA discussed the ongoing collaboration and communication between the UM and care coordination departments. Within the past year, CCHA had communicated with their Member Advisory Committee about trying to help each member better understand the UM process, the care being provided, and the quality of care, regardless of whether the member receives care from the PH or the BH side. A UM staff member also conducted a "UM 101" presentation that was member-friendly and explained what UM does and the background process so that members could understand CCHA's process when there is a request for service(s). Additionally, during the committee meeting, CCHA brought in their grievance and appeal department to help the members further understand the grievance process.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Enhancing monitoring mechanisms to ensure that the provider is notified of the denial and that the member is sent the NABD within the required time frame.
- Providing further training and oversight to ensure that the NABDs include each of the required ASAM dimensions in the inpatient SUD NABDs.
- Continuing to follow established policies and procedures and enhance monitoring procedures to ensure that requesting providers are offered peer-to-peer review prior to the issuance of the member NABD.
- Enhancing monitoring procedures to ensure that additional outreach occurs with the requesting provider when adequate documentation is not received.

Appendix H. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for Denver Health Medical Plan MCO

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 24, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • 10 adult records • Four requests for MH services • Six requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, acute treatment unit, ASAM 3.1 clinically managed low-intensity residential, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored withdrawal management. Diagnoses included major depressive disorder, alcohol use disorder, cocaine use disorder, alcohol dependence, generalized anxiety disorder, cannabis dependence, cocaine dependence, polysubstance dependence, post-traumatic stress disorder, bipolar disorder, bipolar II disorder, amphetamine use disorders, borderline personality disorder, schizophrenia, cannabis use disorder, and recurrent depression disorder. Presenting symptoms included depression, anxiety, agitation, irritability, restlessness, stomach cramps, nausea, tremors, auditory and visual hallucinations, cravings, anxiousness, helplessness, insomnia, suicidal ideation, tiredness, panic attacks, withdrawn behaviors, and hopelessness.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All records demonstrated that the services requested were all subject to prior authorization requirements according to the MCO's prior authorization list. Three records requested ASAM 3.7 WM, which do

Requirements	M/NM	Comments
		not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of nine standard concurrent requests and one retrospective denial.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—requests for additional days based on authorization ending or a post-service request for payment and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
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/NM)*	9/10	In nine cases reviewed, 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.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call or secure email and a copy of the NABD.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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	Nine records demonstrated that the NABD was sent within the required time frame. One record did not meet the SUD service time frame requirement for written notice to the member within 72 hours.

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 time frames were extended.
Did the NABD include the required content? (M/NM)*	8/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing an appeal, access to pertinent records, and a brief area to address the reason for denial. However, in two ASAM SUD denials, the NABD did not list each of the required ASAM dimensions considered in making the determination.
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	Nine denials reviewed contained evidence that a peer-to-peer review was offered. In one post-service (retrospective) request, peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	9/10	Nine records contained evidence that COA based determinations on nationally recognized criteria (InterQual or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**79**	
Total Met Elements	**74**	
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**)

Appendix H. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for Denver Health Medical Plan MCO

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 24, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
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 • 10 requests for MH services
Service requested/indication:		Requests for services included psychological/neuropsychological testing, MH intensive outpatient program, and partial hospitalization program. Diagnoses included major depressive disorder, oppositional defiant disorder, post-traumatic stress disorder, chronic post-traumatic stress disorder, generalized anxiety disorder, mild intellectual disability, autism spectrum disorder, attention-deficit hyperactivity disorder, social anxiety disorder, obsessive compulsive disorder, disruptive mood dysregulation disorder, intermittent explosive disorder, panic disorder, opioid dependence, other stimulant dependence, bipolar disorder, borderline personality disorder, and unspecified personality disorder. Presenting symptoms included depression, anxiety, learning concerns, sensory sensitivities, memory difficulties, low frustration/tolerance, labile moods, temper outbursts, sadness, cravings, difficulties advocating for self, focusing/concentrating difficulties, frequent elopement from school, refusal to complete tasks, suicidal ideation, hyperarousal, dissociative episodes, self-harm urges, intrusive trauma memories, racing thoughts, impulsive behaviors, low motivation, low social skills, comprehension difficulties, stress, mixed obsessional thoughts and acts, anger, and irritability.

Requirements	M/NM	Comments
Is prior authorization required according to 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 eight standard requests and two 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 authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
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 adequate documentation to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	9/10	In nine cases reviewed, 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.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call or secure email and a copy of the NABD.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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	All records demonstrated that 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 determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing an appeal, access to pertinent records, and a brief area to address the reason for 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)*	0/1	One request was denied due to lack of adequate documentation to determine medical necessity and there was no additional outreach to the requesting provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/10	Nine records reviewed contained evidence that a peer-to-peer was offered.
Was the decision based on established authorization criteria? (M/NM)*	9/10	Nine records contained evidence that COA based determinations on nationally recognized criteria (InterQual).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**81**	
Total Met Elements	**77**	
Score (Number Met / Number Applicable) = %	**95%**	

***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	74	94%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
100	81	77	95%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	160	151	94%

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

Summary

DHMP delegated BH and SUD UM to Colorado Access (COA). DHMP did not report any quantitative benefit limitations. COA accepted requests through an online portal and via fax, telephone, and secure email.

Inpatient Services

COA's prior authorization list, policies, and procedures stated that the following inpatient services were subject to authorization and concurrent review requirements during CY 2023:

MH Services

- Acute hospitalization
- Acute treatment unit
- Residential treatment center (short- and long-term)
  - Includes qualified residential treatment programs (QRTP) and psychiatric residential treatment facilities (PRTF)

For acute hospitalization, COA (on behalf of DHMP) required prior authorization. For emergency admissions, COA allowed 24 hours for notification of the admission. Inpatient psychiatric and SUD services for DHMP who are inpatient at DHMP hospital facilities (e.g., Denver Health and Hospital Authority) do not require prior authorization as of July 1, 2022. Crisis stabilization and observation services did not require authorization.

SUD Services

- Inpatient medically monitored (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

Non-medical detoxification (3.2 WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

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

MH Services

- Psychological/neuropsychological testing
- Electroconvulsive therapy
- Partial hospitalization program
- Intensive outpatient program
- BH day treatment
- Out-of-network services (except emergency/crisis care)

SUD Services

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

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

Strengths

DHMP demonstrated an overall score of 94 percent. During the CY 2023 review period, COA used InterQual utilization review criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. DHMP and COA required their UM staff members to pass IRR testing annually with a minimum score of 90 percent. During the MHP interview, DHMP and COA staff members reported that the last IRR testing was conducted in September 2023 and that most staff passed with the required minimum score of 90 percent. DHMP staff members all passed with scores exceeding 90 percent. COA staff members had two staff members who passed with the required minimum score after receiving additional training and coaching.

Based on the review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, HSAG found that all files except two demonstrated that COA followed DHMP's prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization requirements for processing requests for services. In all files except two, COA used nationally recognized utilization review criteria (InterQual or ASAM). Additionally, COA utilized the *ASAM Criteria Navigator* by InterQual for ASAM determinations, and HSAG determined this to be a best practice. HSAG found that COA made the denial determinations within the required time frame, and providers were notified of the denial determination through telephone or secure email and a copy of the NABD for all records reviewed. All records except one inpatient record demonstrated that the member was sent the NABD within the required time frame. No determination time frames were extended.

In all cases reviewed, the denial determination was made by a qualified clinician. In all applicable cases except one outpatient case, the records contained evidence that a peer-to-peer review was offered to the requesting provider.

One outpatient record was denied due to lack of adequate documentation to determine medical necessity; however, the record did not provide documentation of outreach to the requesting provider for additional information. COA staff members confirmed

during the MHP interview that additional outreach did not occur. All records demonstrated that the NABD reason for the denial was consistent with the reason documented in COA's UM system. All NABDs included the required content, such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing an appeal, access to pertinent records, and a brief reason for the denial. Additionally, COA consistently utilized the new revised NABD template language that explained DHMP's delegation to COA across most of the NABDs reviewed. In two SUD inpatient cases, the NABDs did not list the required ASAM dimensions and how they were considered when determining medical necessity.

In addition, staff members explained the continuous bidirectional communication, ongoing collaboration, and regular standing meetings between DHMP and COA. The continuous efforts allow the two entities to be aware of new and upcoming UM changes, share findings from audits, identify gaps in care, and collaborate on different initiatives and interventions.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Enhancing monitoring mechanisms to ensure that the member is sent the NABD within the required time frame.
- Following established policies and procedures to ensure that requesting providers are consistently offered peer-to-peer review and that staff members are documenting when the requesting providers are offered peer-to-peer review.
- Ensuring all denial determinations due to medical necessity use established utilization review criteria (InterQual or ASAM) and staff members document and save criteria used in the UM system.
- Enhancing monitoring procedures to ensure that additional outreach occurs with the requesting provider when adequate documentation is not received.
- Including each of the required ASAM dimensions in the inpatient SUD NABDs and conducting periodic chart audits to ensure consistency.
- As a best practice, including in the NABDs (other than the SUD NABDs, which mostly included the required ASAM dimensions) reference to the MCE's criteria (i.e., InterQual) used in making the determination and including more member-specific information regarding the reason for the denial (e.g., what symptoms COA found to be present or not present related to the criteria).

Appendix I. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans Medicaid Prime

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 16, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • 10 adult records • Six requests for MH services • Four requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, ASAM 3.7 medially monitored intensive inpatient, ASAM 3.7 WM medically monitored withdrawal management, and MH residential treatment center. Diagnoses included major depressive disorder, schizoaffective disorder, alcohol use disorder, amphetamine use disorder, cannabis use disorder, post-traumatic stress disorder, unspecified psychosis (not due to a substance or known physiological condition), alcohol dependence, cannabis dependence, generalized anxiety disorder, other stimulant use, stimulant use disorder, attention-deficit hyperactivity disorder, and bulimia nervosa. Presenting symptoms included anxiety, depression, suicidal ideation, emotional, restlessness, cravings, difficulty concentrating, auditory hallucinations, delusional, mania, grandiose behavior, poor insight, hyperverbal, racing thoughts, insomnia, excessive worry, binge-eating, purging, and irritability.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All records demonstrated that the services requested were all subject to prior authorization according to the MCO's prior authorization list. Two records requested ASAM 3.7 WM level of

Requirements	M/NM	Comments
		care, which do not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of four standard requests and six standard concurrent requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests 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.
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/NM)*	10/10	In all cases, HSAG found that RMHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, and/or a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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 records demonstrated that 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 determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were providing used a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from RMHP in filing an appeal, and access to pertinent records. The NABDs provided also included the reason for denial, member-specific information and included contact information for providers in the area for alternative treatments/services, if applicable.
Was the denial decision made by a qualified clinician? (M/NM)*	10/10	In all cases, 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)*	10/10	All cases reviewed contained evidence that a peer-to-peer review was offered.
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 or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
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**)

Appendix I. Colorado Department of Health Care Policy & Financing
CY 2023 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans Medicaid Prime

Review Period:	January 1, 2023–October 31, 2023
Date of Review:	January 16, 2024
Reviewer:	Lauren Gomez and Courtney Bishop
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The two outpatient records HSAG reviewed consisted of: • Two adult records • One request for MH services • One request for SUD services
Service requested/indication:		Request for service included MH intensive outpatient program and out-of-network SUD intensive outpatient program. Diagnoses included alcohol dependence, major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. Presenting symptoms included anxiety, headaches, agitation, restlessness, depression, and panic attacks.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	M	All records demonstrated that the services requested were all subject to prior authorization according to the MCO's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of one standard request and one standard concurrent request.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either a preservice request or a request for additional days based on authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	2	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	1	One denial was related to the requesting provider being out-of-network when there are in-network providers available.

Requirements	M/NM	Comments
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	2/2	
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	2/2	Providers received a phone call, secure email, and/or a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M/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	2/2	All records 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 determination time frames were extended.
Did the NABD include the required content? (M/NM)*	2/2	All NABDs were providing used a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from RMHP in filing an appeal, and access to pertinent records. The NABDs provided also included the reason for denial, member-specific information and included contact information for providers in the area for alternative treatments/services, if applicable.
Was the denial decision made by a qualified clinician? (M/NM)*	2/2	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.

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)*	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)*	2/2	All records contained evidence that a peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	2/2	All records contained evidence that RMHP based determinations on nationally recognized criteria (MCG or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	2/2	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Total Applicable Elements	**16**	
Total Met Elements	**16**	
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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
20	16	16	100%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
120	96	96	100%

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

Summary

RMHP did not report any quantitative benefit limitations. RMHP accepted requests for authorization via fax, secure email, and telephone. RMHP did not delegate UM activities. RMHP was in partnership with United.

Inpatient Services

RMHP Prime's prior authorization list, policies, and procedures stated that the following inpatient services were subject to prior authorization and concurrent review requirements during CY 2023:

MH Services

- Acute hospitalization
- Acute treatment unit (prior authorization no longer required after August 31, 2023)
- Residential treatment center (short- and long-term)
  - Effective August 31, 2023, RMHP no longer requires prior authorization for acute treatment unit, qualified residential treatment programs (QRTP), and psychiatric residential treatment facilities (PRTF), with the exception of treatment for an eating disorder.

For emergency admission, RMHP allowed 24 hours for notification of the admission. Observation did not require prior authorization, but RMHP did request a call from the admitting facility. Crisis stabilization unit services did not require prior authorization.

SUD Services

- Inpatient medically monitored (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

Non-medical detoxification (3.2 WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

The following outpatient services required prior authorization/concurrent review:

MH Services

- Electroconvulsive therapy
- Partial hospitalization program
- Intensive outpatient program
- BH day treatment
- Out-of-network services (except emergency/crisis care)

SUD Services

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

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)
- Psychological/neurological testing
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

Strengths

RMHP demonstrated an overall score of 100 percent. During the CY 2023 review period, RMHP used MCG utilization review criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. RMHP required its UM staff to pass IRR testing annually with a minimum score of 80 percent. During the MHP interview, RMHP staff members reported the last IRR testing was conducted in November 2023 and all participants passed with the minimum score of 80 percent or better.

Based on the review of 10 inpatient and two outpatient utilization review denial records and associated documents, 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 requirements for processing requests for services. RMHP staff members noted during the interview an increase in the average length of stay for SUD low-intensity residential (3.1) and high-intensity residential (3.5) levels of care, and in an effort to decrease provider administrative burden and improve member care, RMHP extended the initial authorization from 14 days to 30 days beginning in April 2023. During the desk review, HSAG noted fewer outpatient denials in comparison to previous review years. RMHP staff members informed HSAG that UM staff members were more thoroughly considering medical necessity criteria and before the coordinator sent the potential denial to the reviewing provider, the coordinator sent it to a supervisor to see how the member could benefit the most from the type of care.

HSAG found that RMHP made the denial determinations within the required time frame and providers were notified of the denial determinations by telephone, secure email, and/or a copy of the NABD for all records reviewed. Additionally, all records demonstrated that the member was sent the NABD within the required time frame.

In all cases reviewed, the denial determination was made by a qualified clinician. In all applicable cases, the records contained evidence that a peer-to-peer review was offered to the requesting provider. All records demonstrated that the NABD reason for the denial was consistent with the reason documented in the UM system. RMHP's NABDs included the required content such as the member's appeal rights, rights to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from RMHP in filing an appeal, and access to pertinent records. Additionally, the NABDs included member-specific information and contact information for providers in the area for alternative treatments/services, if applicable.

During the MHP interview, RMHP reported working one-on-one with providers and continued training regarding submitting the proper documentation for MH and SUD requests for review and indicated a positive response to these trainings from providers.

RMHP additionally reported enhancing documentation when reaching out to the member after discharge from ASAM level of care treatments/services for case managers to better serve the member. Staff members also reported conducting case management meetings while members were in residential/inpatient treatment level of care to increase engagement in case management services. Additionally, RMHP staff members also reported having dedicated SUD case managers and peer support specialists that follow up with the member post-discharge.

Opportunities for Improvement and Recommendations

HSAG recommends:

- As a best practice, including a plain language explanation next to any medical terminology, as two NABDs contained medical jargon/terminology.

Table J-1 shows the services requiring prior authorization and selected UM policy details in effect throughout the review period. 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 MCE

Service Type/Code	RAE 1 RMHP	RAE 2 NHP	RAE 3 COA	RAE 4 HCI	RAE 5 COA	RAE 6 CCHA	RAE 7 CCHA	DHMP*	RMHP Prime
Inpatient Services (MH)									
Acute Hospitalization	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Emergency Admission	24-hour notifi-cation	24-hour notifi-cation	24-hour notifi-cation	24-hour notifi-cation	24-hour notifi-cation	No**	No**	24-hour notifi-cation	24-hour notifi-cation
Observation	Call on admission	Yes	No	Yes	No	No, but subject to Med Nec review	No, but subject to Med Nec review	No	Call on admission
Acute Treatment Unit (ATU)	No***	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No***
Residential Treatment Center (RTC) (Long and Short Term) (MH)	No***	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No***
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

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

Service Type/Code	RAE 1 RMHP	RAE 2 NHP	RAE 3 COA	RAE 4 HCI	RAE 5 COA	RAE 6 CCHA	RAE 7 CCHA	DHMP*	RMHP Prime
SUD Services^									
Inpatient (3.7 WM)	No	No	No	No	No	No	No	No	No
	If not authorized—Subject to medical necessity review								
Inpatient Medically Monitored (3.7)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
High-Intensity Residential (3.5)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Non-Medical Detoxification (3.2 WM)	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	No	No	No	No	No	No	No	No	No

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

Service Type/Code	RAE 1 RMHP	RAE 2 NHP	RAE 3 COA	RAE 4 HCI	RAE 5 COA	RAE 6 CCHA	RAE 7 CCHA	DHMP*	RMHP Prime
Outpatient Services									
Psychotherapy (P-Tx) (Initial evaluation)	No	No	No	No	No	No	No	No	No
P-Tx (60 minutes)	No	No	No	No	No	No	No	No	No
P-Tx (30 or 45 minutes)	No	No	No	No	No	No	No	No	No
Psychological/ Neurological Testing	No	No	Yes	No	Yes	Yes	Yes	Yes	No
Electroconvulsive Therapy (ECT)	Yes	Yes	Yes	Yes	Yes	No	No	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
Benefit limitations applied?	No	No	No	No	No	No	No	No	No

Service Type/Code	RAE 1 RMHP	RAE 2 NHP	RAE 3 COA	RAE 4 HCI	RAE 5 COA	RAE 6 CCHA	RAE 7 CCHA	DHMP*	RMHP Prime
Services by Out-of-Network (OON) Provider	All services by OON (except emergency/crisis) (cover only if in-network unavailable)								

Acronyms/abbreviations used in Table J-1 and Table J-2 below: ASAM, American Society of Addiction Medicine; IQ, InterQual; 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; Tx, treatment; WM, withdrawal management.

* DHMP does not require prior authorization for inpatient psychiatric and SUD services for members who are inpatient at DHMP hospital facilities.

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

***Effective August 31, 2023, RMHP no longer requires prior authorization for acute treatment unit, qualified residential treatment programs (QRTP), and psychiatric residential treatment facilities (PRTF), with the exception of treatment for an eating disorder.

^SUD inpatient and residential services became a managed care covered benefit as of January 1, 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 RMHP	RAE 2 NHP	RAE 3 COA	RAE 4 HCI	RAE 5 COA	RAE 6 CCHA	RAE 7 CCHA	DHMP	RMHP Prime
Criteria Used	MH-MCG All SUD-ASAM	MH-IQ All SUD-ASAM	MH-IQ All SUD-ASAM	MH-IQ All SUD-ASAM	MH-IQ All SUD-ASAM	MH-MCG All SUD-ASAM	MH-MCG All SUD-ASAM	MH-IQ All SUD-ASAM	MH-MCG All SUD-ASAM
Peer-to-Peer Review	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
IRR Testing/Passing Score	80%	90%*	90%	90%*	90%	90%	90%	90%	80%
Delegation of UM	No	Yes to Carelon	No	No Carelon/ Partner	No	No Anthem/ Partner	No Anthem/ Partner	Yes to COA	No
Level of Reviewer for Medical Necessity Denial Determinations	MD/DO All 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 PhD for psycho-logical testing	MD/DO All Services PhD for psycho-logical testing	MD/DO All Services	MD/DO All Services

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