COLORADO
Department of Health Care Policy & Financing

Fiscal Year 2024–2025 Mental Health Parity Compliance Audit Report

March 2025

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 [Mental Health Parity and Addiction Equity Act of 2008],"[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, six of the nine MCEs scored above 95 percent in calendar year (CY) 2024 record reviews, demonstrating the MCEs' strong adherence to prior authorization policies and procedures.[2] Five MCEs either improved or remained consistent, with scores between 96 and 99 percent. The remaining four MCEs demonstrated a decline in performance from the previous year; one MCE continued to show high compliance with a decline of 3 percentage points, resulting in an overall score of 97 percent. The other three MCEs showed a significant decline with a decrease in overall score ranging between 9 and 15 percentage points.

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, strengths, opportunities for improvement, and recommendations, please refer to Appendix B through Appendix J.

[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 28, 2024.

[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 MCE 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 federal and State regulations, each MCE has a certain amount of flexibility regarding how it structures prior authorization requirements. See Appendix A 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 B through Appendix J.

Table 2-1—Summary of Scores

RAE	MCE	2023 Total Score	Category of Service	Compliance Score	2024 Total Score
RAEs—Mental Health (MH)/Substance Use Disorder (SUD) Services					
1	Rocky Mountain Health Plans (RMHP)	97%	Inpatient	100%	99%^
			Outpatient	99%	
2	Northeast Health Partners (NHP)	91%	Inpatient	91%	96%^
			Outpatient	100%	
3	Colorado Access (COA)	95%	Inpatient	81%	80%v
			Outpatient	79%	
4	Health Colorado, Inc. (HCI)	96%	Inpatient	99%	99%^
			Outpatient	100%	
5	COA	95%	Inpatient	90%	86%v
			Outpatient	81%	
6	Colorado Community Health Alliance (CCHA)	96%	Inpatient	94%	96%~
			Outpatient	99%	
7	CCHA	95%	Inpatient	92%	96%^
			Outpatient	99%	

RAE	MCE	2023 Total Score	Category of Service	Compliance Score	2024 Total Score
MCOs—MH/SUD and Medical/Surgical (M/S) Services					
	Denver Health Medical Plan (DHMP)	94%	Inpatient	81%	81%v
			Outpatient	81%	
	Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)	100%	Inpatient	98%	97%v
			Outpatient	96%	
Total All MCEs		**95%**	**Inpatient**	**92%**	**92%v**
			Outpatient	**93%**	

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

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

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

Definitions

HSAG used the following definitions to evaluate and draw conclusions about the strengths and opportunities for improvement for the MCEs in each of the domains of quality, timeliness, and access to care and services. In this report, the icons will indicate that the strength or opportunity for improvement is related to the associated domain. The Centers for Medicare & Medicaid Services (CMS) defines these terms as follows:

		
Quality	**Timeliness**	**Access**
CMS defines "quality" in the final rule at 42 Code of Federal Regulations (CFR) §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO, PIHP [prepaid inpatient health plan], PAHP [prepaid ambulatory health plan], or PCCM [primary care case management] entity (described in 438.310[c][2]) increases the likelihood of desired outcomes of its enrollees through: its structural and operational characteristics; the provision of services that are consistent with current professional, evidence-based knowledge; and interventions for performance improvement."[1]	The National Committee for Quality Assurance defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCE—e.g., processing appeals and providing timely care.	CMS defines "access" in the final 2016 regulations at 42 CFR §438.320 as follows: "Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 438.68 (network adequacy standards) and 438.206 (availability of services)."[3]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

[2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

[3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.

Strengths

- When additional clinical information was necessary to make a determination, five MCEs documented multiple attempts to outreach the provider for additional information. In some of these instances, the MCEs processed an extension to provide additional time for the provider to respond to the MCE's outreach attempts. 

- In an effort to increase timely access to services, RAE 2 staff members reported assisting in building internet hubs with local libraries to provide members in rural areas with the ability to access telehealth services.
- CCHA staff members described how they collaborated with the Department to update policies ensuring that members admitted to inpatient levels of care in crisis but are later determined to have a non-covered diagnosis will continue to have their stay covered until they are stabilized and safe to discharge to a lower level of care.
- RMHP RAE 1 and Prime increased the passing interrater reliability (IRR) test score from 80 percent to 90 percent. RMHP staff members noted that this change occurred in preparation for transitioning from using Milliman Clinical Guidelines (MCG) to InterQual utilization review criteria for all MH determinations.
- Six MCEs documented proactive and/or timely referrals to care coordination to assist members with access to the right care, at the right time, in the right place.

Opportunities for Improvement

- Three MCEs did not include the clinical criteria used when making a determination within the member letters. Additionally, the same three MCEs did not send an NABD to the member when the denial was labeled as an administrative denial.
- MCEs showed inconsistency in documenting denials for lack of information. Some MCEs document an administrative denial when there is a lack of adequate information to make a determination, other MCEs document lack of information as medical necessity denials. In some instances, MCEs were inconsistent in this categorization, documenting some lack of information denials as administrative and others as not medically necessary.
- Four MCEs did not consistently adhere to internal peer-to-peer review procedures by issuing a medical necessity denial determination to the member before the peer-to-peer review was completed.
- Eight of the MCEs did not consistently send the NABD to the member within the required time frame, despite having accurate policies and procedures.
- Three MCEs did not consistently demonstrate outreach to the requesting provider to obtain additional information before issuing a denial related to a lack of adequate documentation to determine medical necessity.
- HSAG noted a trend of denials for outpatient psychological testing throughout multiple MCEs. MCE staff members reported that providers often raised questions regarding the process required by the Department and MCE regarding this benefit, resulting in a high percentage of overall denials related to the psychological testing benefit.

Recommendations

HSAG recommends that the Department:

- Review the Department's NABD template for clarity and examples regarding how MCEs must include references to the clinical criteria (e.g. InterQual, MCG, or American Society of Addiction Medicine [ASAM]) within the NABD. Monitor the MCEs' implementation of member communication and MCE NABD templates to ensure MCEs include member-specific information, references to the clinical criteria used, and ensure that members are receiving an NABD for all denials except for technical denials related to "clean claim issues."
- Provide MCEs with clarity regarding the Department's definition of medical necessity denials and administrative denials.
- Follow up with the four MCEs that did not adhere to their internal peer-to-peer review procedures before issuing a medical necessity denial determination to the member. Additionally, HSAG recommends that the Department review individual findings for trends and evidence of ongoing issues and consider corrective action plans, when appropriate.
- Follow up 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.
- Follow up 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.
- Review the psychological testing benefit and criteria used for making determinations. Additionally, provide guidance to both MCEs and providers regarding the appropriate use of this benefit.

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 MHPAEA, pursuant to Title 42 of the Code of Federal Regulations (42 CFR) Part 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] 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 2024–2025 findings from that audit of CY 2024 denial records for each Medicaid health plan.

Methodology

HSAG's assessment occurred in five phases:

1. Document Request
2. Desk Review
3. Web-Based 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 selected ABDs. In addition, HSAG requested that each MCE submit a complete list of inpatient and

[3] 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.

outpatient ABDs made between January 1, 2024, and October 31, 2024. 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. Web-Based Interviews

HSAG collaborated with the MCEs and the Department to schedule and conduct web-based 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 regarding findings, opportunities for improvement (if any), and recommendations for process improvement, if applicable.

As a result of the initial desk review and web-based 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 Services Requiring Prior Authorization and Policies, by MCE

Table A-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 A-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	24-hour notifi-cation	Yes	No	Yes	No	No, but subject to MN review	No, but subject to MN review	No	24-hour notifi-cation
Acute Treatment Unit (ATU)	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Residential Treatment Center (RTC) (Long and Short Term) (MH)	Yes **	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes**
Crisis Stabilization Unit (CSU)	No	After the 5th visit per episode of care	No	After the 5th visit per episode of care	No	No	No	No	No
SUD Services									
Inpatient (3.7 WM)	No	No	No	No	No	No	No	No	No
	If not authorized—Subject to medical necessity review								

Appendix A. Colorado Department of Health Care Policy & Financing
CY 2024 Utilization Management Monitoring Tool
for RAE 1—Rocky Mountain Health Plans

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 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 Program (IOP)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Routine Outpatient Tx	No	No	No	No	No	No	No	No	No
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

Appendix A. Colorado Department of Health Care Policy & Financing CY 2024 Utilization Management Monitoring Tool for RAE 1—Rocky Mountain Health Plans

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
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
Services by Out-of-Network (OON) Provider	All services by OON (except emergency/crisis) (cover only if in-network unavailable)								

Additional acronyms/abbreviations used in Table A-1 and Table A-2 below: ASAM, American Society of Addiction Medicine; IQ, InterQual; MCG, Milliman Clinical Guidelines; MN, 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.

** For RAE 1 and RMHP Prime: Long-term residential treatment requires prior authorization for HB modifiers only, except for CMHC, QRTP, and PRTF.

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

Table A-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 (through 2/28/2025) 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 (through 2/28/2025) All SUD–ASAM
Peer-to-Peer Review	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Interrater Reliability (IRR) Testing/Passing Score	90%*	90%	90%	90%	90%	90%	90%	90%	90%*
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.

Appendix B. Colorado Department of Health Care Policy & Financing
CY 2024 Utilization Management Monitoring Tool
for RAE 1—Rocky Mountain Health Plans

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 16, 2025
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 • No children/adolescent records • Five requests for MH services • Five requests for SUD services
Service requested/indication:		Request for services included inpatient hospitalization, psychiatric residential treatment facility, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored WM. Diagnoses included alcohol use disorder, major depressive disorder, other specified eating disorder, oppositional defiant disorder, post-traumatic stress disorder, borderline personality disorder, opioid dependence, other stimulant dependence, alcohol dependence, nicotine dependence, polysubstance use disorder, psychosis not due to substances, and generalized anxiety disorder. Presenting symptoms included substance withdrawal, anxiety, headaches, chronic back issues, irritability, entitled behavior, resistance to treatment, high relapse risk, suicidal ideations, history of trauma, paranoia, self-harm, suicidal ideations with plan, body dysmorphia, depression, obsessive thinking, problematic sleep, chronic purging, self-harm, feelings of worthlessness/guilt, poor concentration, history of sexual abuse, criminal behavior, neuropathy, unresolved grief, confusion, sweats, tremors, minimal

Requirements	M/NM	Comments
		coping skills, lack of insight, low impulse control, financial issues, unemployment, homelessness, lack of sober support, impaired interpersonal skills, restlessness, drug cravings, negative self-talk, mild mind racing, command auditory hallucinations, chronic pain, and emotional dysregulation.
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 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 one standard request and nine expedited 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)	0	
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, RMHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services	10/10	All 10 records demonstrated that the NABD was sent within the required time frame.

Requirements	M/NM	Comments
• Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
5. Did the NABD include the required content? (M/NM)*	10/10	All 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, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable.
6. 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.
7. 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.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All denials reviewed contained evidence that RMHP's peer review process was followed.
9. 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, Colorado Statewide Standardized Utilization Management guidelines, or ASAM).

Requirements	M/NM	Comments
10. 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**)

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 16, 2025
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 • Seven requests for MH services • Three requests for SUD services
Service requested/indication:		Requests for services included electroconvulsive therapy, MH intensive outpatient program, MH partial hospitalization program, ASAM 2.1 intensive outpatient program, and ASAM 2.5 partial hospitalization services. Diagnoses included bipolar disorder unspecified, major depressive disorder, anxiety disorder unspecified, opioid dependence uncomplicated, other stimulant dependance uncomplicated, cannabis use disorder, bipolar II disorder, borderline personality disorder, alcohol dependence uncomplicated, generalized anxiety disorder, post-traumatic stress disorder, nicotine dependence, reaction to severe stress unspecified, conduct disorder unspecified, and reactive attachment disorder of childhood. Presenting symptoms included longstanding depressive symptoms, multiple medication trials with limited benefits, multiple psychiatric hospitalizations, history of suicide attempts, suicidal ideations, impulsivity, irritability, relationship problems, agitation, restless sleep, cravings, fogginess, stress sensitivity, anxiety, depression, difficulty with emotional regulation, increased alcohol use, history of trauma, memory issues, difficulty with

Requirements	M/NM	Comments
		concentration, fatigue, restlessness, anhedonia, opposition and defiance, poor judgement, behavioral issues, disordered eating, low self-esteem, recent hospitalization, family discord, childhood trauma, decompensation of mental health, attachment related issues, and self-harm history.
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 expedited 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)	8	Eight 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.
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, RMHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD 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
• Expedited MH Services = 72 hours following the request for services • Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	1/1	RMHP 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.
5. Did the NABD include the required content? (M/NM)*	9/10	All 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. Nine NABDs provided also included the reason for denial, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable. However, in one ASAM SUD denial, the NABD did not list each of the required ASAM dimensions considered in making the determination.
6. 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.
7. 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. The record contained evidence of RMHP reaching out to the provider multiple times for additional information with no response from the provider.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All records contained evidence that RMHP followed its peer-to-peer review policy.
9. 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).

Requirements	M/NM	Comments
10. 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	**81**	
Score (Number Met / Number Applicable) = %	**99%**	

*** Scored Elements**

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

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

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

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score:*
100	82	81	99%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score:*
200	162	161	99%

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

Summary of Services Requiring Prior Authorization

Refer to Appendix A for a list of RMHP's services requiring prior authorization.

Strengths

- RMHP's Adverse Determination Notice Policy and procedures included very detailed instructions and member-focused requirements. 
- In instances when additional clinical information was necessary to make a determination, RMHP documented multiple attempts to outreach the provider for additional information. In one instance, RMHP processed an extension to provide additional time for the provider to respond to outreach attempts. 
- When appropriate, RMHP completed timely care management referrals to ensure members received assistance accessing the appropriate level of care. 

- RMHP increased the passing IRR test score from 80 percent to 90 percent. RMHP staff members noted that this was done in preparation for transitioning from using MCG to InterQual utilization review criteria for all MH determinations.

Opportunities for Improvement

- When denying a prior authorization due to lack of clinical information, RMHP issues a medical necessity denial. In instances where the requested service is for SUD, the NABD does not include the required documentation of consideration of the six ASAM dimensions.

Recommendations

HSAG recommends that RMHP:

- Consult with the Department for guidance regarding defining the appropriate denial type (i.e., administrative or medical necessity) and clarify policies and procedures to ensure all NABDs issued for SUD medical necessity denials include the six ASAM dimensions.

Appendix C. Colorado Department of Health Care Policy & Financing
CY 2024 Utilization Management Monitoring Tool
for RAE 2—Northeast Health Partners

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 15, 2025
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 • No children/adolescent records • Four requests for MH services • Six requests for SUD services
Service requested/indication:		Requests for service included inpatient hospitalization, residential crisis stabilization unit (CSU), ASAM 3.1 clinically managed low-intensity residential services, ASAM 3.2 WM clinically managed residential withdrawal management, ASAM 3.5 clinically managed high-intensity residential services, ASAM 3.7 medically monitored intensive inpatient services, ASAM 3.7 WM medically monitored inpatient withdrawal management. Diagnoses included bipolar I disorder, cannabis use disorder, post-traumatic stress disorder, alcohol use disorder, stimulant use disorder, generalized anxiety disorder, major depressive disorder, opioid use disorder, unspecified anxiety disorder, schizophrenia, unspecified bipolar and related disorder, amphetamine or other stimulant withdrawal, and unspecified depressive disorder. Presenting symptoms included suicidal ideations, auditory hallucinations, psychosis, verbal aggression, erratic behaviors, posturing, agitation, anxiety, poor sleep quality, previous psychiatric hospitalization, experiences auditory and visual hallucinations, extensive trauma history, poor insight, lack of

Requirements	M/NM	Comments
		impulse control, alcohol withdrawal, unstable housing, maladaptive coping skills, ongoing knee pain, unresolved grief, mild post-acute withdrawal syndrome, difficulty regulating emotions, mood swings, cravings, history of seizures, decrease in appetite, feelings of hopelessness, drinking until blackout, irritability, mood swings, stomach cramps, difficulty concentrating, and unemployment.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	Nine 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. One record was a concurrent request for a residential CSU. According to Carelon policy, Residential CSU does not require prior authorization until after the fifth visit per episode of care. One record was an initial request for ASAM 3.2 WM, which does not require prior authorization for the initial 5 days. Staff members verified that this record should have been issued the standard five-day minimum authorization.
Type of request: (Standard [S], Expedited [E], or Retrospective [R])		All 10 samples were expedited requests. One of the samples was an expedited request for SUD residential treatment for a Special Connections member. Special Connections members include members who are pregnant or within one year postpartum and have a prior authorization decision turnaround time requirement of 24 hours.
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.

Requirements	M/NM	Comments
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	9/10	In nine cases, Carelon (NHP's delegate) followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria. One of the cases was an initial request for ASAM 3.2 WM, which does not require prior authorization.
2. Was the provider notice sent within the required time frames (see below)? (M/NM)*	7/10	Providers received a phone call, secure email, and/or copy of the NABD within the required time frame in seven of the 10 samples.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for 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	8/10	Eight records demonstrated that the NABD was sent within the required timeframe. One record did not meet the SUD service timeframe requirement for written notice to the member within 72 hours. An additional record did not meet the 24-hour Special Connections time frame requirement.
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
5. Did the NABD include the required content? (M/NM)*	10/10	All 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, the clinical criteria used, member-specific information, and the contact

Requirements	M/NM	Comments
		information for providers in the area offering alternative treatments/services, if applicable.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No cases were denied for lack of information.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/10	Nine records contained evidence that NHP's peer-to-peer review policy was followed. In one record, the NABD was sent to the member prior to the completion of the peer-to-peer review.
9. 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).
10. 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	**73**	
Score (Number Met / Number Applicable) = %	**91%**	

*** Scored Elements**

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

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 22, 2025
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 • Seven requests for MH services • Three requests for SUD services
Service requested/indication:		Requests for service included electroconvulsive therapy, MH intensive outpatient, MH partial hospitalization program, and ASAM 2.1 intensive outpatient. Diagnoses included schizoaffective disorder unspecified, alcohol use disorder, post-traumatic stress disorder, major depressive disorder, generalized anxiety disorder, unspecified anxiety disorder, major depressive disorder with psychotic features, cannabis use disorder severe, amphetamine-type SUD, opioid use disorder, and cannabis intoxication with perceptual disturbances. Presenting symptoms included increased drinking, psychotic symptoms, command hallucinations, history of self-harm, suicidal ideation, depression, anxiety attack, instability, history of suicide attempts, anxiety, poor self-esteem, poor body image, craving for alcohol, angry, irritable, dependent, impulsivity, sensitivity to stress, feeling overwhelmed, paranoia, difficulty sleeping, chronic relapse, inability to exercise refusal skills, poor boundaries, criminological thinking, minimal insight, extensive trauma history,

Requirements	M/NM	Comments
		post-acute withdrawal syndrome, guilt, lack of motivation, and exhaustion.
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])		All records within the sample were standard 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)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, Carelon (NHP's delegate) followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for 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		
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
5. Did the NABD include the required content? (M/NM)*	10/10	All 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, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable.
6. 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.
7. 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.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All records contained evidence that NHP's peer-to-peer review policy was followed.
9. 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).
10. 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**)

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
100	80	73	91%

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

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

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	160	153	96%

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

Summary of Services Requiring Prior Authorization

Refer to Appendix A for a list of NHP's services requiring prior authorization.

Strengths

- NHP reported an increase in utilization of its online provider portal, Provider Connect, increasing efficiency of the utilization management process.
- NHP has updated its UM and care management systems to allow communication between the two, improving NHP's ability to provide efficient and timely care management services.
- NHP sponsored two conferences with a focus on provider education around the SUD continuum of care and improving documentation for SUD providers.
- NHP reported using funds from the American Rescue Plan Act (ARPA) to expand high-intensity outpatient services in some of the rural areas, increasing access to SUD services.

- In order to increase timely access to services, RAE 2 staff reported assisting in building internet hubs with local libraries to provide members in rural areas with the ability to access telehealth services.
- NHP has implemented a behavioral health transformation program in which coaches work with behavioral health and SUD providers to offer support and training as needed.

Opportunities for Improvement

- In several cases, NHP did not notify the provider or member of the denial within the required timeframe.
- NHP reviewers incorrectly selected the type of request (i.e., standard or urgent) in several cases.
- In one case, NHP completed a prior authorization review for medical necessity despite the Department's direction that an initial review at 3.2 WM level of care is not required.
- Many of the cases included a note stating the case was being referred to the second-level reviewer due to the number of units already approved at the requested level of care. In one case, the first-level reviewer noted that the clinical criteria was met but still referred for a second-level review due to the number of units already approved.

Recommendations

HSAG recommends that NHP:

- Enhance monitoring mechanisms to ensure that the provider and member are notified within the required timeframe.
- Provide ongoing training and auditing to ensure clinical reviewers are proficient in navigating the UM system and that requests are meeting required turnaround times.
- Implement additional training for providers and clinical reviewers to ensure only the levels of care that require prior authorization are reviewed.

- Document specific policies and procedures related to the requirement of second-level reviews after a specific length of stay at a level of care, specifically when clinical criteria is met, to ensure equity and remove barriers in receiving the right care, in the right place, at the right time.

Appendix D. Colorado Department of Health Care Policy & Financing
CY 2024 Utilization Management Monitoring Tool
for RAE 3—Colorado Access

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 15, 2025
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 3.5 clinically managed high-intensity residential, 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 alcohol dependence, major depressive disorder, attention-deficit/hyperactivity disorder, schizoaffective disorder bipolar type, autism spectrum disorder, intermittent explosive disorder, bipolar disorder unspecified, post-traumatic stress disorder, other psychoactive substance abuse, generalized anxiety disorder, opioid dependence, other stimulant dependence, and cannabis abuse. Presenting symptoms included anxiety, insomnia, depression, anxiety, panic attacks, increased alcohol use, suicide attempt, impulsivity, increasing agitation, destructive behaviors, mood dysregulation leading to concerns for overall safety, blood in urine, suicidal ideation with plan, intoxication, high relapse risk, relationship issues, emotional dysregulation, restless legs, low

Requirements	M/NM	Comments
		energy/fatigue, restlessness, isolation, history of substance use, complicated grief, and lack of housing.
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 expedited 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 authorization ending, or post-service requests for payment and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	6	Six 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)	4	Three administrative denials were related to lack of adequate documentation to determine medical necessity and one denial was related to a non-covered benefit.
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, COA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services	7/10	Seven records demonstrated that the NABD was sent within the required time frame. In three administrative denials, COA did not send an NABD to the member.

Requirements	M/NM	Comments
• Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	0/2	COA extended two denial determination timeframes to obtain additional information. COA did not send an extension letter to the member in either of the cases.
5. Did the NABD include the required content? (M/NM)*	4/10	Four 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, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable. COA did not send an NABD in three of the administrative denials in the sample. An additional three samples were medical necessity denials that did not include the clinical criteria used in making the determination.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	3/3	Three requests were administratively denied due to lack of adequate documentation to determine medical necessity. COA attempted to reach the requesting provider to obtain the additional documentation in all three samples.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	6/6	Six cases reviewed contained evidence that COA offered a peer-to-peer review. In three administrative denials for lack of information and one administrative denial for a non-covered diagnosis a peer-to-peer review was not applicable.

Requirements	M/NM	Comments
9. 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).
10. 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)*	6/10	Six samples included NABDs containing information about the reason for the denial that was consistent with the reason documented in the UM system. COA did not send an NABD in three administrative denials in the samples. One additional sample included an NABD with a denial reason that did not match the reason documented in the UM system.
Total Applicable Elements	**81**	
Total Met Elements	**66**	
Score (Number Met / Number Applicable) = %	**81%**	

*** 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, 2024–October 31, 2024
Date of Review:	January 15, 2025
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 child/adolescent records • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for services included psychological/neuropsychological testing, MH partial hospitalization program, MH intensive outpatient program, out-of-network psychotherapy, electroconductive therapy, and ASAM 2.1 intensive outpatient services. Diagnoses included major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder, attention-deficit/hyperactivity disorder, treatment resistant depression, bipolar disorder, and alcohol dependence. Presenting symptoms included suicidal ideations, homicidal ideations, substance use, anger, irritability, overwhelm, guilt, cravings for alcohol, medication non-compliance, mild withdrawal from substances, sleep issues, relationship issues, trauma, high risk of relapse, and anhedonia.
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 10 standard requests.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		Nine requests for service were new requests—either preservice requests or requests for additional days based on authorization ending. One denial was a termination of previously approved benefits.
Reason for the denial:		
Medical necessity? (Y/N)	7	Seven 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)	2	Two administrative denials were related to lack of adequate documentation to determine medical necessity.
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, COA followed policies and procedures related to which services require prior authorization and used nationally recognized criteria.
2. 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 in nine of the sample cases reviewed.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for 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	8/10	Eight records demonstrated that the NABD was sent within the required timeframe. COA did not send an NABD in two of the administrative denials in the sample cases reviewed.

Requirements	M/NM	Comments
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	0/2	COA extended two denial determination timeframes to obtain additional information. COA did not send an extension letter to the member in either of the cases.
5. Did the NABD include the required content? (M/NM)*	0/10	COA did not send an NABD in two of the samples. The remaining eight samples did not include the clinical criteria used in making the determination.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	2/2	Two requests were administratively denied due to lack of adequate documentation to determine medical necessity and COA outreached the provider for more information in both cases.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	7/7	Seven cases reviewed contained evidence that COA offered a peer-to-peer review. In two administrative denials for lack of information and one denial due to an out of network provider, a peer-to-peer review was not applicable.
9. Was the decision based on established authorization criteria? (M/NM)*	10/10	All 10 records contained evidence that COA based determinations on nationally recognized criteria (InterQual).
10. 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. COA did not send an NABD in two of the administrative denial cases reviewed.
Total Applicable Elements	**81**	
Total Met Elements	**64**	
Score (Number Met / Number Applicable) = %	**79%**	

*** 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	66	81%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
100	81	64	79%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	162	130	80%

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

Summary of Services Requiring Prior Authorization

Refer to Appendix A for a list of COA's services requiring prior authorization.

Strengths

- Clinical reviewers often notified care management of discharge in order to facilitate safe transitions of care. 
- COA upgraded its UM system to automatically accept provider requests submitted by fax into its system, improving efficiency, timeliness, and accuracy. 
- COA added a care management module enhancement to its UM system, allowing UM staff and CM staff to communicate directly within the same system to improve care management for members. 

Opportunities for Improvement

- Denials for lack of information were labeled as not medically necessary in the UM system notes; however, the providers were sent denial notices with a heading of "Administrative Denial."
- In cases denied for lack of information and in which a denial notice with a heading of "Administrative Denial" was sent to the provider, COA did not send an NABD to the member.
- In most of the sample cases reviewed, COA did not include information about the clinical criteria used to make the determination in the NABD.
- In sample cases where COA issued an extension, COA did not send the member the required extension letter.
- In one of the sample cases reviewed, COA approved the requested services, sending the member and provider notice of approval. When the provider submitted the member discharge information, COA discovered that the provider was out of network. COA then retroactively denied the services that had previously been approved.

Recommendations

HSAG recommends that COA:

- Consult with the Department for guidance regarding necessary updates to policy, procedures, and training related to selecting and documenting the appropriate denial type (i.e., administrative or medical necessity).
- Ensure that members are receiving an NABD for all denials except for technical denials related to "clean claim issues."
- Review and update COA's NABD template to include the required documentation of clinical criteria used to make a determination.
- When issuing extensions, enhance UM procedures and ongoing monitoring procedures to ensure the member receives the required extension letter.
- Provide continuous staff member training and ongoing monitoring to ensure that staff members do not terminate or reduce previously approved services.

Appendix E. Colorado Department of Health Care Policy & Financing
CY 2024 Utilization Management Monitoring Tool
for RAE 4—Health Colorado, Inc.

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 17, 2025
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, residential treatment center, MH partial hospitalization program, 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, alcohol use disorder, generalized anxiety disorder, oppositional defiant disorder, stimulant use disorder, cannabis use disorder, post-traumatic stress disorder, unspecified depressive disorder, disruptive mood dysregulation disorder, adjustment disorders unspecified, opioid use disorder, amphetamine-type SUD, attention-deficient, and hyperactivity disorder combined. Presenting symptoms included suicidal ideations, relationship issues, stress related to medical concerns, confusion, irritability, agitation, hopelessness, guilt, shame, tremors related to alcohol withdrawal, financial difficulties, cold sweats, diarrhea, nausea, recent suicide attempt, homicidal ideation, truancy, anxiety, difficulty with sleep, intermittent appetite, history of sexual abuse, elopement, history of self-harm, history of long-term substance use, poor decision making,

Requirements	M/NM	Comments
		anger, instability, self-sabotage, chronically unhoused, constipation, minimum sober supports, lack of housing, inability to maintain sobriety outside of a structured setting, dizziness, muscle aches, fatigue, sleep disturbances, and chills.
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 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 is permitted.
Type of request: (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of seven expedited requests, two standard requests, and one retrospective requests.
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	
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HCI followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 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
• Expedited MH Services = 72 hours following the request for services • Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
5. Did the NABD include the required content? (M/NM)*	10/10	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, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable.
6. 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.
7. 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.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/9	All applicable records demonstrated that peer-to-peer review was offered. In one instance, a peer-to-peer review was not applicable due to a post-service (retrospective) request.
9. 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).

Requirements	M/NM	Comments
10. 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	**78**	
Score (Number Met / Number Applicable) = %	**99%**	

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

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 17, 2025
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 MH partial hospitalization program, MH intensive outpatient, psychological testing, ASAM 1.0 outpatient treatment, ASAM 2.1 intensive outpatient treatment. Diagnoses included anorexia nervosa restricting type, unspecified other (or unknown) substance-related disorder, post-traumatic stress disorder, major depressive disorder, generalized anxiety disorder, opioid use disorder, mood disorder due to another medical condition with mixed features, and acute stress disorder. Presenting symptoms included concern of physical exercise routines after eating, intermittent restrictive eating behavioral with weight lost, history of substance use, concerning dietary habits, self-harm, suicidal ideation, history of criminal behavior, depression, dissociation, functional impairment, anger issues, emotional dysregulation, grief, trauma, inability to maintain sobriety outside of controlled environment, low frustration tolerance, anxiety, panic attacks, history of trauma, history of multiple suicide attempts, and history of multiple episodes of care.

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	The 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 10 standard 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)	0	
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HCI followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. 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 within the required time frame.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All 10 records demonstrated that the NABD was sent within the required time frame.

Requirements	M/NM	Comments
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
5. Did the NABD include the required content? (M/NM)*	10/10	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, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable.
6. 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.
7. 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.
8. 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.
9. 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).
10. 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**)

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

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

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

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	159	158	99%

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

Summary of Services Requiring Prior Authorization

Refer to Appendix A for a list of HCI's services requiring prior authorization.

Strengths

- HCI reported an increase in utilization of its online provider portal, Provider Connect, increasing efficiency of the utilization management process.
- HCI described implementing a behavioral health transformation program in which coaches work with behavioral health and SUD providers to offer support and training, as needed.
- HCI staff members reported updating their UM and care management systems to allow communication between the two, improving HCI's ability to provide efficient and timely care management services.
- HCI reported partnering with the Department to expand the SUD provider network with high-intensity outpatient services grants.

Opportunities for Improvement

- One record did not meet the SUD service time frame requirement for written notice to the member within 72 hours 
- HCI reviewers incorrectly selected the type of request (i.e., standard or urgent) in several cases. 

Recommendations

HSAG recommends that HCI:

- Provide ongoing training and enhance auditing to ensure clinical reviewers are proficient in navigating the UM system and that UM staff meets required prior authorization turnaround times.
- Provide ongoing training and auditing to ensure clinical reviewers are proficient in navigating the UM system and that requests are meeting required turnaround times.

Appendix F. Colorado Department of Health Care Policy & Financing
CY 2024 Utilization Management Monitoring Tool
for RAE 5—Colorado Access

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 15, 2025
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 alcohol dependence, cocaine dependence, bipolar disorder, major depressive disorder, unspecified mood disorder, alcohol use disorder, anxiety disorder unspecified, stimulant dependence, post-traumatic stress disorder, and schizophrenia. Presenting symptoms included mood swings, intermittent tremors, suicide attempt, anxiety, agitation, suicidal ideations, post-acute withdrawal syndrome, headaches, mild mental health symptoms, concerns related to living environment, lack of housing, difficulty with sleep, chronic pain, auditory hallucinations, history of trauma, and substance withdrawal.
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

Requirements	M/NM	Comments
		necessity review and concurrent review for continued authorization are permitted.
Type of request: (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of eight expedited requests and two retrospective requests.
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)	9	Nine denials were related to not meeting medical necessity. One of the medical necessity denials was a partial denial labeled a medical necessity denial in which part of the service was approved and part of the service was denied due to lack of adequate documentation to determine 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 administrative denial was related to lack of adequate documentation to determine medical necessity.
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, COA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services	9/10	Nine records demonstrated that the NABD was sent within the required time frame. In one of the administrative denial samples, COA did not send an NABD.

Requirements	M/NM	Comments
• Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
5. Did the NABD include the required content? (M/NM)*	5/10	Five 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, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable. COA did not send an NABD in one of the administrative denials in the sample. An additional four samples were medical necessity denials that did not include the clinical criteria used in making the determination.
6. 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.
7. 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 were denied due to lack of adequate documentation to determine medical necessity. COA attempted to contact the requesting provider to obtain the additional documentation in one of the cases.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	7/7	Seven records contained evidence that a peer-to-peer review was offered. In two post-service (retrospective) requests and one administrative denial, a peer-to-peer review was not applicable.
9. Was the decision based on established authorization criteria? (M/NM)*	10/10	All 10 records contained evidence that COA based determinations on nationally recognized criteria (InterQual or ASAM).

Requirements	M/NM	Comments
10. 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. COA did not send an NABD in one of the administrative denials.
Total Applicable Elements	**79**	
Total Met Elements	**71**	
Score (Number Met / Number Applicable) = %	**90%**	

*** 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 2024 Utilization Management Monitoring Tool
for RAE 5—Colorado Access

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 15, 2024
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 • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for services included psychological testing, out-of-network outpatient services, MH intensive outpatient program, MH partial hospitalization program, and ASAM 2.1 intensive outpatient program. Diagnoses included borderline personality disorder, major depressive disorder, post-traumatic stress disorder, alcohol use disorder, methamphetamine use disorder, bipolar disorder, attention and concentration disorder, trauma and stress related disorder, attention-deficit/hyperactivity disorder, generalized anxiety disorder, neurodevelopmental disorder, developmental delay, social anxiety disorder, obsessive compulsive disorder, and psychosis. Presenting symptoms included trauma, polysubstance abuse, trouble staying asleep, fatigue, irritability, poor motivation, problems with work and school performance, depression, anxiety, high relapse risk, chronic substance use, suicidal ideations, difficulties with impulse control, hopelessness, inattention, learning challenges, psychosis, executive dysfunction, and memory concerns.

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 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 authorization ending, or post-service requests for payment and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	8	Eight 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)	2	Two denials were related to lack of adequate documentation to determine medical necessity.
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, COA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for 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. In two of the administrative denials, COA did not send an NABD.

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		
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	0/1	COA extended one determination to obtain additional clinical information. COA did not send an extension letter to the member in this case.
5. Did the NABD include the required content? (M/NM)*	0/10	COA did not send an NABD in two of the administrative denials in the sample. An additional eight samples were medical necessity denials that did not include the clinical criteria used in making the determination.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	3/3	Three requests for service were denied due to lack of adequate documentation to determine medical necessity. COA attempted to contact the provider for additional information in all three cases.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	7/7	Seven records contained evidence that a peer-to-peer review was offered. In one post-service (retrospective) request and two administrative denials, a peer-to-peer review was not applicable.
9. 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).
10. 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. COA did not send an NABD in two of the administrative denials.
Total Applicable Elements	**81**	
Total Met Elements	**66**	
Score (Number Met / Number Applicable) = %	**81%**	

*** 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	71	90%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
100	81	66	81%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	160	137	86%

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

Summary of Services Requiring Prior Authorization

Refer to Appendix A for a list of COA's services requiring prior authorization.

Strengths

- Clinical reviewers often notified care management of discharge in order to facilitate safe transitions of care. 
- COA upgraded its UM system to automatically accept provider requests submitted by fax into its system, improving efficiency, timeliness, and accuracy. 
- COA added a care management module enhancement to its UM system, allowing UM staff and CM staff to communicate directly within the same system to improve care management for members. 

Opportunities for Improvement

- Denials for lack of information were labeled as not medically necessary in the UM system notes; however, the providers were sent denial notices with a heading of "Administrative Denial."
- In cases denied for lack of information and in which a denial notice with a heading of "Administrative Denial" was sent to the provider, COA did not send an NABD to the member.
- In most of the sample cases reviewed, COA did not include information about the clinical criteria used to make the determination in the NABD.
- In sample cases where COA issued an extension, COA did not send the member the required extension letter.

Recommendations

HSAG recommends that COA:

- Consult with the Department for guidance regarding necessary updates to policy, procedures, and training related to selecting and documenting the appropriate denial type (i.e., administrative or medical necessity).
- Ensure that members are receiving an NABD for all denials except for technical denials related to "clean claim issues."
- Review and update COA's NABD template to include the required documentation of clinical criteria used to make a determination.
- When issuing extensions, enhance UM procedures and ongoing monitoring procedures to ensure the member receives the required extension letter.

Appendix G. Colorado Department of Health Care Policy & Financing
CY 2024 Utilization Management Monitoring Tool
for RAE 6—Colorado Community Health Alliance

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 23, 2025
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Six adult records • Four children/adolescent records • Seven requests for MH services • Three requests for SUD services
Service requested/indication:		Requests for service included inpatient hospitalization, psychiatric residential treatment facility, 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 alcohol use disorder, opioid use disorder, bipolar II, unspecified mood disorder, generalized anxiety disorder, post-traumatic stress disorder, unspecified psychosis not due to a substance, unspecified disruptive impulse control and conduct disorder, attention-deficit/hyperactivity disorder, autism spectrum disorder with associated intellectual impairment, unspecified anxiety disorder, major depressive disorder, opioid dependence, oppositional defiant disorder, conduct disorder childhood-onset type, and alcohol dependence. Presenting symptoms included anxiety, depression, restlessness, cravings, sleep disturbances, lack of insight, relationship problems, restricted range of emotions, destabilization in community, history of suicide attempt, increased crisis events, paranoid delusions of people trying to kill them, tearful, disoriented, passive suicidal ideation, command auditory hallucinations to kill himself,

Requirements	M/NM	Comments
		polysubstance abuse, increased aggression toward family and at school, anger, lack of self-control, anhedonia, hopelessness, loss of interest, fatigue, restlessness, elevated pulse, sweating, bone and joint aches, yawning, tremors, gooseflesh skin, cravings, chills, drug dreams, sporadic escalations triggered by odd or simple circumstances, defiance, resistance, and alcohol related liver disease.
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 care at 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])		All 10 samples were expedited 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)	9	Nine 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 a non-covered diagnosis.
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, CCHA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. Was the provider notice sent within the required time frames (see below)? (M/NM)*	8/10	Providers received a phone call, a secure email, fax, and/or a copy of the NABD within the required time frame in eight of the sample cases reviewed. Two records did not meet the 72-hour expedited request time frame.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and	7/10	Seven cases demonstrated that the NABD was sent within the required time frame. Three cases demonstrated that the NABD was not sent within the 72-hour expedited time frame requirement.

Requirements	M/NM	Comments
Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	2/2	CCHA extended two determination timeframes. In both cases, CCHA sent the member an extension letter within the required time frame and included the required content.
5. Did the NABD include the required content? (M/NM)*	10/10	All 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, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No cases reviewed were denied for lack of information.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All denials reviewed contained evidence that a peer-to-peer review was offered.
9. 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
10. 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	**77**	
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 2024 Utilization Management Monitoring Tool
for RAE 6—Colorado Community Health Alliance

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 23, 2025
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 • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for service included psychological testing, MH partial hospitalization program, and ASAM 2.1 intensive outpatient program. Diagnoses included major depressive disorder, attention-deficit/hyperactivity disorder, post-traumatic stress disorder, disruptive mood dysregulation disorder, autism spectrum disorder, fragile X syndrome, and alcohol dependence. Presenting symptoms included inattention, poor attention span, depression, trouble with focusing and reading in school, fidgety, poor concentration, severe aggressive behaviors at home and school, panic attacks, possible sexual assault as a child, disorganization, distractibility, high risk for relapse, feelings of shame, and lack of coping skills.
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 10 standard 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.

Requirements	M/NM	Comments
Reason for the denial:		
Medical necessity? (Y/N)	9	Nine 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 a non-covered diagnosis.
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, CCHA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All records demonstrated that the NABD was sent within the required time frame.
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
5. Did the NABD include the required content? (M/NM)*	10/10	All 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, the clinical

Requirements	M/NM	Comments
		criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied due to lack of adequate documentation to determine medical necessity
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	8/9	Eight denials reviewed contained evidence that a peer-to-peer review was offered. In one denial record reviewed, a peer-to-peer review was offered; however, it was after the NABD was issued to the member. Another record was an administrative denial in which a peer-to-peer review was not applicable.
9. 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).
10. 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	**78**	
Score (Number Met / Number Applicable) = %	**99%**	

*** Scored Elements**

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

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
100	82	77	94%

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

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

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	161	155	96%

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

Summary of Services Requiring Prior Authorization

Refer to Appendix A for a list of CCHA's services requiring prior authorization.

Strengths

- When clinically indicated, UM reviewers proactively noted the potential need for care coordination services and submitted timely referrals for care coordination 
- CCHA occasionally issued extensions when in the best interest of the member, ensuring the provider and member have sufficient time to submit appropriate clinical information. 
- CCHA collaborated with the Department to update policies ensuring that members admitted to inpatient levels of care in crisis but are later determined to have a non-covered diagnosis will continue to have their stay covered until they are stabilized and safe to discharge to a lower level of care. 

Opportunities for Improvement

- In one case, the NABD was sent to the member prior to the completion of the peer-to-peer review.
- In several cases, the documentation of the requesting provider's denial of a peer-to-peer review was not clearly or consistently documented.

Recommendations

HSAG recommends that CCHA:

- Continue to follow established policies and procedures and enhance monitoring procedures to ensure that requesting providers are offered a peer-to-peer review prior to the issuance of the member NABD.
- Provide ongoing training and regular auditing to ensure efforts regarding peer-to-peer reviews are clearly and consistently documented.

Appendix H. Colorado Department of Health Care Policy & Financing
CY 2024 Utilization Management Monitoring Tool
for RAE 7—Colorado Community Health Alliance

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 23, 2025
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Five adult records • Five children/adolescent records • Seven requests for MH services • Three requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, psychiatric residential treatment facility, 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, opioid use disorder, persistent adjustment disorder with mixed depressed mood and anxiety, other stimulant dependence, attention-deficit/hyperactivity disorder, major depressive disorder, post-traumatic stress disorder, dissociative identity disorder, bipolar disorder, borderline intellectual functioning, anxiety disorder unspecified, reactive attachment disorder, trichotillomania, severe intellectual disability, disruptive behavior disorder, autism spectrum disorder, developmental delay, and cannabis dependence. Presenting symptoms suicidal ideations with intent and plan, multiple previous hospitalizations, increased depression, history of ongoing methamphetamine use, previous history of alcohol use, multiple detox episodes, fatigue, anxiety, sleep disturbances, difficulty concentrating, multiple suicide attempts, high risk of relapse, lack of family support, hopelessness, confusion, paranoia,

Requirements	M/NM	Comments
		poor impulse control, lacks stable housing, poor decision making, emotional dysregulation, anger, increasing suicidal and homicidal ideation, opposition to parental intervention, verbal and physical aggression toward others, and inability to self-regulate.
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. 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 three standard requests and seven expedited 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)	7	Seven 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)	3	One denial was related to the exhaustion of IMD benefits and two denials were related to non-covered diagnoses.
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, CCHA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. Was the provider notice sent within the required time frames (see below)? (M/NM)*	8/10	Providers received a phone call, secure email, fax, and/or copy of the NABD within the required time frame in eight of the 10 cases.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services	7/10	Seven cases demonstrated that the NABD was sent within the required time frame. Three records did not meet the SUD service or expedited MH service time frame requirement for written notice to the member within 72 hours.

Requirements	M/NM	Comments
• Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
5. Did the NABD include the required content? (M/NM)*	10/10	All 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, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied due to lack of adequate documentation to determine medical necessity
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	6/7	Seven denials reviewed contained evidence that a peer-to-peer review was offered. In one denial record reviewed, a peer-to-peer review was offered; however, it was after the NABD was issued to the member. Three records were administrative denials in which peer-to-peer reviews were not applicable.
9. 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
10. 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	**77**	
Total Met Elements	**71**	
Score (Number Met / Number Applicable) = %	**92%**	

*** 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 2024 Utilization Management Monitoring Tool
for RAE 7—Colorado Community Health Alliance

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 23, 2025
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 child/adolescent record • 10 requests for MH services • No requests for SUD services
Service requested/indication:		Requests for services included psychological testing. Diagnoses included major depressive disorder, mental disorder not otherwise specified, generalized anxiety disorder, and unspecified attention-deficit/hyperactivity disorder. Presenting symptoms included acting out behavior, distractibility, inattention, poor attention span, violence, physical aggression, anxiety, depression, history of trauma, bulimia nervosa, self-injurious behaviors, low motivation, polysubstance use, labile mood, history of behavioral issues, and low frustration tolerance.
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.
Type of request: (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of nine standard 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 or a new request for payment resulting in a post-service (retrospective review).

Requirements	M/NM	Comments
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 when there were in-network providers available.
Other (describe): (Y/N)	0	
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, CCHA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All cases demonstrated that the NABD was sent within the required time frame.
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
5. Did the NABD include the required content? (M/NM)*	10/10	All 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, the clinical

Requirements	M/NM	Comments
		criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied due to lack of adequate documentation to determine medical necessity
8. 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 denial record reviewed, a peer-to-peer review was offered; however, it was after the NABD was issued to the member.
9. 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).
10. 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	**79**	
Score (Number Met / Number Applicable) = %	**99%**	

*** Scored Elements**

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

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
100	77	71	92%

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

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

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	157	150	96%

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

Summary of Services Requiring Prior Authorization

Refer to Appendix A for a list of CCHA's services requiring prior authorization.

Strengths

- When clinically indicated, UM reviewers proactively noted the potential need for care coordination services and submitted timely referrals for care coordination 
- CCHA occasionally issued extensions when in the best interest of the member, ensuring the provider and member have sufficient time to submit appropriate clinical information. 
- CCHA collaborated with the Department to update policies ensuring that members admitted to inpatient levels of care in crisis but are later determined to have a non-covered diagnosis will continue to have their stay covered until they are stabilized and safe to discharge to a lower level of care. 

Opportunities for Improvement

- In one case, the NABD was sent to the member prior to the completion of the peer-to-peer review.
- In several cases, the documentation of the requesting provider's denial of a peer-to-peer review was not clearly or consistently documented.

Recommendations

HSAG recommends that CCHA:

- Continue to follow established policies and procedures and enhance monitoring procedures to ensure that requesting providers are offered a peer-to-peer review prior to the issuance of the member NABD.
- Provide ongoing training and regular auditing to ensure efforts regarding peer-to-peer reviews are clearly and consistently documented.

Appendix I. Colorado Department of Health Care Policy & Financing
CY 2024 Utilization Management Monitoring Tool
for Denver Health Medical Plan MCO

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 24, 2025
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, stimulant use disorder, post-traumatic stress disorder, generalized anxiety disorder, unspecified psychosis, alcohol use disorder, opioid use disorder, amphetamine-type substance use, anxiety disorder unspecified, schizoaffective disorder, and cocaine use disorder. Presenting symptoms included suicidal ideation with plan, agitation, anger, cravings, sleep disturbances, restlessness, fatigue, difficulty concentrating, high risk for relapse, ongoing alcohol abuse, history of trauma, insomnia, unresolved grief, lack of insight, low self-esteem, irritability, strained relationships, tactile disturbances, paranoia, auditory hallucinations, depression, and anxiety.
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 not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.

Requirements	M/NM	Comments
Type of request: (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of eight expedited requests and two retrospective reviews.
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)	9	Nine 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 sample was administratively denied due to lack of adequate information to determine medical necessity.
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, 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.
2. Was the provider notice sent within the required time frames (see below)? (M/NM)*	8/10	Providers received a phone call or secure email and a copy of the NABD in eight of the 10 samples.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for 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. In one record, COA did not send an NABD. Two records did not meet the SUD service time frame requirement for written notice to the member within 72 hours. An additional record did not meet the retrospective time frame of notice within 30 days of receipt by the UM department.
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	0/1	One determination time frame was extended, but no extension letter was sent to the member.

Requirements	M/NM	Comments
5. Did the NABD include the required content? (M/NM)*	4/10	Four 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, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable. In one case, COA did not send an NABD. An additional five NABDs did not list the clinical criteria used to make the determination.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	1/2	Two services were denied for lack of documentation from the provider. In one of the cases the requesting provider was contacted for additional information.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	8/8	All denials reviewed contained evidence that a peer-to-peer review was offered. In two cases, a peer-to-peer review was not applicable due to a post-service (retrospective) request.
9. 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).
10. 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. In one administrative denial, COA on behalf of DH MCO did not send an NABD.
Total Applicable Elements	**81**	
Total Met Elements	**66**	
Score (Number Met / Number Applicable) = %	**81%**	

*** 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 2024 Utilization Management Monitoring Tool
for Denver Health Medical Plan MCO

Review Period:	January 1–October 31, 2024
Date of Review:	January 24, 2025
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 psychological testing, MH partial hospitalization services, MH intensive outpatient services, and ASAM 2.1 intensive outpatient services. Diagnoses included attention-deficit/hyperactivity disorder, developmental delays, anorexia nervosa, bipolar disorder, major depressive disorder, generalized anxiety disorder, post-traumatic stress disorder, other stimulant dependence, mixed obsessional thoughts, disruptive mood dysregulation, intermittent explosive disorder, bipolar disorder, and borderline personality disorder. Presenting symptoms included anxiety, memory issues, difficulty with sustained attention, increased physical activity, meal refusal, emotional dysregulation, anger, anxiety, ruminating thoughts, agitation, decline in daily functioning, passive suicidal ideation, decision fatigue, excessive worry, chronic relapse, difficultly with verbal communication, does not take directions, makes no attempt at human interaction, limited verbal skills, and sleep disturbances.
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.

Requirements	M/NM	Comments
Type of request: (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of 10 standard 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)	9	Nine 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 a non-covered diagnosis.
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, 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.
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for 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	8/10	Eight records demonstrated that the NABD was sent within the required time frame. In one record, COA did not send an NABD. An additional record did not send a completed NABD until three months after the denial determination was made.
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.

Requirements	M/NM	Comments
5. Did the NABD include the required content? (M/NM)*	0/10	Nine NABDs did not include the clinical criteria used when making the determination. In one record, COA did not send an NABD.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied due to lack of adequate documentation to determine medical necessity.
8. 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 was offered. In one denial record reviewed, a peer-to-peer review was offered; however, it was after the NABD was issued to the member.
9. 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 & ASAM).
10. 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. In one record, COA did not send an NABD. An additional NABD cited the denial reason as not medically necessary when the UM notes documented the denial was due to a non-covered diagnosis.
Total Applicable Elements	**80**	
Total Met Elements	**65**	
Score (Number Met / Number Applicable) = %	**81%**	

*** 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	66	81%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
100	80	65	81%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	161	131	81%

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

Summary of Services Requiring Prior Authorization

Refer to Appendix A for a list of DHMP's services requiring prior authorization.

Strengths

- In one case, COA (DHMP's delegate) approved an alternative level of care without requiring the provider to submit an additional request.
- COA upgraded its UM system to automatically accept provider requests submitted by fax into its system, improving efficiency, timeliness, and accuracy.
- COA added a care management module enhancement to its UM system, allowing UM staff and CM staff to communicate directly within the same system to improve care management for members.

Opportunities for Improvement

- Denials for lack of information were labeled as not medically necessary in the UM system notes; however, the providers were sent denial notices with a heading of "Administrative Denial."
- In the case denied for lack of information and in which a denial notice with a heading of "Administrative Denial" was sent to the provider, COA did not send an NABD to the member.
- In most of the sample cases reviewed, COA did not include information about the clinical criteria used to make the determination in the NABD.
- In one sample case where COA issued an extension, COA did not send the member the required extension letter.

Recommendations

HSAG recommends that COA:

- Consult with the Department for guidance regarding necessary updates to policy, procedures, and training related to selecting and documenting the appropriate denial type (i.e., administrative or medical necessity).
- Ensure that members are receiving an NABD for all denials except for technical denials related to "clean claim issues."
- Review and update COA's NABD template to include the required documentation of clinical criteria used to make a determination.
- When issuing extensions, enhance UM procedures and ongoing monitoring procedures to ensure the member receives the required extension letter.

Appendix J. Colorado Department of Health Care Policy & Financing
CY 2024 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans Medicaid Prime

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 16, 2025
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, 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 bipolar disorder, major depressive disorder, alcohol dependence, opioid dependence, major depressive disorder with catatonia, other stimulant dependence, schizophrenia unspecified, cannabis abuse, sedative hypnotic/anxiolytic abuse uncomplicated, and anxiety disorder unspecified. Presenting symptoms included trouble sleeping, passive suicidal ideation, history of suicide attempts, paranoia, anxiety, depression, periods of catatonia, increased tolerance of substance, seizure disorder, mood swings, restlessness, irritability, agitation, stress sensitivity, family relationship issues, feelings of worthlessness, feelings of guilt and shame, chronic homelessness, psychosis including audio and visual hallucinations, aggression toward others, drug cravings, history of trauma, and high relapse risk.
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. One record requested ASAM 3.7 WM level of

Requirements	M/NM	Comments
		care, 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])		All 10 samples were expedited requests. One of the samples was an expedited request for SUD residential treatment for a Special Connections member. Special Connections members include members who are pregnant or within one year postpartum and have a prior authorization decision turnaround time requirement of 24 hours.
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	
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, RMHP Prime followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for 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. One record did not meet the SUD service time frame requirement for written notice to the member within 72 hours. An additional record did not meet the 24-hour Special Connections time frame requirement.

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		
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
5. Did the NABD include the required content? (M/NM)*	10/10	All 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, the clinical criteria used, member-specific information, and the contact information for providers in the area offering alternative treatments/services, if applicable.
6. 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.
7. 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.
8. 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.
9. Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that RMHP Prime based determinations on nationally recognized criteria (MCG or ASAM).
10. 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	**78**	
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**)

Review Period:	January 1, 2024–October 31, 2024
Date of Review:	January 16, 2025
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • 10 adult records • Four requests for MH services • Six requests for SUD services
Service requested/indication:		Request for service included MN intensive outpatient services, out of network psychotherapy, self-help/peer services, and ASAM 2.1 intensive outpatient services. Diagnoses included alcohol dependence uncomplicated, post-traumatic stress disorder, major depressive disorder, generalized anxiety disorder, cannabis abuse uncomplicated, anxiety disorder unspecified, and dependent personality disorder. Presenting symptoms included irritability, stress, difficulty sleeping, fatigue, sweating, palpitations, relationship issues, history of trauma, anxiety, cirrhosis of the liver, hair loss, negative thoughts, isolation, heavy drinking, flat affect, chronic relapse, chronic pain, frequent nightmares, emotional dysregulation, hypervigilance, flashbacks, auditory and visual hallucinations, high risk for relapse, and unresolved grief.
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.
Type of request: (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of four standard requests and six expedited requests.

Requirements	M/NM	Comments
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)	8	Eight denials were related to not meeting medical necessity. Two of the medical necessity denials were related to lack of adequate information to determine medical necessity.
Out-of-network provider? (Y/N)	2	Two denials were related to the requesting provider being out of network when there are in-network providers available.
Other (describe): (Y/N)	0	
1. Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, RMHP Prime followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
2. 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.
3. Was the member notice sent within the required time frame? (M/NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services or Continued Request for Inpatient and Residential SUD Services = 10 calendar days following the request for services • Initial Request for Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Initial Request for Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension, or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All records demonstrated that the NABD was sent within the required time frame.
4. If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	2/2	Two determination timeframes were extended. In both cases an extension letter was sent to the member within the required time frame and included the required content.

Requirements	M/NM	Comments
5. 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 labeled as medical necessity denials due to lack of information, the NABD did not list each of the required ASAM dimensions considered in making the determination.
6. 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.
7. If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	2/2	Two requests for service were denied due to lack of adequate documentation to determine medical necessity. RMHP Prime did attempt to contact the provider for additional information in both cases.
8. If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All denials contained evidence that a peer-to-peer review was offered.
9. Was the decision based on established authorization criteria? (M/NM)*	9/10	Nine records contained evidence that RMHP Prime based determinations on nationally recognized criteria (MCG or ASAM). In one case, RMHP Prime used ASAM criteria for a service to which ASAM does not apply.
10. 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	**84**	
Total Met Elements	**81**	
Score (Number Met / Number Applicable) = %	**96%**	

*** Scored Elements**

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

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

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
100	80	78	98%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: *
100	84	81	96%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: *
200	164	159	97%

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

Summary of Services Requiring Prior Authorization

Refer to Appendix A for a list of RMHP Prime's services requiring prior authorization.

Strengths

- RMHP Prime's Adverse Determination Notice Requirements and supporting documents included very detailed instructions and member-focused requirements.
- In instances when UM staff members needed additional clinical information to make a determination, RMHP Prime documented multiple attempts to outreach the provider for additional information. In two instances, RMHP Prime processed an extension to provide additional time for the provider to respond to outreach attempts.
- When appropriate, RMHP Prime completed timely care management referrals to ensure members received assistance accessing the appropriate level of care.

- RMHP Prime increased the passing IRR test score from 80 percent to 90 percent. RMHP Prime staff members noted that this was done in preparation for transitioning from using MCG to InterQual utilization review criteria for all MH determinations. 

Opportunities for Improvement

- When denying a prior authorization due to lack of clinical information, RMHP Prime issues a medical necessity denial. In instances where the requested service is for SUD, the NABD does not include the required documentation of consideration of the six ASAM dimensions. 

Recommendations

HSAG recommends that RMHP Prime:

- Consult with the Department for guidance regarding defining the appropriate denial type (i.e., administrative or medical necessity) and clarify policies and procedures to ensure all NABDs issued for SUD medical necessity denials include the six ASAM dimensions.