COLORADO
Department of Health Care Policy & Financing

FY 2022–2023 Mental Health Parity Compliance Audit Report

April 2023

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

Adverse Benefit Determinations Record Review

Pursuant to Colorado's house bill (HB) 19-1269, which states "The State Department shall contract with an External Quality Review Organization (EQRO) at least annually to monitor MCEs' utilization management programs and policies, including those that govern adverse determinations, to ensure compliance with the MHPAEA,"[1-1] the Colorado Department of Health Care Policy & Financing (the Department) has requested that Health Services Advisory Group, Inc. (HSAG), Colorado's EQRO, perform an assessment of Colorado's seven regional accountable entities (RAEs) and two Medicaid managed care organizations (MCOs)—collectively referred to hereafter as "health plans" or "MCEs" [managed care entities]—to determine whether each MCE has implemented and followed its own written policies, procedures, and organizational processes related to utilization management (UM) regulations. The Department chose to meet this objective through a review of 10 inpatient and 10 outpatient adverse benefit determination (ABD) records for each Medicaid MCE (to the extent full samples were available). Through record reviews, HSAG has determined whether each MCE demonstrated compliance with specified federal and State managed care regulations as well as its own policies and procedures. For additional information regarding the background of this project and the methodology used, please refer to Section 3. Background and Methodology.

Overview of Results

Overall, the statewide average score for the mental health parity (MHP) audit increased from 93 percent in the calendar year (CY) 2021 record reviews to 96 percent in the CY 2022 record reviews.[1-2] In CY 2021, scores for the two MCOs and the seven RAEs ranged from 81 percent to 100 percent. In CY 2022, scores ranged from 91 percent to 100 percent. One MCE showed consistent performance between CY 2021 and CY 2022 with a 97 percent total score in both years. Four MCEs demonstrated improved overall performance in CY 2022 as compared to CY 2021. The remaining four MCEs' total scores demonstrated a decline in performance in CY 2022 as compared to CY 2021. For additional information about the statewide findings, assessment, opportunities for improvement, and recommendations, please refer to Section 2. Findings and Assessment. For health plan-specific findings, opportunities for improvement, and recommendations, please refer to Appendix A through Appendix I.

[1-1] Colorado General Assembly. House Bill 19-1269 Mental Health Parity Insurance Medicaid. Available at: https://leg.colorado.gov/sites/default/files/2019a_1269_signed.pdf. Accessed on: Sept 21, 2022.

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

2. Findings and Assessment

Findings

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

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

Table 2-1—Summary of Scores

Managed Care Entity		2021 Total Score	Category of Service	Compliance Score	2022 Total Score
Regional Accountable Entities—Mental Health (MH)/Substance Use Disorder (SUD) Services					
Region 1	Rocky Mountain Health Plans (RMHP)	91%	Inpatient	99%	99%^
			Outpatient	100%	
Region 2	Northeast Health Partners (NHP)	98%	Inpatient	93%	91%v
			Outpatient	86%	
Region 3	Colorado Access (COA)	100%	Inpatient	98%	96%v
			Outpatient	94%	
Region 4	Health Colorado, Inc. (HCI)	94%	Inpatient	93%	92%v
			Outpatient	89%	
Region 5	Colorado Access (COA)	99%	Inpatient	93%	94%v
			Outpatient	94%	
Region 6	Colorado Community Health Alliance (CCHA)	86%	Inpatient	96%	97%^
			Outpatient	99%	
Region 7	Colorado Community Health Alliance (CCHA)	81%	Inpatient	90%	92%^
			Outpatient	93%	

Managed Care Entity	2021 Total Score	Category of Service	Compliance Score	2022 Total Score
Managed Care Organizations—MH/SUD and Medical/Surgical (M/S) Services				
Denver Health Medical Plan (DHMP)	97%	Inpatient	98%	97%~
		Outpatient	96%	
Rocky Mountain Health Plans Medicaid Prime (RMHP Prime)	89%	Inpatient	100%	100%^
		Outpatient	100%	
Total All MCEs	**93%**	**Inpatient**	**96%**	**96%^**
		Outpatient	**96%**	

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

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

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

Assessment

Overall, the statewide average score for the MHP audit increased from 93 percent in the CY 2021 record reviews to 96 percent in the CY 2022 record reviews. One MCE showed consistent performance (DHMP with a 97 percent total score in both years). Four MCEs improved overall performance (RMHP RAE 1: 91 percent to 99 percent, CCHA RAE 6: 86 percent to 97 percent, CCHA RAE 7: 81 percent to 92 percent, and RMHP Prime: 89 percent to 100 percent). The remainder of the RAEs' total scores declined in performance as follows:

- NHP RAE 2: 98 percent to 91 percent
- COA RAE 3: 100 percent to 96 percent
- HCI RAE 4: 94 percent to 92 percent
- COA RAE 5: 99 percent to 94 percent

Strengths

All MCEs used nationally recognized utilization review criteria as follows:

- RMHP RAE 1 and Prime used Milliman Clinical Guidelines (MCG) utilization review criteria for all MH determinations and American Society of Addiction Medicine (ASAM) level of care criteria for all SUD determinations.
- NHP RAE 2 and HCI RAE 4 used InterQual utilization review criteria for all MH determinations and ASAM level of care criteria for all SUD determinations.
- COA RAEs 3 and 5 and DHMP used InterQual utilization review criteria for all MH determinations and ASAM level of care criteria for all SUD determinations.

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

All MCEs followed their policies and procedures regarding interrater reliability (IRR) testing and required UM staff members to participate in IRR testing annually. IRR testing ensures the consistency and quality of UM decisions. RMHP RAE 1, RMHP Prime, NHP RAE 2, and HCI RAE 4 required an 80 percent IRR passing score, and COA RAEs 3 and 5, CCHA RAEs 6 and 7, and DHMP required an IRR passing score of 90 percent.

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

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

Eight of nine MCEs were in full compliance of following outlined policies and procedures in offering peer-to-peer review with the requesting provider before issuing a medical necessity denial determination.

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

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

Opportunities for Improvement and Recommendations

1. Seven MCEs were out of compliance for timeliness in notifying the provider of the denial determination and/or sending the NABD to the member within the required time frame, despite accurate policies and procedures. HSAG found noncompliance in:
   - Two of 14 records for NHP RAE 2:
     - One record demonstrated that NHP did not send the member, who was a Special Connections member, an NABD or notify the provider within the 24-hour time frame required by the Department.

  - One inpatient SUD record did not meet the Department's requirement for timely notice to the member within 72 hours.
- One of 20 records for COA RAE 3:
  - One inpatient SUD record did not meet the Department's requirement for timely notice to the member within 72 hours.
- Four of 13 records for HCI RAE 4:
  - In one outpatient record, HSAG found that HCI did not meet the requirement to send notice of the denial within 10 calendar days as required by 10 Code of Colorado Regulations (CCR) 2505-10 8.209.
  - One record demonstrated that HCI did not meet the Department's requirement for timely notice to a Special Connections member within 24 hours.
  - Two inpatient SUD records did not meet the Department's requirement for timely notice to the member within 72 hours.
- Two of 20 records for COA RAE 5:
  - Two inpatient SUD records demonstrated that COA did not meet the Department-required 72-hour time frame for notice to the member. Additionally, in one case, the provider was also not notified within the required 72-hour time frame.
- Three of 20 records for CCHA RAE 6:
  - One inpatient and one outpatient expedited MH record did not meet the required time frame for written NABD sent to the member within 72 hours as required by §438.404.
  - One record for an inpatient Special Connections member did not meet the time frame for written notice sent to the member within 24 hours as required by the Department.
- Eight of 20 records for CCHA RAE 7:
  - Three MH inpatient records demonstrated that CCHA did not meet the required 72-hour time frame for timely notice to the member as required by §438.404.
  - One SUD inpatient record demonstrated that CCHA did not meet the Department's requirement for timely notice to the member within 72 hours.
  - Two expedited SUD records did not meet the requirement to send notice of the denial within 72 hours as required by §438.404. Additionally, the provider was also not notified within the required time frame.
  - One MH outpatient record did not meet the requirement to send notice of the denial determination within 10 calendar days as required by 10 CCR 8.209 to the member or provider.
- Two records for DHMP:
  - One inpatient SUD record did not meet the required time frame for written notice sent to the member within 72 hours as required by the Department.
  - For one standard MH outpatient request, DHMP did not meet the requirement to send notice of the denial within 10 calendar days as required by 10 CCR 8.209.

HSAG recommends that the Department work with these MCEs to develop and implement ongoing staff training and monitoring to ensure adherence to the required time frames.

2. Four MCEs did not consistently include all required ASAM dimensions within the NABD to demonstrate to the member how each of the dimension were used when making the denial determination. HSAG found:
   - One inpatient SUD NABD for RMHP RAE 1 did not include the required ASAM dimensions.
   - Two inpatient SUD NABDs for CCHA RAE 6 only listed the ASAM dimensions that were not met.
   - Three inpatient SUD NABDs for CCHA RAE 7 only listed the ASAM dimension that were not met.
   - One inpatient SUD NABD for DHMP did not include the required ASAM dimensions.

   HSAG recommends that the Department continue to work with the MCEs and monitor compliance with using the ASAM dimensions in the applicable NABDs to ensure clear and consistent communication with the members regarding an SUD inpatient or residential denial determination.

3. While all MCEs articulated (in policy and process and during the MHP interviews) the intent to write NABD letters in language that is easy to understand for members, HSAG found that six MCEs (NHP RAE 2, COA RAE 3, HCI RAE 4, COA RAE 5, CCHA RAE 7, and DHMP) sent NABDs that included high reading-grade-level scores. Across the MCEs, common findings included:
   - Use of medical terminology without plain language explanation to further simplify the NABD for the member.
   - Use of acronyms without spelling the acronym out in its entirety the first time it is used within the NABD (e.g., Intensive Outpatient [IOP]).
   - Not stating member-specific information to provide background information to the member (e.g., what symptoms were found to be present or not present). This often caused the NABD to be short, unclear, and/or not member friendly.

   HSAG recommends that the Department continue to encourage the MCEs to implement best practices in completing member-specific information in the NABD template and provide guidance to the MCEs to consistently use the Department-approved template in a way that provides complete and accurate information in a clear, and easy-to-understand format and reading grade level.

3. Background and Methodology

Background

In fiscal year (FY) 2019–2020, the Department contracted with a vendor to perform a comparative analysis of policies, procedures, and organizational practices related to Colorado's seven RAEs and two MCOs that serve Colorado's Medicaid population for compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), pursuant to 42 Code of Federal Regulations (CFR) 438 Subpart K, and Colorado's Behavioral Health Care Coverage Modernization Act, pursuant to the Colorado HB 19-1269. This analysis included a comparison of MH and SUD services provided by the RAEs to M/S services provided by Colorado's Medicaid MCOs as well as by Colorado's fee-for-service (FFS) providers. The analysis assessed policies, procedures, and organizational practices related to the authorization of services and provider network management as well as compliance with non-quantitative treatment limitations (NQTLs) in four categories of care: inpatient, outpatient, pharmacy, and emergency services. In FY 2020–2021, the Department began contracting with HSAG to annually review each Medicaid health plan's[3-1] UM program and related policies and procedures, as well as a sample of prior authorization denials to determine whether the health plans followed federal and State regulations and health plan internal policies and procedures. This report contains HSAG's FY 2022–2023 findings from that audit of CY 2022 denial records for each Medicaid health plan.

Methodology

HSAG's assessment occurred in five phases:

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

1. Document Request

HSAG requested that each MCE submit documents including UM policies and procedures (as well as any related protocols, workflow diagrams, or program descriptions) and UM criteria used for the selected ABDs. In addition, HSAG requested that each MCE submit a complete list of inpatient and

[3-1] The definition of health plan is any of the following: managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management entity (PCCM-E). Colorado's regional accountable entities (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, 2022, and October 31, 2022. Using a random sampling technique, HSAG selected 20 ABDs for each MCE (10 inpatient files and 10 outpatient files). The MCEs then submitted to HSAG all records and pertinent documentation related to each ABD chosen. All data and file transfers were completed using HSAG's Secure Access File Exchange (SAFE) site.

2. Desk Review

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

3. Telephonic Interviews

HSAG collaborated with the MCEs and the Department to schedule and conduct telephonic interviews with key MCE staff members to:

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

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

4. Analysis

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

5. Reporting

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

Appendix A. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans RAE 1

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 27, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Eight adult records • Two children/adolescent records • Four requests for MH services • Six requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, residential treatment center, acute treatment unit, 3.2 WM clinically managed withdrawal management, 3.5 clinically managed high-intensity residential, 3.7 medically monitored intensive inpatient, and 3.7 WM medically monitored withdrawal management. Diagnoses included opioid dependence, other stimulant dependence, major depressive disorders, bipolar disorders, mood disorder, conduct disorder, oppositional defiant disorder, attention-deficit hyperactivity disorder, obsessive-compulsive disorder, alcohol use disorder, adjustment disorder, schizoaffective disorder, unspecified psychosis, alcohol dependence, generalized anxiety disorder, post-traumatic stress disorder. Presenting symptoms included anxiety, depression, poor insight, irritability, insomnia, auditory hallucinations, visual hallucinations, delusional ideation, body aches, nausea, vomiting, suicidal ideation, self-harming behaviors, aggression, conduct issues,

Requirements	M/NM	Comments
		impulsive behaviors, hyperverbal, withdrawn, headaches, destructive behaviors, and restlessness.
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 a WM level of care, one for ASAM 3.2 WM and one for 3.7 WM, which do not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of three standard requests, one expedited request, and six expedited concurrent requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on authorizations ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that RMHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services	10/10	All records demonstrated that the NABD was sent within the required time frame.

Requirements	M/NM	Comments
• Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	9/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial. However, one SUD denial did not list the required ASAM dimensions considered within the NABD.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All records contained evidence the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that RMHP based determinations on nationally recognized criteria (MCG or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.

Requirements	M/NM	Comments
Total Applicable Elements	**90**	
Total Met Elements	**89**	
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**)

Appendix A. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans RAE 1

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 27, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Five adult records • Five children/adolescent records • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for services included psychological/neuropsychological evaluation and testing, out-of-network psychological/neuropsychological evaluation and testing, out-of-network psychotherapy (60 minutes), partial hospitalization program, and SUD intensive outpatient program. Diagnoses included generalized anxiety disorders, attention-deficit hyperactivity disorders, adjustment disorders, autism spectrum disorders, major depressive disorders, opioid dependence, and post-traumatic stress disorders. Presenting symptoms included anxiety, depression, poor concentration and focus, restlessness, forgetfulness, insomnia, difficulties with social and emotional communication/regulation, mood difficulties, stress, trouble with coping, isolation, suicidal ideation, and nightmares.
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. This included the prior authorization

Requirements	M/NM	Comments
		requirement for psychological/neuropsychological evaluation and testing services through April 2022.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of nine standard requests and one expedited request.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new preservice requests.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	4	Four denials were related to the requesting provider being out of network when there were in-network providers available.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that RMHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All records demonstrated that the NABD was sent within the required time frame.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All records contained evidence the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that RMHP based determinations on nationally recognized criteria (MCG or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**90**	
Total Met Elements	**90**	
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: *
110	90	89	99%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
110	90	90	100%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
220	180	179	99%

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

Summary

RMHP staff members reported no quantitative benefit limitations. RMHP accepted requests for authorization through the provider portal online system, via fax, secure email, and by telephone. RMHP did not delegate UM activities. RMHP was in partnership with United.

Inpatient Services

RMHP's prior authorization list, policies, and procedures stated that the following inpatient services were subject to prior authorization and concurrent review requirements during CY 2022:

Mental Health

- Acute hospitalization
- Acute treatment unit
- Residential treatment center (short and long term)

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

Observation did not require prior authorization, but RMHP did request a call from the facility on admission. Crisis stabilization unit services did not require prior authorization.

SUD Services

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

Non-medical detoxification (3.2WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission, and RMHP did not impose a penalty for lack of notification within the first four/five days; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

The following outpatient services required prior authorization/concurrent review:

Mental Health

- Psychological/neurological testing only from January through April 2022
- Electroconvulsive therapy
- Partial hospitalization program
- Intensive outpatient program
- Behavioral health (BH) day treatment
- Out-of-network services (except emergency/crisis care)

SUD Services

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

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)
- Psychological/neurological testing—except from January through April 2022
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

Strengths

RMHP demonstrated an overall score of 99 percent. During the CY 2022 review period, RMHP used MCG utilization review criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. RMHP required its UM staff to pass IRR testing annually with a minimum score of 80 percent. During the MHP interview, RMHP staff members reported that the last IRR testing was conducted in November 2022 and all participants passed with the minimum score of 80 percent or better.

Based on review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, HSAG found that all files demonstrated that RMHP followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization and requirements for processing requests for services. RMHP used nationally recognized utilization review criteria (MCG or ASAM) for all records reviewed. HSAG found that RMHP made the denial determinations within the required time frame and providers were notified of the denial determinations through telephone and received a copy of the NABD for all records reviewed. Additionally, all records demonstrated that the member was sent the NABD within the required time frame.

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

All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system. RMHP's NABDs included the required content such as the member's appeal rights, rights to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and the reason for the denial. One SUD inpatient NABD did not list the required ASAM dimensions and how they were considered when determining medical necessity.

HSAG reviewed the NABDs and found that all NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test. While the NABDs were member-friendly and included the required content, HSAG found that some NABDs listed the requested service date as the date the denial determination was made. For instance, the NABD may have stated "On 2/1/2022, RMHP received a request from your provider, Dr. <<Name>>, for psychological testing. After review, we have denied the request on 12/20/2021." Per guidance from the Department and as a best practice, the date the MCE denied the request should be the date of the denial determination for a new request for service or the date the current authorization expires (or the first non-authorized day) for concurrent/continued requests.

During the MHP interview, RMHP reported continued training and education for providers regarding ASAM levels of care and how to submit proper and thorough documentation requests for review. RMHP included ASAM training videos on the website and provided more direct virtual training opportunities with providers regarding administrative documentation needs to ensure sufficient and complete requests for authorizations.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Periodic staff trainings and record review audits to ensure all inpatient and residential SUD NABDs list the required ASAM dimensions and how they were considered when determining medical necessity.
- Staff training and updating the NABD template to ensure language regarding the date of the denial determination is used correctly.
- Working with the Department for additional assistance and guidance to ensure that the NABDs are clear and cohesive for the member.

Appendix B. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Northeast Health Partners RAE 2

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 23, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Six adult records • Four children/adolescent records • Five requests for MH services • Five requests for SUD services
Service requested/indication:		Requests for service included MH residential treatment center, inpatient hospitalization, ASAM 3.1 clinically managed low-intensity residential services, acute treatment unit, ASAM 3.5 clinically managed high-intensity residential services, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored withdrawal management. Diagnoses included bipolar disorders, attention-deficit hyperactivity disorder, anxiety disorders, alcohol use disorders, major depressive disorder, alcohol dependence, cannabis dependence, stimulant use disorders, opioid use disorders, substance use disorder, conduct disorder, and other mental health disorders. Presenting symptoms included depression, anxiety, withdrawn behaviors, agitation, irritability, cravings, body aches, anger, and cold sweats.
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 3.7WM,

Requirements	M/NM	Comments
		which do not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of three standard requests, seven standard concurrent requests, and one expedited concurrent request.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that NHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	9/10	Providers received a phone call or email and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services	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, and one record did not meet the Special Connections member requirement for written notice to the member within 24 hours.

Requirements	M/NM	Comments
• Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	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, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All records contained evidence that the peer-to-peer was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that the RAE based determinations on nationally recognized criteria (InterQual or ASAM).
Was 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.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	7/10	Three NABDs scored reading grade levels higher than sixth grade using the Flesch-Kincaid readability test.
Total Applicable Elements	**90**	
Total Met Elements	**84**	
Score (Number Met / Number Applicable) = %	**93%**	

***Scored Elements**

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

Appendix B. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Northeast Health Partners RAE 2

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 23, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The five outpatient records HSAG reviewed consisted of: • Two adult records • Three children/adolescent records • Five requests for MH services. One authorization request was voided at the requesting provider's request due to no successful contact with the member and the member had been discharged from the program with no service units used.
Service requested/indication:		Requests for service included partial hospitalization program and electroconvulsive therapy. Diagnoses included bipolar disorders, panic disorders, generalized anxiety disorders, major depressive disorders, depressive disorder, autism spectrum disorder, attention-deficit hyperactivity disorder, alcohol use disorder, cannabis use disorder, substance use disorder, and opioid use disorder. Presenting symptoms included anxiety, depression, insomnia, separation fears, nightmares, agitation, aggression, behavioral issues, self-harming behaviors, poor coping skills, restlessness, and hyper-activity.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All five records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of three standard requests and two standard concurrent requests.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	4	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	1	One medical necessity denial was also related to being not a covered benefit. In system notes, NHP stated that the requested partial hospitalization program is not a covered benefit for an autism spectrum disorder diagnosis.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	4/4	In all cases, HSAG found that NHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	4/4	Providers received both a phone call and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	4/4	In all cases reviewed, NHP demonstrated that the NABD was sent within the required time frame.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	4/4	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, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	4/4	In all cases reviewed, a qualified clinician made the denial determination.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	4/4	All records contained evidence that the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	4/4	All records contained evidence that the RAE based determinations on nationally recognized criteria (InterQual).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	3/4	Most NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system. One NABD stated only that the reason for the denial was due to not being a covered benefit but did not state the other reason of not meeting medical necessity, as was stated in the system notes.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	0/4	All NABDs scored high reading grade levels using the Flesch-Kincaid readability test.
Total Applicable Elements	**36**	
Total Met Elements	**31**	
Score (Number Met / Number Applicable) = %	**86%**	

***Scored Elements**

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

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

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
110	90	84	93%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
48	36	31	86%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
158	126	115	91%

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

Summary

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

Inpatient Services

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

Mental Health

- Acute hospitalization
- Observation
- Acute treatment unit
- Residential treatment center (long and short term)
- Crisis stabilization unit (after the fifth visit per episode of care)

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

SUD Services

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

Non-medical detoxification (3.2WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission, and Beacon did not impose a penalty for lack of notification within the first four/five days; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

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

Mental Health

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

SUD Services

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

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

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

Strengths

NHP demonstrated an overall score of 91 percent. During the review period (CY 2022), Beacon used InterQual utilization review criteria for all MH utilization review determinations and ASAM level of care criteria for all SUD determinations. Beacon required its UM staff members to pass IRR testing annually with a minimum score of 80 percent. Beacon reported that the last IRR testing occurred in summer 2022 and UM staff members all exceeded the minimum score of 80 percent. During the MHP interview, Beacon staff members reported ongoing effort to consistently utilize the SUD authorization form to standardize requests. Based on review of 10 inpatient and four outpatient utilization review denial records and associated documentation, the records reviewed for NHP demonstrated that Beacon used nationally recognized utilization review criteria (InterQual or ASAM) and documented which criteria were used for determinations.

In all cases reviewed, HSAG also found that Beacon followed its policies and procedures related to which services require prior authorization. HSAG found that Beacon notified providers of the denial determinations by telephone or email and received a copy of the NABD within the required time frame for all records reviewed except in one inpatient record. Additionally, two inpatient records demonstrated that the member was not sent the NABD within the required time frame, including one Special Connections member. During the record review, the Special Connections record indicated that the clinical documentation for the request did not indicate the member was a Special Connections member; and once Beacon was made aware of this, it did not change how this case was processed and therefore did not meet the timeliness requirement. When HSAG asked Beacon if there is any place in the

UM system to identify whether a member is a special connections member, Beacon stated that UM staff would have to look at past authorizations to verify if a member is a Special Connections member.

HSAG found that in all cases reviewed, the denial determination was made by a qualified clinician and requesting providers were offered a peer-to-peer review.

Most NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system. One outpatient NABD only stated the reason for the denial as not being a covered benefit and did not provide any other information regarding the service not meeting medical necessity. Beacon staff members clarified that the NABD could have been clearer and provided more context to the member regarding the reasons for the denial. All NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records. Inpatient SUD NABDs also included the required language regarding how each ASAM dimension was considered when determining medical necessity. While most inpatient NABDs scored easy-to-understand reading grade levels using the Flesch-Kincaid readability test, all outpatient NABDs and three inpatient NABDs scored high reading grade levels. The NABDs often contained medical terminology without simplifying the language for the member or did not use member-friendly language to explain the reason for the denial. Beacon staff members reported during the interview that Beacon tried to establish basic language to use within the NABD template, but it continues to struggle due to trying to make the NABDs more detailed while also being clear and specific. Beacon further explained that it does periodic training about readability within the notices; however, staff members reported that training has not occurred "in a while."

During the MHP interview, Beacon staff members reported that when a particular level of care is denied and a lower level of care is recommended, if the member has been receiving services and the denial is related to a concurrent request to continue services, care coordination staff members are part of the member's discharge planning process and would coordinate follow-up. If the member had not been receiving services and the denial was related to a new request, the NABD may refer the member to care coordination to find a provider or to contact NHP/Beacon to request care coordination services.

Opportunities for Improvement and Recommendations

HSAG recommends:

- That Beacon monitor timeliness by ensuring that the provider and the member are made aware of the denial determination within the required time frame.
- While Beacon did include ASAM dimension language within the NABDs, it did not have the requirement for ASAM dimensions to be include in the NABD within its UM program policies and documents. As a best practice, applicable UM documents and policies and procedures should outline the required ASAM language within inpatient and residential SUD NABDs.
- Continuous and regular training for UM staff to ensure that NABDs are clear in describing the reason(s) for the denial and are written at an easy-to-understand reading grade level. Additionally, should Beacon use any medical terminology, HSAG recommends including a plain language explanation next to any medical terminology.

Appendix C. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Colorado Access RAE 3

Review Period:	January 1, 2022–October 31, 2022
Date of Review:	January 17, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Six adult records • Four children/adolescent records • Six requests for MH services • Four requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, acute treatment unit, MH residential treatment services, ASAM 3.1 clinically managed low-intensity residential services, ASAM 3.7 medically monitored intensive inpatient services, and ASAM 3.7 WM medically monitored withdrawal management. Diagnoses included anxiety disorder, major depressive disorders, post-traumatic stress disorders, opioid use disorders, methamphetamine use disorder, alcohol use disorders, schizoaffective disorder, schizophrenia, generalized anxiety disorders, stimulant use disorder, other stimulant dependence, and autism spectrum disorder. Presenting symptoms included depression, isolation, anxiety, situational anxiety, suicidal ideation, flashbacks, poor appetite, poor coping skills, body shaking, drug-seeking behaviors, altercations with peers, impulsive behaviors, and nightmares.
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,

Requirements	M/NM	Comments
		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 and eight expedited concurrent requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, HSAG found that COA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call or secure email and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services	9/10	Nine records demonstrated that the NABD was sent within the required time frame. One record did not meet the SUD service time frame requirement for written notice to the member within 72 hours.

Requirements	M/NM	Comments
• Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All records contained evidence the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that COA based determinations on nationally recognized criteria (InterQual or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	9/10	All NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**90**	
Total Met Elements	**88**	
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, 2022—October 31, 2022
Date of Review:	January 17, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Seven adult records • Three children/adolescent records • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for services included psychological/neuropsychological evaluation and testing, partial hospitalization program, SUD intensive outpatient program, MH intensive outpatient program, electroconvulsive therapy, and BH day treatment. Diagnoses included post-traumatic stress disorders, major depressive disorders, attention-deficit hyperactivity disorders, depressive disorders, anxiety disorder, oppositional defiant disorder, bipolar disorders, other stimulant dependence, panic disorder, borderline personality disorders, generalized anxiety disorders, unspecified psychosis, autism spectrum disorder, and opioid dependence. Presenting symptoms included depression, anxiety, insomnia, self-harming behaviors, defiant behavior, forgetfulness, concentration issues, comprehension issues, emotional dysregulation, anxiety attacks, anhedonia, weight gain, difficulty coping with changes, isolation, suicidal ideations, and auditory hallucinations.
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.

Requirements	M/NM	Comments
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of all standard requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new preservice requests.
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)	2	Two denials had limited submitted or updated clinical information to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, HSAG found that COA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call or secure email and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All records demonstrated that the NABD was sent within the required time frame.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	1/1	COA extended one denial determination to obtain additional clinical documentation. An extension letter was sent to the member within the requested time frame and included the required content.

Requirements	M/NM	Comments
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	1/2	Two requests for service were denied due to lack of documentation to determine medical necessity. One record contained no evidence in the record of COA reaching out to the provider for additional information, and during the interview, COA staff confirmed additional outreach did not occur.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All records reviewed contained evidence the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that COA based determinations on nationally recognized criteria (InterQual and ASAM).
Was 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 record, the UM system notes stated the member was denied the requested service due to meeting a higher level of care; however, this information was not documented in the NABD.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	6/10	Six NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**93**	
Total Met Elements	**87**	
Score (Number Met / Number Applicable) = %	**94%**	

***Scored Elements**

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

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

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
110	90	88	98%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
110	93	87	94%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
220	183	175	96%

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

Summary

COA staff reported no quantitative benefit limitations and did not delegate UM activities. COA accepted requests for authorization through an online portal and via fax, telephone, and secure email.

Inpatient Services

COA's prior authorization list, policies, and procedures stated that the following inpatient services are subject to authorization and concurrent review requirements during CY 2022:

Mental Health

- Acute hospitalization
- Acute treatment unit
- Residential treatment center (short and long term)

For acute hospitalizations, COA required prior authorization. For emergency admissions, COA allowed 24 hours for notification of the admission. Crisis stabilization unit and observation services did not require prior authorization.

SUD Services

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

Non-medical detoxification (3.2WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission, and COA did not impose a penalty for lack of notification within the first four/five days; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

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

Mental Health

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

SUD Services

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

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

- Routine outpatient treatment

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

Strengths

COA demonstrated an overall score of 96 percent. During the CY 2022 review period, COA used InterQual utilization review criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. COA required its UM staff to pass IRR testing annually with a minimum score of 90 percent. During the MHP interview, COA staff members stated that the last IRR testing was conducted in December 2022 and all participants passed with the minimum score of 90 percent or better.

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

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

Two outpatient records were denied due to lack of adequate documentation to determine medical necessity; however, one record did not provide documentation of additional outreach occurring to the requesting provider for additional information. COA staff confirmed during the MHP interview that additional outreach did not occur. All inpatient records and nine outpatient records demonstrated that the NABDs contained information about the reason for the denial that was consistent with the reason

documented in the UM system. All NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and the reason for the denial.

HSAG reviewed the NABDs and found most of the letters reviewed scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Monitoring timeliness by ensuring that the member is sent the NABD within the required time frame.
- Enhancing monitoring procedures to ensure additional outreach occurs with the requesting provider when adequate documentation is not received.
- Periodic staff training and monthly record audits to ensure that NABDs are at an easy-to-understand reading grade level.
- As a best practice, other than the SUD NABDs, which included the required ASAM dimensions, including reference to the health plan's criteria (i.e., InterQual) used in making the determination within the NABD and including more member-specific information regarding the reason for the denial (e.g., what symptoms COA found to be present or not present related to the criteria).

Appendix D. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Health Colorado, Inc. RAE 4

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 20, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Eight adult records • Two children/adolescent records • Three requests for MH services • Seven requests for SUD services
Service requested/indication:		Requests for service included inpatient hospitalization, MH residential treatment center, acute treatment unit, ASAM 3.1 clinically managed low-intensity residential, ASAM 3.5 clinically managed high-intensity residential services, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored withdrawal management. Diagnoses included opioid use disorders, unspecified schizophrenia disorders, alcohol use disorders, bipolar disorder, alcohol dependence, stimulant use disorders, panic disorder, post-traumatic stress disorders, major depressive disorder, generalized anxiety disorder, substance use disorder, and attention-deficit hyperactivity disorder. Presenting symptoms included anxiety, irritability, aggression, depression, agitation, frustration, restlessness, difficulty concentrating, drowsiness, insomnia, hot flashes, cold sweats, body shaking, muscle cramps/tightness, nausea, auditory hallucinations, withdrawn behaviors, suicidal ideation, defiant and reckless behaviors, and fatigue.
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

Requirements	M/NM	Comments
		prior authorization list. Two records requested ASAM 3.7 WM, which do not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of three standard requests, six standard concurrent requests, and one retrospective denial.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or a post-service request (retrospective) for payment of services not yet reviewed for medical necessity.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that HCI followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	9/10	Providers received a phone call and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services	7/10	Seven records demonstrated that the NABD was sent within the required time frame. Two records did not meet the SUD service time frame requirement for written notice to the member within 72 hours, and one record did not meet the Special Connections member requirement for written notice to the member within 24 hours.

Requirements	M/NM	Comments
• Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	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, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/9	In one instance, peer-to-peer review was not applicable for the retrospective denial. HCI followed its peer review policy for all records reviewed.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that HCI based determinations on nationally recognized criteria (InterQual or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	8/10	Two NABDs scored high reading grade levels using the Flesch-Kincaid readability test.
Total Applicable Elements	**89**	
Total Met Elements	**83**	
Score (Number Met / Number Applicable) = %	**93%**	

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

Appendix D. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Health Colorado, Inc. RAE 4

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 20, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The three outpatient records HSAG reviewed consisted of: • Two adult records • One child/adolescent record • Three requests for MH services
Service requested/indication:		Requests for service included partial hospitalization program and MH intensive outpatient. Diagnoses included major depressive disorders, disruptive mood dysregulation disorder, post-traumatic stress disorder, bipolar disorder, and alcohol dependence. Presenting symptoms included depression, agitation, anxiety, and poor sleep.
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All three records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of three standard concurrent requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	3	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.

Requirements	M/NM	Comments
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	3/3	In all three records reviewed, HSAG found that HCI followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	3/3	Providers received a phone call or email and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	2/3	Two records demonstrated that the NABD was sent within the required time frame. One record was sent 11 calendar days following the request for service.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	3/3	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, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	3/3	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.

Requirements	M/NM	Comments
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied from lack of information from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	3/3	All records reviewed contained evidence that the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	3/3	All records contained evidence that the RAE based determinations on nationally recognized criteria (InterQual).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	3/3	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	1/3	Two NABDs scored high reading grade levels using the Flesch-Kincaid readability test.
Total Applicable Elements	**27**	
Total Met Elements	**24**	
Score (Number Met / Number Applicable) = %	**89%**	

***Scored Elements**

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

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

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
110	89	83	93%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
33	27	24	89%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
143	116	107	92%

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

Summary

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

Inpatient Services

Beacon's prior authorization list, policies, and procedures stated that the following inpatient services are subject to prior authorization and/or concurrent review requirements during CY 2022:

Mental Health

- Acute hospitalization
- Observation
- Acute treatment unit
- Residential treatment center (long and short term)
- Crisis stabilization unit (after the fifth visit per episode of care)

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

SUD Services

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

Non-medical detoxification (3.2WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission, and Beacon did not impose a penalty for lack of notification within the first four/five days; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

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

Mental Health

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

SUD Services

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

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

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

Strengths

HCI demonstrated an overall score of 92 percent. During the review period (CY 2022), Beacon used InterQual utilization review criteria for all MH utilization review determinations and ASAM level of care criteria for all SUD determinations. Beacon required its UM staff members to pass IRR testing annually with a minimum score of 80 percent. Beacon reported the last IRR testing occurred in summer 2022 and UM staff members all exceeded the minimum score of 80 percent. During the MHP interview, Beacon staff members reported ongoing effort to consistently utilize the SUD authorization form to standardize requests. Beacon had submitted a full sample list of outpatient records to HSAG for review; however, most of the outpatient records submitted were administrative denials which were not within the scope of the revies this year, as determined by the Department. Therefore, HSAG reviewed only the medical necessity denials. During the MHP interview, Beacon staff members clarified that the administrative denials were documented incorrectly in the system as medical necessity denials causing the sample to be pulled incorrectly. Based on review of 10 inpatient and three outpatient utilization review denial records and associated documentation, the records reviewed for HCI demonstrated that Beacon used nationally recognized utilization review criteria (InterQual and ASAM) and documented which criteria were used for determinations.

In all cases reviewed, HSAG also found that Beacon followed its policies and procedures related to which services require prior authorization. HSAG found that Beacon notified providers of the denial determinations by telephone or email and received a copy of the NABD within the required time frame for all records reviewed except in one inpatient record. Additionally, in three inpatient records and one outpatient record, HSAG found that members, including one Special Connections member, were not sent the NABDs within the required time frame.

HSAG found that in all cases reviewed, the denial determination was made by a qualified clinician and in all applicable records reviewed, the requesting providers were offered a peer-to-peer review.

All NABDs contained information about the reason for the denial that was consistent with the reason documented in Beacon's UM system. The NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and the reason for the denial. Inpatient SUD NABDs also included the required language regarding how each ASAM dimension was considered when determining medical necessity. While most inpatient NABDs scored easy-to-understand reading grade levels using the Flesch-Kincaid readability test, two outpatient and two inpatient NABDs scored at high reading grade levels. NABDs often contained medical terminology without simplifying the language for the member or

did not use member-friendly language to explain the reason for the denial. Beacon staff reported during the interview that Beacon tried to establish basic language to use within the NABD template, but it continues to struggle due to trying to make the NABDs more detailed while also being clear and specific. Beacon further explained that it does periodic training about readability within the notices; however, training had not occurred in the review period.

During the MHP interview, Beacon staff members reported that when a particular level of care is denied and a lower level of care is recommended, if the member has been receiving services and the denial is related to a concurrent request to continue services, care coordination staff are part of the member's discharge planning process and would coordinate follow-up. If the member had not been receiving services and the denial was related to a new request, the NABD may refer the member to care coordination to find a provider or to contact HCI/Beacon to request care coordination services.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Periodic training and record audits to ensure that UM staff members are correctly identifying and documenting denial reasons within the UM system.
- That Beacon monitor timeliness by ensuring that the provider and the member are made aware of the denial determinations within the required time frame.
- While Beacon did include ASAM dimension language within the NABDs, it did not have the requirement for ASAM dimensions to be include in the NABD within its UM program policies and documents. As a best practice, applicable UM documents and policies and procedures should outline the required ASAM language within inpatient and residential SUD NABDs.
- Continuous and regular training for UM staff to ensure that NABDs are written at an easy-to-understand reading grade level. Additionally, should Beacon use any medical terminology, HSAG recommends including a plain language explanation next to any medical terminology.

Appendix E. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Colorado Access RAE 5

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 17, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Nine adult records • One child/adolescent record • Four requests for MH services • Six requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, acute treatment unit, ASAM 3.1 clinically managed low-intensity residential services, residential treatment center, ASAM 3.5 clinically managed high-intensity residential services, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored withdrawal management services. Diagnoses included major depressive disorders, post-traumatic stress disorders, unspecified psychosis, delusional disorder, other psychoactive substance use, stimulant use disorder, schizophrenia, alcohol dependence, alcohol use disorder, other stimulant dependence, cannabis dependence, attention-deficit hyperactivity disorder, and oppositional defiant disorder. Presenting symptoms included anxiety, depression, psychosis, paranoia, suicidal ideation, inability to concentrate, poor appetite, insomnia, agitation, aggression, irritability, headaches, panic attacks, hopelessness, restlessness, brain fog, visual hallucinations, defiant and disruptive behaviors, and impulsivity.

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. Two records requested ASAM 3.7 WM, which do not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of one standard preservice request, one expedited preservice request, six expedited concurrent requests, and two retrospective denials.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests, requests for additional days based on authorization ending, or post-service requests for payment and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	1	One denial was related to lack of adequate information to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that COA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	9/10	Providers received a phone call or secure email and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services	8/10	Eight records demonstrated that the NABD was sent within the required time frame. Two records did not meet the SUD service

Requirements	M/NM	Comments
• Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		time frame requirement for written notice to the member within 72 hours.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	1/1	COA extended one determination to obtain additional clinical information. An extension letter was sent to the member within the required time frame and included the required content.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	1/1	One request for service was denied due to lack of adequate documentation to determine medical necessity. COA did attempt to contact the provider for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	8/8	Eight records contained evidence that the peer-to-peer review was offered. In two retrospective denials, peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that COA based determinations on nationally recognized criteria (InterQual or ASAM).
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.

Requirements	M/NM	Comments
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	7/10	Seven NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**90**	
Total Met Elements	**84**	
Score (Number Met / Number Applicable) = %	**93%**	

***Scored Elements**

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

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

Appendix E. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Colorado Access RAE 5

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 17, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Four adult records • Six children/adolescent records • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for services included psychological/neuropsychological evaluation and testing, partial hospitalization program, MH and SUD intensive outpatient program, and electroconvulsive therapy. Diagnoses included major depressive disorders, generalized anxiety disorders, social anxiety disorders, other psychoactive substance abuse, panic disorder, other stimulant dependence, post-traumatic stress disorders, disruptive mood dysregulation disorders, adjustment disorder, oppositional defiant disorders, conduct disorder, alcohol use disorder, unspecified mood affective disorder, cocaine dependence, and alcohol dependence. Presenting symptoms included anxiety, depression, difficulties with social skills/interacting, low motivation, nightmares, poor appetite, labile mood, agitation, isolation, insomnia, decreased energy and mood, anhedonia, feelings of worthlessness, homicidal ideation, guilt, self-harm behaviors, panic attacks, suicidal ideation, dysregulated emotions, angry outbursts, impulsive behavior, defiant and disruptive behavior, and frustration.

Requirements	M/NM	Comments
Is prior authorization required according to the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N)	Y	All records demonstrated that the services requested were all subject to prior authorization requirements according to the RAE's prior authorization list.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of nine standard requests and one standard concurrent request.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	9/10	In nine cases reviewed, HSAG found that COA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria. In one case, COA did not document UM criteria used to review the case. During the interview, COA staff confirmed that UM criteria were not used to make the denial determination.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call or secure email and a copy of the NABD.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services	10/10	All records demonstrated that the NABD was sent within the required time frame.

Requirements	M/NM	Comments
• Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services		
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All records contained evidence that the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	9/10	Nine records contained evidence that COA based determinations on nationally recognized criteria (InterQual or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	7/10	Seven NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**90**	
Total Met Elements	**85**	
Score (Number Met / Number Applicable) = %	**94%**	

***Scored Elements**

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

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

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
110	90	84	93%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
110	90	85	94%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
220	180	169	94%

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

Summary

COA staff reported no quantitative benefit limitations and did not delegate UM activities. COA reported requests for authorization were received through an online portal and via fax, telephone, and secure email.

Inpatient Services

COA's prior authorization list, policies, and procedures stated that the following inpatient services are subject to authorization and concurrent review requirements during CY 2022:

Mental Health

- Acute hospitalization
- Acute treatment unit
- Residential treatment center (short and long term)

For acute hospitalization, COA required prior authorization. For emergency admissions, COA allowed 24 hours for notification of the admission. Crisis stabilization unit and observation services did not require authorization.

SUD Services

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

Non-medical detoxification (3.2 WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission, and COA did not impose a penalty for lack of notification within the first four/five days; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

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

Mental Health

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

SUD Services

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

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

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

Strengths

COA demonstrated an overall score of 94 percent. During the CY 2022 review period, COA used InterQual utilization review criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. COA required its UM staff to pass IRR testing annually with a minimum score of 90 percent. During the MHP interview, COA staff members reported that the last IRR testing was conducted in December 2022 and all participants passed with the minimum score of 90 percent or above.

Based on review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, HSAG found that COA followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization. In all records, except one outpatient record, COA used nationally recognized utilization review criteria (InterQual or ASAM). During the MHP interview, COA staff confirmed that InterQual was not documented in the specified record or used in the denial determination for psychological/neurological evaluation and testing. In most cases, HSAG found that COA made the denial determinations within the required time frame and providers were notified of the denial determinations through a phone call or secure email and received a copy of the NABD. Additionally, all outpatient records demonstrated that the member was sent the NABD within the required time frame. Two SUD inpatient records did not meet the required 72-hour time frame to send the NABD to the member. COA utilized an extension for one inpatient record to obtain additional documentation. HSAG found the extension letter was sent to the member within the required time frame and included the required content.

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

One inpatient record was denied due to lack of adequate documentation to determine medical necessity, COA attempted to contact the requesting provider for additional information. All NABDs contained information about the reason for the denial that was consistent with the reason documented in COA's UM system. All NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and the reason for the denial.

HSAG reviewed the NABDs and found most of the letters reviewed scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Ensuring all denial determinations due to medical necessity use established utilization review criteria (InterQual or ASAM).
- Enhancing monitoring procedures to ensure that the provider is made aware of the denial determination within the required time frame and the member is sent the NABD within the required time frame.
- Periodic staff training and monthly record audits to ensure NABDs are at an easy-to-understand reading grade level for the member.
- As a best practice, other than the SUD NABDs, which included the required ASAM dimensions, including reference to the health plan's criteria (i.e., InterQual) used in making the determination within the NABD and including more member-specific information regarding the reason for the denial (e.g., what symptoms COA found to be present or not present, related to the criteria).

Appendix F. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Colorado Community Health Alliance RAE 6

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 18, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Six adult records • Four children/adolescent records • Eight requests for MH services • Two requests for SUD services
Service requested/indication:		Requests for service included inpatient hospitalization, acute treatment unit, MH residential treatment center, ASAM 3.1 clinically managed low-intensity residential treatment, and ASAM 3.5 clinically managed high-intensity residential treatment. Diagnoses included major depressive disorders, reactive attachment disorder, post-traumatic stress disorder, anxiety disorder, alcohol dependence, opioid dependence, stimulant use disorder, attention-deficit hyperactivity disorder, and schizophrenia. Presenting symptoms included depression, anxiety, cravings, nightmares, defiant and disruptive behaviors, difficulty maintaining friendships with peers, visual hallucinations, irritability, and self-harm urges.
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.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of two standard requests, one standard concurrent request, and seven expedited concurrent requests.

Requirements	M/NM	Comments
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)	1	One denial was related to lack of updated clinical information to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, HSAG found that CCHA followed its policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, or fax and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	8/10	Eight records demonstrated that the NABD was sent within the required time frame. One record did not meet the expedited MH service time frame requirement for written notice to the member within 72 hours, and one record did not meet the Special Connections member requirement for written notice to the member within 24 hours.
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.

Requirements	M/NM	Comments
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, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial. However, two ASAM SUD denials did not list each of the required ASAM dimensions considered within the NABD.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	1/1	One request for service was denied due to lack of updated clinical information to determine medical necessity. CCHA did attempt to contact the provider for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/9	Nine denials reviewed contained evidence that the peer-to-peer review was offered. For one denial, peer-to-peer was not applicable due to the parent/guardian requesting residential treatment center for the member.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that CCHA based determinations on nationally recognized criteria (MCG or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**90**	
Total Met Elements	**86**	
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**)

Appendix F. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Colorado Community Health Alliance RAE 6

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 18, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • 10 adult records • Six requests for MH services • Four requests for SUD services
Service requested/indication:		Requests for service included MH and SUD intensive outpatient programs, partial hospitalization program, and psychological/neuropsychological evaluation and testing. Diagnoses included alcohol dependence, major depressive disorders, opioid dependence, generalized anxiety disorders, post-traumatic stress disorders, attention-deficit hyperactivity disorders, bipolar disorder, and autism-spectrum disorder. Presenting symptoms included depression, anxiety, disordered thinking, difficulties with social-emotional communicating and executive functioning, sensory sensitivities, restricted interests, passive suicidal ideation, withdrawn behaviors, and poor memory and eye contact.
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.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of six standard requests and four expedited concurrent requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on the authorization ending.

Requirements	M/NM	Comments
Reason for the denial:		
Medical necessity? (Y/N)	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)	3	Two denials were related to lack of clinical information or updated clinical information to determine medical necessity. One medical necessity denial was also related to autism spectrum disorder testing not being a covered benefit when it is covered by Medicaid FFS.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that CCHA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, or fax and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	9/10	Nine records demonstrated that the NABD was sent within the required time frame. One record did not meet the expedited MH service time frame requirement for written notice to the member within 72 hours.
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
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	2/2	Two requests for service were denied due to lack of adequate documentation to determine medical necessity. CCHA did attempt to contact the providers for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All denials reviewed contained evidence that the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that CCHA based determinations on nationally recognized criteria (MCG or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test. While ASAM dimensions are not required for outpatient SUD NABDs, CCHA did list the ASAM dimensions that were not met in some outpatient NABDs; however, in some instances, CCHA used roman numerals for the ASAM dimensions, which the member may find difficult to understand.
Total Applicable Elements	**92**	
Total Met Elements	**91**	
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: *
110	90	86	96%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
110	92	91	99%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
220	182	177	97%

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

Summary

CCHA reported no quantitative benefit limitations. CCHA accepted requests for authorization electronically through an online portal, via fax, and by telephone. CCHA staff members reported that CCHA changed its fax number in the reporting year but kept the previous fax number open while the transition occurred and for some time after to receive authorization requests. CCHA did not delegate UM activities. CCHA was in partnership with Anthem.

Inpatient Services

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

Mental Health

- Inpatient acute hospitalization
- Acute treatment unit
- Residential treatment center (long and short term)

For acute hospitalizations, CCHA required prior authorization. For emergency admissions, CCHA allowed 24 hours for notification of the admission. Observation level of care did not require prior authorization but was subject to medical necessity review. Treatment in a crisis stabilization unit did not require prior authorization.

SUD Services

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

Non-medical detoxification (3.2WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission, and CCHA did not impose a penalty for lack of notification within the first four/five days; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

The following outpatient services required prior authorization/concurrent review:

Mental Health

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

SUD Services

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

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

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

Strengths

CCHA demonstrated an overall score of 97 percent. During the review period (CY 2022), CCHA used MCG utilization review criteria for all MH utilization review determinations and ASAM level of care criteria for all SUD determinations. CCHA required its UM staff members, including medical directors, to pass IRR testing annually with a minimum score of 90 percent. During the MHP interview, CCHA reported that the last IRR testing occurred in June 2022 and UM staff members all passed with the minimum score of 90 percent or better.

Based on review of 10 inpatient and 10 outpatient utilization review denial records and associated documentation, the records review demonstrated that CCHA used nationally recognized utilization review criteria and documented which criteria were used for determinations. HSAG found that CCHA made the denial determinations within the required time frame and providers were notified of the denial determinations through telephone, secure email, or fax and received a copy of the NABD within the required time frame. However, two inpatient records and one outpatient record demonstrated that the member was not sent notice of the determination within the required time frame.

In all cases reviewed, the denial determination was made by a qualified clinician and requesting providers were offered a peer-to-peer review.

In one inpatient record and two outpatient records that were denied due to lack of adequate documentation to determine medical necessity, CCHA followed policies and procedures in attempting to reach out to the requesting provider for additional information. All NABDs contained information about the reason for the denial that was consistent with the reason documented in CCHA's UM system. Most of CCHA's NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and the reason for the denial. However, two inpatient SUD NABDs did not include the complete list of the required ASAM dimensions and how they were considered when determining medical necessity within the NABD. During the desk review, HSAG noted within the *UM Program Description* that CCHA did not include that discussion of each ASAM dimension is required in the NABD. HSAG recommended that CCHA update the *UM Program Description* document to include this information.

All inpatient and outpatient NABDs reviewed scored easy-to-understand reading grade levels using the Flesch-Kincaid readability test.

CCHA implemented a new care coordination referral desktop process after a previous suggestion from HSAG to ensure continuity of care after a denial determination is made during certain circumstances such as: when a member has been denied residential treatment center level of care, when a member is age 20 and under and requested benefits could fall under Early and Periodic Screening, Diagnostic and Treatment (EPSDT), when a member has been denied SUD treatment, and when it is determined that the member's needs are complex and the member could benefit from additional support and resources. HSAG determined that this is a best practice, and CCHA should continue implementation of this best practice and ensure any member who experiences one of these circumstances receives care coordination services, and if the member is referred to care coordination, it is documented in the system.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Monitoring timeliness by ensuring that members are sent the NABD in the required time frame or utilize extensions, if needed, to meet compliance.

- Including each of the required ASAM dimensions in the inpatient SUD NABDs and continuing to work with the Department to ensure that the NABDs include this requirement. Furthermore, CCHA should update the applicable document to ensure that each of the ASAM dimensions are listed in the NABD along with other required language.
- Continuing to use easy-to-understand language and ensuring that NABDs are member-friendly, such as using numbers instead of roman numerals for the ASAM dimensions. Additionally, if an acronym is used in the notice, CCHA should spell out the meaning of the acronym the first time it is used to ensure that the member understands the meaning of the acronym.

Appendix G. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Colorado Community Health Alliance RAE 7

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 18, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Six adult records • Four children/adolescent records • Seven requests for MH services • Three requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, ASAM 3.1 clinically managed low-intensity residential, ASAM 3.2 WM clinically managed withdrawal management, ASAM 3.7 WM medically monitored withdrawal management, acute treatment unit, and MH residential treatment center. Diagnoses included major depressive disorders, post-traumatic stress disorder, attention-deficit hyperactivity disorder, autistic disorder, opioid dependence, bipolar disorders, alcohol dependence, stimulant use disorder, and other stimulant dependence. Presenting symptoms included depression, anxiety, agitation, fleeting suicidal ideations, paranoia, insomnia, self-harm urges, poor insight and impulse control, irritability, aggression, defiant behaviors, and tiredness.
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 at WM level of care, one for ASAM 3.2 WM and one for 3.7 WM, which do not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.

Requirements	M/NM	Comments
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of one standard request, one expedited request, and eight expedited concurrent requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests were new requests—either preservice requests or requests for additional days based on the authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	1	One denial was related to lack of clinical information to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that CCHA followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call, secure email, or fax and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	6/10	Six cases demonstrated that the NABD was sent within the required time frame. Four cases demonstrated that the NABD was not sent within the required 72-hour time frame.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	7/10	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, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial. However, three ASAM SUD denials did not list each of the required ASAM dimensions considered within the NABD.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	1/1	One request for service was denied due to lack of clinical information to determine medical necessity. CCHA did attempt to contact the provider for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/10	Nine denials contained evidence that the peer-to-peer review was offered. CCHA confirmed during the interview that peer-to-peer review did not occur for one denial reviewed.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that CCHA based determinations on nationally recognized criteria (MCG or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	9/10	Nine NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**91**	
Total Met Elements	**82**	
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 G. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Colorado Community Health Alliance RAE 7

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 18, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Nine adult records • One child/adolescent record • Eight requests for MH services • Two requests for SUD services
Service requested/indication:		Requests for services included psychological/neuropsychological evaluation and testing, partial hospitalization program, MH and SUD intensive outpatient programs, and out-of-network psychotherapy. Diagnoses included post-traumatic stress disorders, major depressive disorders, generalized anxiety disorders, attention-deficit hyperactivity disorders, mild intellectual disabilities, borderline personality disorder, disruptive mood dysregulation disorder, dysthymic disorder, other stimulant dependence, obsessive-compulsive disorder, and opioid dependence. Presenting symptoms included depression, anxiety, poor attention span, inattention, easily distracted, auditory visual hallucinations, hopelessness, withdrawn behaviors, cravings, nightmares, poor appetite, and agitation.
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.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of six standard requests, one standard concurrent request, and three expedited concurrent requests.

Requirements	M/NM	Comments
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	1	One denial was related to lack of updated clinical information to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, HSAG found that CCHA followed its policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	8/10	Providers received a phone call or fax and a copy of the NABD. Two providers were not notified of the denial determination within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	7/10	Seven records demonstrated that the NABD was sent within the required time frame. Two records did not meet the expedited service time frame requirement for written notice to the member within 72 hours. One record did not meet the standard outpatient service time frame requirement for written notice to the member within 10 calendar days.
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
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	1/1	One request for service was denied due to lack of adequate documentation to determine medical necessity. CCHA did attempt to contact the providers for additional information.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	10/10	All denials reviewed contained evidence that the peer-to-peer review was offered.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that CCHA based determinations on nationally recognized criteria (MCG or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	9/10	Nine NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test. While ASAM dimensions are not required for outpatient SUD NABDs, CCHA did list the ASAM dimensions that were not met in some outpatient NABDs; however, in one NABD, CCHA used roman numerals for the ASAM dimensions, which the member may find difficult to understand.
Total Applicable Elements	**91**	
Total Met Elements	**85**	
Score (Number Met / Number Applicable) = %	**93%**	

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

Total Inpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Inpatient Record Review Score: *
110	91	82	90%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
110	91	85	93%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
220	182	167	92%

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

Summary

CCHA reported no quantitative benefit limitations. CCHA accepted requests for authorization electronically through an online portal, via fax, and by telephone. CCHA staff members reported that CCHA changed its fax number in the reporting year but kept the previous fax number open while the transition occurred and for some time after to receive authorization requests. CCHA did not delegate UM activities. CCHA was in partnership with Anthem.

Inpatient Services

CCHA's prior authorization list, policies, and procedures stated that the following inpatient services are subject to prior authorization and concurrent review requirements during CY 2022:

Mental Health

- Inpatient acute hospitalization
- Acute treatment unit
- Residential treatment center (long and short term)

For acute hospitalizations, CCHA required prior authorization. For emergency admissions, CCHA allowed 24 hours for notification of the admission. Observation level of care did not require prior authorization but was subject to medical necessity review. Treatment in crisis stabilization unit did not require prior authorization.

SUD Services

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

Non-medical detoxification (3.2WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission, and CCHA did not impose a penalty for lack of notification within the first four/five days; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

The following outpatient services required prior authorization/concurrent review:

Mental Health

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

SUD Services

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

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

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

Strengths

CCHA demonstrated an overall score of 92 percent. During the review period (CY 2022), CCHA used MCG utilization review criteria for all MH utilization review determinations and ASAM level of care criteria for all SUD determinations. CCHA required its UM staff members, including medical directors, to pass IRR testing annually with a minimum score of 90 percent. During the MHP interview, CCHA reported that the last IRR testing occurred in June 2022 and UM staff members all passed with the minimum score of 90 percent or better.

Based on review of 10 inpatient and 10 outpatient utilization review denial records and associated documentation, the records review demonstrated that CCHA used nationally recognized utilization review criteria and documented which criteria were used for determinations. HSAG found that CCHA made the denial determinations within the required time frame and providers were notified of the denial determinations through telephone, secure email, or fax and received a copy of the NABD within the required time frame for all inpatient records reviewed. In two outpatient records, providers were not notified of the denial determination within the required time frame. In four inpatient and three outpatient records reviewed, the member was not sent notice of the determination within the required time frame.

In all cases reviewed, the denial determination was made by a qualified clinician. In almost all cases, the requesting providers were offered a peer-to-peer review.

In one inpatient record and one outpatient record that were denied due to lack of adequate documentation to determine medical necessity, CCHA followed policies and procedures in attempting to reach out to the requesting provider for additional information. All NABDs contained information about the reason for the denial that was consistent with the reason documented in CCHA's UM system. CCHA's NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and the reason for the denial. Three inpatient SUD NABDs did not include the complete list of the ASAM dimensions and how they were considered when determining medical necessity within the NABD. During the desk review, HSAG noted within the *UM Program Description* that CCHA did not include that discussion of each ASAM dimension is required in the NABD. HSAG recommended that CCHA update the *UM Program Description* document to include this information.

Almost all inpatient and outpatient NABDs reviewed scored easy-to-understand reading grade levels using the Flesch-Kincaid readability test.

CCHA implemented a new care coordination referral desktop process after a previous suggestion from HSAG to ensure continuity of care after a denial determination is made during certain circumstances such as: when a member has been denied residential treatment center level of care, when a member is age 20 and under and requested benefits could fall under EPSDT, when a member has been denied SUD treatment, and when it is determined that the member's needs are complex and the member could benefit from additional support and resources. HSAG determined that this is a best practice, and CCHA should continue implementation of this best practice and ensure any member who falls under one of those circumstances receives continuity of care, and if the member is referred to care coordination, it is documented in the system.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Monitoring timeliness by ensuring that the provider is notified verbally or in writing and the member is sent written notice of the denial determination within the required time frame.

- Following established policies and procedures to ensure requesting providers are consistently offered peer-to-peer review. Additionally, HSAG recommends revising the *UM Program Description* document to ensure consistency between CCHA's written policies, program descriptions, and organizational processes.
- Including each of the required ASAM dimensions in the inpatient SUD NABDs and continuing to work with the Department to ensure that the NABDs include this requirement. Furthermore, CCHA should update the applicable documents to ensure that each of the ASAM dimensions are listed in the NABD along with other required language.
- Continuing to use easy-to-understand language and ensuring that NABDs are member-friendly, such as using numbers instead of roman numerals for the ASAM dimensions. Additionally, if an acronym is used in the notice, CCHA should spell out the meaning of the acronym the first time it is used to ensure that the member understands the meaning of the acronym.

Appendix H. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Denver Health Medical Plan MCO

Review Period:	January 1, 2022–October 31, 2022
Date of Review:	January 25, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Eight adult records • Two children/adolescent records • Five requests for MH services • Five requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, acute treatment unit, ASAM 3.1 clinically managed low-intensity residential services, ASAM 3.5 clinically managed high-intensity residential services, ASAM 3.7 medically monitored intensive inpatient, and ASAM 3.7 WM medically monitored withdrawal management services. Diagnoses included alcohol dependence, major depressive disorders, schizophrenia, other stimulant dependence, opioid dependence, generalized anxiety disorders, post-traumatic stress disorder, cannabis use disorder, nicotine use disorder, alcohol use disorder, panic disorder, borderline personality disorder, substance use disorder, psychotic disorder, intellectual disability, bipolar disorder, and attention-deficit hyperactivity disorder. Presenting symptoms included depression, anxiety, delusional thinking, catatonia, passive suicidal ideation, body aches, shaking, restless leg syndrome, nightmares, insomnia, and easily distracted.
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. Two records requested ASAM 3.7 WM, which do

Requirements	M/NM	Comments
		not require prior authorization; however, medical necessity review and concurrent review for continued authorization are permitted.
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of one expedited request, seven expedited concurrent requests, and two retrospective reviews.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or post-service requests and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, HSAG found that COA (DHMP's delegate), on behalf of DHMP, followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call or secure email and a copy of the NABD.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	9/10	Nine records 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
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	9/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial. However, one ASAM SUD denial did not list each of the required ASAM dimensions considered within the NABD.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	8/8	Eight denials reviewed contained evidence that the peer-to-peer review was offered. In two post-service (retrospective) requests, peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that COA based determinations on nationally recognized criteria (InterQual or ASAM).
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.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**88**	
Total Met Elements	**86**	
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**)

Appendix H. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Denver Health Medical Plan MCO

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 25, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • Six adult records • Four children/adolescent records • Eight requests for MH services • Two requests for SUD services
Service requested/indication:		Requests for services included psychological/neuropsychological evaluation and testing, partial hospitalization program, and MH and SUD intensive outpatient programs. Diagnoses included post-traumatic stress disorder, major depressive disorders, generalized anxiety disorders, social anxiety disorder, mild intellectual disabilities, attention-deficit hyperactivity disorders, other psychoactive substance dependence, schizoaffective disorder, bipolar disorder, cocaine dependence, unspecified psychosis, and cannabis use disorder. Presenting symptoms included depression, anxiety, low energy, insomnia, anger, loss of interest, distraction issues, difficulty concentrating, struggling to retain information, forgetfulness, social withdrawing, hyper-sensitivity, auditory hallucinations, suicidal and homicidal ideations, attention-seeking behaviors, stress, limited insight and judgement, changes in eating behaviors, and poor impulse control.
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 nine standard requests and one retrospective denial.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or a new request for payment resulting in a post-service (retrospective review)
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases reviewed, HSAG found that COA (DHMP's delegate), on behalf of DHMP, followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call or secure email and a copy of the NABD.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	9/10	Nine records demonstrated that the NABD was sent within the required time frame. One NABD was sent to the member seven months after the denial determination. COA staff clarified during the interview that once staff members were aware of the mistake, an NABD was sent to the member.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	NA	No determination time frames were extended.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing, and access to pertinent records; the template also addressed the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/9	Nine denials reviewed contained evidence that the peer-to-peer review was offered. One was a retrospective denial and the member had been discharged; therefore, a peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that COA based determinations on nationally recognized criteria (InterQual or ASAM).
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.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	7/10	Seven NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**89**	
Total Met Elements	**85**	
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: *
110	88	86	98%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
110	89	85	96%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
220	177	171	97%

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

Summary

DHMP delegated UM for BH services to Colorado Access (COA). DHMP staff reported no quantitative benefit limitations. COA accepted requests for authorization through an online portal and via fax, telephone, and secure email.

Inpatient Services

COA's prior authorization list, policies, and procedures stated that the following inpatient services are subject to authorization and concurrent review requirements during CY 2022:

Mental Health

- Acute hospitalization
- Acute treatment unit
- Residential treatment center (short and long term)

For acute hospitalization, COA (on behalf of DHMP) required prior authorization. For emergency hospitalizations, COA allowed 24 hours for notification of the admission. Inpatient psychiatric and SUD services for DHMP members who are inpatient at

DHMP hospital facilities (e.g., Denver Health and Hospital Authority) did not require prior authorization. During the MHP interview, DHMP and COA staff members explained that this process was effective as of July 1, 2022. Crisis stabilization and observation services did not require authorization.

SUD Services

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

Non-medical detoxification (3.2WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission, and COA did not impose a penalty for lack of notification within the first four/five days; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

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

Mental Health

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

SUD Services

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

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

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

Strengths

DHMP demonstrated an overall score of 97 percent. During the CY 2022 review period, COA used InterQual utilization review criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. DHMP and COA required their UM staff members to pass IRR testing annually with a minimum score of 90 percent. During the MHP interview, DHMP and COA staff members reported that the last IRR testing was conducted in December 2022 and that most staff passed with the required minimum score of 90 percent. One staff member was able to pass after additional training.

Based on review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, HSAG found that all files demonstrated that COA followed DHMP's prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization and requirements for processing requests for services. COA used nationally recognized utilization review criteria (InterQual or ASAM) for all records reviewed. HSAG found that COA made the denial determinations within the required time frame and providers were notified of the denial determination through telephone or secure email and received a copy of the NABD for all records reviewed. All records, except one inpatient and one outpatient record, demonstrated that the member was sent the NABD within the required time frame. The one outpatient record showed that the NABD was sent seven months after the denial determination was made, and once staff were made aware of the mistake, COA sent the NABD to the member.

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

All NABDs contained information about the reason for the denial that was consistent with the reason documented in COA's UM system. All NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and the reason for the denial. One SUD inpatient NABD did not list the required ASAM dimensions and how they were considered when determining medical necessity within the NABD.

HSAG reviewed the NABDs and found that the majority of the letters reviewed scored at easy-to-understand reading grade levels using the Flesch-Kincaid readability test. During the MHP interview, DHMP and COA staff members reported that a new NABD template was developed that explains to DHMP members how COA coordinates BH services on behalf of DHMP. DHMP and COA staff members were unsure of the exact implementation date; however, the sample template provided to HSAG was dated September 18, 2022. HSAG noted the new template within two outpatient files, but it was not used consistently across records after the September date. HSAG recognizes this template as a best practice as the new language within the template provides the member with a better understanding of the delegation between DHMP and COA.

In addition, DHMP staff explained the open communication lines and regular standing meetings between DHMP and COA to ensure that staff members are aware of UM changes or updates and to provide opportunities to discuss and collaborate between the two entities.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Enhancing monitoring procedures to ensure that the member is sent the NABD within the required time frame.
- Periodic staff training and monthly record audits to ensure NABDs are at an easy-to-understand reading grade level and include the required language such as the ASAM dimensions within inpatient and residential SUD NABDs. Additionally, ensuring staff that are assigned to DHMP authorizations use the correct revised template regarding DHMP's delegation to COA.
- As a best practice, other than the SUD NABDs, which ordinarily included the required ASAM dimensions, including reference to the health plan's criteria (i.e., InterQual) used in making the determination within the NABD and including more member-specific information regarding the reason for the denial (e.g., what symptoms COA found to be present or not present related to the criteria).

Appendix I. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans Medicaid Prime

Review Period:	January 1, 2022—October 31, 2022
Date of Review:	January 27, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Inpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 inpatient records HSAG reviewed consisted of: • Eight adult records • Two children/adolescent records • Eight requests for MH services • Two requests for SUD services
Service requested/indication:		Requests for services included inpatient hospitalization, residential treatment center, ASAM 3.1 clinically managed low-intensity residential, and ASAM 3.5 clinically managed high-intensity residential. Diagnoses included alcohol dependence, major depressive disorders, post-traumatic stress disorder, antisocial personality disorder, intermittent explosive disorder, other stimulant dependence, social phobia, attention-deficit hyperactivity disorders, autism spectrum disorders, other psychoactive substance abuse, cocaine dependence, bipolar disorder, schizoaffective disorder, unspecified psychosis, disruptive mood dysregulation disorder, unspecified intellectual disabilities, generalized anxiety disorder, and oppositional defiant disorder. Presenting symptoms included anxiety, depression, insomnia, night terrors/flashbacks, paranoia, irritability, explosive and aggressive behaviors, sexually problematic behaviors, separation anxiety, and anger issues.
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.

Requirements	M/NM	Comments
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of two standard requests, one expedited request, and seven expedited concurrent requests.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests or requests for additional days based on authorization ending.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	0	No denials were related to the requesting provider being out of network.
Other (describe): (Y/N)	1	One denial was related to lack of adequate documentation to determine medical necessity.
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that RMHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call or email and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All records demonstrated that the NABD was sent within the required time frame.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	1/1	RMHP extended one determination and an extension letter was sent to the member within the required time frame and included the required content.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	1/1	One request was denied due to lack of adequate documentation to determine medical necessity. RMHP did attempt to make contact multiple times to obtain the required documentation.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	8/8	Eight cases reviewed contained evidence that the peer-to-peer review was offered. In two residential treatment center requests, the parent/guardian requested the service and peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that RMHP based determinations on nationally recognized criteria (MCG or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**90**	
Total Met Elements	**90**	
Score (Number Met / Number Applicable) = %	**100%**	

***Scored Elements**

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

Appendix I. Colorado Department of Health Care Policy & Financing
CY 2022 Utilization Management Monitoring Tool
for Rocky Mountain Health Plans Medicaid Prime

Review Period:	January 1, 2022–October 31, 2022
Date of Review:	January 27, 2023
Reviewer:	Barbara McConnell and Lauren Gomez
Category of Service:	Outpatient
File #:	Aggregate

Requirements	M/NM	Comments
Date of initial request: Aggregate		The 10 outpatient records HSAG reviewed consisted of: • 10 adult records • Nine requests for MH services • One request for SUD services
Service requested/indication:		Requests for services included SUD intensive outpatient program, out-of-network psychotherapy (60 minutes), and psychological/neuropsychological evaluation and testing. Diagnoses included alcohol dependence, adjustment disorder, bipolar disorders, attention-deficit hyperactivity disorders, mild cognitive impairment, obsessive compulsive disorder, nonpsychotic mental disorder, major depressive disorders, post-traumatic stress disorders, generalized anxiety disorders, mild intellectual disabilities, and autistic disorder. Presenting symptoms included anxiety, depression, panic attacks, irritability, memory issues, difficulty concentrating, intrusive and distressing thoughts, hypervigilance, insomnia, trouble with interpersonal relationships, flashbacks, cognitive and adaptive functioning deficits, learning difficulties, repetitive behaviors, trauma, obsessive/compulsive behaviors, mood swings, and manic episodes.
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. This included the prior authorization requirement for psychological/neuropsychological evaluation and testing services through April 2022.

Requirements	M/NM	Comments
Type of request (Standard [S], Expedited [E], or Retrospective [R])		The sample consisted of eight standard requests, one standard concurrent request, and one retrospective review.
Type of denial: (Termination [T], New Request [NR], or Claim [CL])		All requests for service were new requests—either preservice requests, request for additional days based on authorization ending, or post-service request for payment and subsequent retrospective review.
Reason for the denial:		
Medical necessity? (Y/N)	10	All denials were related to not meeting medical necessity.
Out-of-network provider? (Y/N)	2	Two denials were related to the requesting provider being out-of-network when there were in-network providers available.
Other (describe): (Y/N)	0	
Followed internal policies related to the prior authorization list and the reason for denial? (M/NM)*	10/10	In all cases, HSAG found that RMHP followed policies and procedures related to which services require prior authorization and used nationally recognized UM criteria.
Date of denial determination:		
Date provider was notified (need not be in writing):		
Was the provider notice sent within the required time frames (see below)? (M/NM)*	10/10	Providers received a phone call or an email and a copy of the NABD within the required time frame.
Date notice of adverse benefit determination (NABD) sent to the member:		
Was the member notice sent within the required time frame? (M or NM)* • Standard Inpatient/Outpatient/Residential MH Services and Outpatient SUD Services = 10 calendar days following the request for services • Standard Inpatient and Residential SUD Services = 72 hours following the request for services • Expedited MH Services = 72 hours following the request for services • Special Connections Inpatient and Residential SUD Services = 24 hours following the request for services • Termination, Suspension or Reduction of Services prior to the end of an authorization period = 10 calendar days in advance of the proposed date to end or change the services	10/10	All records demonstrated that the NABD was sent within the required time frame.

Requirements	M/NM	Comments
If extended, was extension notification sent to the member with the required content? (M/NM/NA)*	1/1	RMHP extended one determination and an extension letter was sent to the member within the required time frame and included the required content.
Did the NABD include the required content? (M/NM)*	10/10	All NABDs were provided using a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the MCO in filing, and access to pertinent records; the template also included a field for the MCE to use to address the reason for the denial.
Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)*	10/10	In all cases reviewed, a qualified clinician made the denial determinations for services not meeting medical necessity.
If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)*	NA	No services were denied for lack of documentation from the provider.
If the MCE has a peer review policy/procedure/process, was it followed? (M/NM/NA)*	9/9	Nine records contained evidence the peer-to-peer review was offered. In one post-service (retrospective) request, a peer-to-peer review was not applicable.
Was the decision based on established authorization criteria? (M/NM)*	10/10	All records contained evidence that RMHP based determinations on nationally recognized criteria (MCG or ASAM).
Was the reason for denial in the utilization management (UM) system consistent with the reason the member was provided in the NABD letter? (M/NM)*	10/10	All NABDs contained information about the reason for the denial that was consistent with the reason documented in the UM system.
Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)*	10/10	All NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test.
Total Applicable Elements	**90**	
Total Met Elements	**90**	
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: *
110	90	90	100%

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

Total Outpatient Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Outpatient Record Review Score: **
110	90	90	100%

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

Total Scorable Elements:	Total Applicable Elements:	Total Met Elements:	Total Record Review Score: ***
220	180	180	100%

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

Summary

RMHP staff reported no quantitative benefit limitations. RMHP accepted requests for authorization through the provider portal online system and via fax, secure email, and telephone. RMHP did not delegate UM activities. RMHP was in partnership with United.

Inpatient Services

RMHP Prime's prior authorization list, policies, and procedures stated that the following inpatient services were subject to prior authorization and concurrent review requirements during the CY 2022:

Mental Health

- Acute hospitalization
- Acute treatment unit
- Residential treatment center (short and long term)

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

SUD Services

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

Non-medical detoxification (3.2WM) and inpatient (3.7 WM) levels of care do not need prior authorization for admission, and RMHP did not impose a penalty for lack of notification within the first four/five days; however, all days were subject to medical necessity review, including continued/concurrent reviews.

Outpatient Services

The following outpatient services required prior authorization/concurrent review:

Mental Health

- Psychological/neurological testing only from January through April 2022
- Electroconvulsive therapy
- Partial hospitalization program
- Intensive outpatient program
- BH day treatment
- Out-of-network services (except emergency/crisis care)

SUD Services

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

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

- Routine outpatient treatment
- Routine psychotherapy (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)
- Psychological/neurological testing—except from January through April 2022
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystem therapy

Strengths

RMHP demonstrated an overall score of 100 percent. During the CY 2022 review period, RMHP used MCG utilization review criteria for all MH determinations and ASAM level of care criteria for all SUD determinations. RMHP required its UM staff to pass IRR testing annually with a minimum score of 80 percent. During the MHP interview, RMHP staff members reported that the last IRR testing was conducted in November 2022 and all participants passed with the minimum score of 80 percent or better.

Based on review of 10 inpatient and 10 outpatient utilization review denial records and associated documents, HSAG found that all files demonstrated that RMHP followed its prior authorization list and UM policies and procedures with regard to which services were subject to prior authorization and requirements for processing requests for services. RMHP used nationally recognized utilization review criteria (MCG or ASAM) for all records reviewed. HSAG found that RMHP made the denial determinations within the required time frame and providers were notified of the denial determinations through a phone call or email and received a copy of the NABD for all records reviewed. Additionally, all records demonstrated that the member was sent the NABD within the required time frame. RMHP utilized an extension in one inpatient and one outpatient record. HSAG found the extension letter was sent to the member within the required time frame and included the required content.

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

In one inpatient record that was denied due to lack of adequate documentation to determine medical necessity, RMHP followed policies and procedures in attempting to make additional contact in order to try to obtain the required documentation needed to make the determination. All NABDs contained information about the reason for the denial that was consistent with the reason documented in RMHP's UM system. All NABDs included the required content such as the member's appeal rights, right to request a State fair hearing following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and the reason for the denial.

HSAG reviewed the NABDs and found that all NABDs scored at an easy-to-understand reading grade level using the Flesch-Kincaid readability test. While the NABDs were member-friendly and included the required content, HSAG found that some NABDs listed the requested service date as the date the denial determination was made. For instance, the NABD may have stated, "On 2/1/2022, RMHP received a request from your provider, Dr. <<Name>>, for psychological testing. After review, we have denied the request on 12/20/2021." Per guidance from the Department and as a best practice, the date the MCE denied the request should be the date of the denial determination for a new request for service or the date the current authorization expires (or the first non-authorized day) for concurrent/continued requests.

During the MHP interview, RMHP reported continued training and education for providers regarding ASAM levels of care and how to submit proper and thorough documentation requests for review. RMHP included ASAM training videos on the website and provided more direct virtual training opportunities with providers regarding administrative documentation needs to ensure sufficient and complete requests for authorizations.

Opportunities for Improvement and Recommendations

HSAG recommends:

- Staff training and updating the NABD template to ensure language regarding the date of the denial determination is used correctly.
- Working with the Department for additional assistance and guidance to ensure that the NABDs are clear and cohesive for the member.

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

Table J-1 shows the services requiring prior authorization and selected UM policy details through December 31, 2021. The table represents categories of service and may not include all Current Procedural Terminology (CPT) code types.

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

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

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

Service Type/Code	RMHP RAE 1	NHP RAE 2	COA RAE 3	HCI RAE 4	COA RAE 5	CCHA RAE 6	CCHA RAE 7	DHMP ***	RMHP Prime
SUD Services*									
Inpatient (3.7 WM)	No	No	No**	No	No**	No	No	No**	No
	If not authorized—Subject to medical necessity review								
Inpatient Medically Monitored (3.7)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
High-Intensity Residential (3.5)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Non-Medical Detoxification (3.2 WM)	No	No	No	No	No	No	No	No	No
	If not authorized—Subject to medical necessity review								
Low- and Medium-Intensity Residential (3.1/3.3)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Intensive Outpatient (IOP)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Routine Outpatient Tx	No**	No	No	No	No	No	No	No	No**

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

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

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

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

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

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

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

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

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

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

Criteria/Policies	RMHP RAE 1	NHP RAE 2	COA RAE 3	HCI RAE 4	COA RAE 5	CCHA RAE 6	CCHA RAE 7	DHMP	RMHP Prime
Criteria Used	MH-MCG All SUD-ASAM	MH-IQ All SUD-ASAM*	MH-IQ All SUD-ASAM	MH-IQ All SUD-ASAM*	MH-IQ All SUD-ASAM	MH-MCG All SUD-ASAM	MH-MCG All SUD-ASAM	MH-IQ All SUD-ASAM	MH-MCG All SUD-ASAM
Peer-to-Peer Review	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
IRR Testing/Passing Score	80%	80%	90%	80%	90%	90%	90%	90%	80%
Delegation of UM	No	Yes to Beacon	No	No Beacon/ Partner	No	No Anthem/ Partner	No Anthem/ Partner	Yes to COA	No
Level of Reviewer for Medical Necessity Denial Determinations	MD/DO All Services*	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.