COLORADO
Department of Health Care Policy & Financing

# SFY 2019–2020 Record Reviews for Mental Health Parity Compliance

*April 2021*

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

HSAG HEALTH SERVICES ADVISORY GROUP

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# 1. Executive Summary

## Background

In state fiscal year (SFY) 2019–2020, the Colorado Department of Health Care Policy and Financing (the Department) contracted with a vendor to perform a comparative analysis of policies, procedures, and organizational practices related to Colorado's seven regional accountable entities (RAEs) and two managed care organizations (MCOs) that serve Colorado's Medicaid population for compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), pursuant to 42 Code of Federal Regulations (CFR) 438 Subpart K, and Colorado's Behavioral Health Care Coverage Modernization Act, pursuant to the Colorado house bill (HB) 19-1269. This analysis included a comparison of mental health (MH) and substance use disorder (SUD) services provided by the RAEs to medical/surgical (M/S) services provided by Colorado's Medicaid MCOs as well as by Colorado's fee-for-service (FFS) providers. The analysis assessed policies, procedures, and organizational practices related to the authorization of services and provider network management as well as compliance with non-quantitative treatment limitations (NQTLs) in four categories of care: inpatient, outpatient, pharmacy, and emergency services.

## SFY 2019–2020 Adverse Benefit Determinations Record Review

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

### *Methodology*

HSAG's assessment occurred in five phases:

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

### 1. Document Request

HSAG requested that each health plan submit documents including UM policies and procedures (as well as any related protocols, workflow diagrams, or program descriptions) and UM criteria used for the selected ABDs. In addition, HSAG requested that each health plan submit a complete list of inpatient and outpatient ABDs made between May 1, 2020, and October 31, 2020. Using a random sampling technique, HSAG selected 20 ABDs for each health plan (10 inpatient files and 10 outpatient files). The health plans then submitted to HSAG all records and pertinent documentation related to each ABD chosen. All data and file transfers were completed using HSAG's Safe Access File Exchange (SAFE) site.

### 2. Desk Review

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

### 3. Telephonic Interviews

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

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

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

### 4. Analysis

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

### 5. Reporting

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

## Findings

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

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

**Table 1-1—Summary of Scores**

| Health Plan | Region | Compliance Score |
|---|---|---|
| **Regional Accountable Entities (MH/SUD Services)** | | |
| Rocky Mountain Health Plans (RMHP) | 1 | 100% |
| Northeast Health Partners (NHP) | 2 | 98% |
| Colorado Access (COA) | 3 | 100% |
| Health Colorado, Inc. (HCI) | 4 | 99% |
| Colorado Access (COA) | 5 | 98% |
| Colorado Community Health Alliance (CCHA) | 6 | 84% |
| Colorado Community Health Alliance (CCHA) | 7 | 83% |
| **Managed Care Organizations (MH/SUD and M/S Services)** | | |
| Denver Health Medical Plan (DHMP) | | 100% |
| Rocky Mountain Health Plans Medicaid Prime (RMHP Prime) | | 100% |
| **Total All Health Plans** | | 96% |

# Assessment

## *Strengths*

All health plans followed their policies and procedures regarding the use of nationally recognized utilization review (UR) criteria as follows:

- RMHP RAE 1 and RMHP Prime used Milliman Clinical Guidelines (MCG) criteria for MH treatment and American Society of Addiction Medicine (ASAM) level of care criteria for SUD services.
- NHP RAE 2 and HCI RAE 4 used InterQual for MH treatment and ASAM level of care criteria for SUD services.
- COA RAEs 3 and 5 and DHMP used InterQual criteria for both MH and SUD treatment.
- CCHA RAEs 6 and 7 used MCG criteria for both MH and SUD treatment.

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

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

Eight of nine health plans were in full compliance with the time frames for sending NABDs.

All health plans' policies and procedures described an appropriate level of expertise required for UM staff members making denial determinations, and record reviews demonstrated that all health plans followed these guidelines.

All health plans used a Department-approved NABD template letter that included the required information and notified members of their right to an appeal.

## *Opportunities for Improvement and Recommendations*

1. Two RAEs (CCHA RAEs 6 and 7) were out of compliance for timeliness in regard to sending NABDs, despite accurate policies and procedures. HSAG found noncompliance for NABD timeliness in seven of 20 records for CCHA RAE 6 and four of 20 records for CCHA RAE 7.

   HSAG recommended that the Department work with CCHA RAEs 6 and 7 to develop and implement ongoing staff training and monitoring to ensure that Colorado-specific timelines are adhered to, as Colorado timelines are more stringent than those in other states in which CCHA's partner organization works.

2. While all health plans had policies and procedures that described proactively offering peer-to-peer discussions prior to finalizing denial determinations when making medical necessity determinations, three RAEs (NHP RAE 2, HCI RAE 4, and CCHA RAE 7) had instances in which the offer was not adequately documented in the electronic documentation system.

   - For NHP RAE 2, HSAG found in two records of 12 reviewed for this element that there was no evidence the requesting providers were offered a peer-to-peer review with a medical director for medical necessity denials.
   - For HCI RAE 4, HSAG found in one record of 10 reviewed for this element that there was no evidence the requesting provider was offered a peer-to-peer review with a medical director.
   - For CCHA RAE 7, HSAG found in four of 12 records reviewed for this element there was no evidence the requesting provider was offered a peer-to-peer review with a medical director.

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

3. While all RAEs articulated (in policy and during interviews) the intent to write NABD letters in language easy to understand for members, HSAG found that three RAEs (COA RAE 5, CCHA RAE 6, and CCHA RAE 7) sent some letters that contained complex or confusing information.

   - For COA RAE 5, HSAG found that three of 20 letters included conflicting statements regarding whether the services were denied.
   - For CCHA, HSAG found that in 15 of 20 records reviewed for RAE 6 and 16 of 20 records reviewed for RAE 7, the RAE often referred the member to a page in the Health First Colorado Member Handbook, which contained general benefit information not clearly connected to the reason a service would not be covered. In addition, letters contained technical descriptions of all MCG criteria for approving a service, which included technical language and medical jargon and did not specify what related specifically to the member's symptoms and needs.

   HSAG recommended that the Department work with COA to revise standard NABD language for partial approvals of service, and with CCHA to determine the appropriate level and amount of information needed to ensure that members fully understand the reason for the denial in a manner most suited to each individual member.

# Appendix A. Colorado Department of Health Care Policy and Financing
# FY 2020–2021 Utilization Management Monitoring Tool
# for Rocky Mountain Health Plans RAE 1

| | |
|---|---|
| **Review Period:** | May 1–October 31, 2020 |
| **Date of Review:** | December 1–January 31, 2020 |
| **Reviewer:** | Barbara McConnell |
| **Category of Service:** | Inpatient and Outpatient |
| **File #:** | Aggregate |

| Requirements | M/A | Comments |
|---|---|---|
| Date of initial request: Aggregate | | The records HSAG reviewed consisted of:<br>• 10 inpatient (eight adults, two children/adolescents)<br>• 10 outpatient (eight adults, two children/adolescents)<br>Requests for service included inpatient acute care, residential treatment, intensive outpatient program (MH and SUD), partial hospitalization, psychotherapy at 60 minutes, diagnostic evaluation from out-of-network provider, and psychological testing. |
| Service requested/indication: | | Covered diagnoses included attention-deficit/hyperactivity disorder (ADHD), depressive/mood disorders, bipolar disorder, adjustment disorder, and schizophrenic spectrum disorders.<br>Non-covered diagnoses included SUD and autism spectrum disorders (ASD).<br>Presenting symptoms included psychosis, paranoia, suicidal ideations, anxiety, and aggression toward property and others. |
| Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N) | Y | All 20 records demonstrated that the services requested were all subject to prior authorization requirements per the RAE's prior authorization list. |
| Type of request (Standard [S], Expedited [E], or Retrospective [R]) | | The sample consisted of 13 standard requests, one urgent preservice request, and six urgent 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/A | Comments |
|---|---|---|
| Reason for the denial: | | |
| Medical necessity? (Y/N) | 11 | Eleven denials were related to not meeting medical necessity. |
| Not a covered benefit/diagnosis? (Y/N) | 9 | The "not a covered benefit" reason category included the non-covered diagnosis of ASD, requests from an out-of-network provider, and reaching the 15-day IMD benefit limitation. |
| Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N) | 2 | Two of the "not a covered benefit" reason category cases were related to the primary diagnosis of ASD. |
| Out-of-network provider? (Y/N) | 4 | Four of the "not a covered benefit" reason category cases were related to the requesting provider being out of network. In two of these cases, a physician reviewed for medical necessity to ensure that an equivalent service was available from an in-network physician. |
| Other (describe): (Y/N) | 3 | Three of the "not a covered benefit" reason category cases were due to reaching more than 15 days in an IMD. |
| Followed internal policies related to the prior authorization list and the reason for denial? (M/N)* | 20/20 | In all cases, HSAG found that RMHP RAE 1 followed policies and procedures related to which services require prior authorization and followed nationally recognized UM criteria. |
| Were both the provider and member notified (member in writing)? (M/NM)* | 20/20 | Members received a written NABD. Providers received both a phone call and a copy of the NABD. |
| Date notice of adverse benefit determination (NABD) sent: | | |
| Was the notice sent within required time frame? (M or NM)* (S = 10 calendar days after; E = 72 hours after; T = 10 calendar days advance notice)? | 20/20 | Although all 20 cases reviewed were in compliance with the required time frames, there were two outpatient requests that had been inaccurately documented in the system as expedited requests and were initially thought to be out of compliance. During the interview, RMHP staff members clarified that all outpatient requests were processed as standard requests. |
| If extended, was extension notification sent to the member with the required content? (M/NM/NA)* | NA | No determinations were extended. |

| Requirements | M/A | Comments |
|---|---|---|
| Did the NABD include the required content? (M/NM)* | 20/20 | All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request a State fair hearing (SFH) 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 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)* | 14/14 | Six cases were processed as administrative denials that did not require a medical necessity review. |
| 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-to-peer review policy/procedure/process, was it followed? (M/NM/NA)* | 16/16 | In four of the administrative denials, a peer-to-peer review was not necessary. |
| Was the decision based on established authorization criteria? (M/NM)* | 20/20 | All records contained evidence that the RAE based determinations on nationally recognized criteria (MCG and ASAM) and the RAE contract/benefit package. |
| Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)* | 20/20 | The reason for the denial was found to be easy to understand in all 20 NABDs reviewed. |
| **Total Applicable Elements** | **150** | |
| **Total Met Elements** | **150** | |
| **Score (Number Met / Number Applicable) = %** | **100%** | |

***Scored Elements**

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

**A** = Applicable

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

## Summary

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

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

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

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

The following outpatient services required prior authorization/concurrent review:

- Psychotherapy (60-minute sessions) after the 12th visit
- Psychological/neurological testing
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- Behavioral health (BH) day treatment
- Out-of-network services (except emergency/crisis care)

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

- Psychotherapy (initial evaluation, 30-minute and 45-minute sessions)
- Psychotherapy (60-minute sessions) for the first 12 visits
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

RMHP accepted requests for authorization electronically through an "auto-auth" online system, via fax, and by telephone. RMHP did not delegate UM activities. RMHP was in partnership with United. RMHP staff members reported that, previously, Optum (a subsidiary of United) staff members performed UM activities for RMHP and that those individuals were brought into RMHP's UM operations as RMHP employees. During the review period, RMHP used MCG UR criteria for MH determinations and ASAM levels of care criteria for SUD determinations. RMHP required its UM staff members to pass interrater reliability testing annually with a minimum score of 90 percent.

Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, HSAG found that RMHP followed its prior authorization list and UM policies and procedures with regard to which services are subject to prior authorization and requirements for processing requests for services. NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all of the required information. In all cases involving a medical necessity review (and in some administrative denials), RMHP offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. Board-certified psychiatrists reviewed all medical necessity denials. A registered nurse (RN) or master's level clinician made administrative denials. Administrative denials included denials for reasons not related to medical necessity. In some denials involving requests for out-of-network care, an MD reviewed for medical necessity to ensure that an equivalent service was available from an in-network provider.

The reason category of "not a covered benefit" included when the member had a non-covered diagnosis (SUD [for inpatient requests], developmental disability diagnoses), requests from out-of-network providers, or when a member reached 15 days in an IMD in a single month. When a member reached 15 days in an IMD within the same month, RMHP authorized payment for the first 15 days and denied payment on the 16th day and forward.

In two outpatient requests reviewed, the system notes indicated that the request was expedited; however, the request was processed using the standard time frame of up to 10 calendar days rather than the 72-hour expedited time frame. RMHP staff members clarified that all outpatient requests are, by definition, standard requests; therefore, these cases were scored "met." In another case, the system documentation indicated that the request was a concurrent review, when the request was actually a new request for the service. HSAG recommended that the Department encourage RMHP to evaluate documentation protocols to ensure accuracy.

# Appendix B. Colorado Department of Health Care Policy and Financing
# FY 2020–2021 Utilization Management Monitoring Tool
# for Northeast Health Partners RAE 2

| | |
|---|---|
| **Review Period:** | May 1–October 31, 2020 |
| **Date of Review:** | December 1–January 31, 2020 |
| **Reviewer:** | Barbara McConnell |
| **Category of Service:** | Inpatient and Outpatient |
| **File #:** | Aggregate |

| Requirements | M/A | Comments |
|---|---|---|
| Date of initial request: Aggregate | | The records HSAG reviewed consisted of:<br>• 10 inpatient (four adults, six children/adolescents)<br>• Two outpatient (both adults)<br>Requests for service included inpatient acute care, residential treatment, crisis stabilization unit, acute treatment unit, and intensive outpatient program (SUD). |
| Service requested/indication: | | Covered diagnoses included impulse control/oppositional defiant, conduct disorder, ADHD, depressive/mood disorders, post-traumatic stress disorder (PTSD), and borderline personality disorder.<br>Non-covered diagnoses included SUD, ASD, and substance-induced psychosis.<br>Presenting symptoms included psychosis, paranoia, disorganized thinking, depression, anxiety, suicidal ideations, homicidal ideations, and aggression toward property and others. |
| Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N) | Y | All 12 records demonstrated that the services requested were all subject to prior authorization requirements per the RAE's prior authorization list. |
| Type of request (Standard [S], Expedited [E], or Retrospective [R]) | | The sample consisted of five standard requests, five urgent concurrent requests, and two retrospective denials (denying payment post discharge). |
| Type of denial: (Termination [T], New Request [NR], or Claim [CL]) | | All denials except two were related to new requests for service; either preservice requests or requests for additional days based on the authorization ending. Two denials were determined retroactively once discharge summaries were received. |

| Requirements | M/A | Comments |
|---|---|---|
| Reason for the denial: | | |
| Medical necessity? (Y/N) | 7 | Seven denials were related to not meeting medical necessity. |
| Not a covered benefit/diagnosis? (Y/N) | 5 | The "not a covered diagnosis" reason category included two ASD and three SUD diagnoses. |
| Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N) | 2 | Two denials were related to the primary diagnosis of ASD. |
| Out-of-network provider? (Y/N) | 0 | No denials were related to the requesting provider being out of network. |
| Other (describe): (Y/N) | 0 | |
| Followed internal policies related to the prior authorization list and the reason for denial? (M/N)* | 12/12 | In all cases, HSAG found that RAE 2 followed policies and procedures related to which services require prior authorization and followed nationally recognized UM criteria. |
| Were both the provider and member notified (member in writing)? (M/NM)* | 12/12 | Members received a written NABD. Providers received both a phone call and a copy of the NABD. |
| Date notice of adverse benefit determination (NABD) sent: | | |
| Was the notice sent within required time frame? (M or NM)* (S = 10 calendar days after; E = 72 hours after; T = 10 calendar days advance notice)? | 12/12 | All NABDs were sent within the required time frames. |
| If extended, was extension notification sent to the member with the required content? (M/NM/NA)* | NA | No determinations were extended. |
| Did the NABD include the required content? (M/NM)* | 12/12 | All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and 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)* | 12/12 | In all cases a qualified clinician made the determination, including those related to a non-covered diagnosis. |

| Requirements | M/A | Comments |
|---|---|---|
| If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)* | NA | No services were denied for lack of documentation from the provider. |
| If the MCE has a peer-to-peer review policy/procedure/process, was it followed? (M/NM/NA)* | 10/12 | In two records reviewed, NHP staff members did not clearly document in the system notes that a peer-to-peer review was offered to the requesting provider. |
| Was the decision based on established authorization criteria? (M/NM)* | 12/12 | All records contained evidence that the RAE based determinations on nationally recognized criteria (InterQual or ASAM) and the RAE contract/benefit package. |
| Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)* | 12/12 | All NABD letters contained language at an easily understood reading level. |
| **Total Applicable Elements** | **96** | |
| **Total Met Elements** | **94** | |
| **Score (Number Met / Number Applicable) = %** | **98%** | |

***Scored Elements**

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

**A =** Applicable

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

## Summary

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

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

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

Beacon did not use an observation code.

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

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) after the 25th visit
- Psychological/neurological testing (as of January 1, 2021, this no longer requires prior authorization)
- Assertive community treatment
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment

- Out-of-network services (except emergency/crisis care)
- Half-day psychosocial rehabilitation
- Multisystemic therapy

The only outpatient services that did not require prior authorization/concurrent review during the review period were routine psychotherapy initial evaluations and psychotherapy services (30-minute, 45-minute, and 60-minute sessions) for the first 12 visits.

Beacon, on behalf of NHP, accepted requests for authorization electronically through a website, via fax, and by telephone. The website allowed the upload of medical record documentation but was not an automated review/approval system. Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, HSAG found that Beacon used a separate code for non-covered diagnoses, which included SUD (for inpatient requests) and developmental disability diagnoses. The records reviewed for NHP RAE 2 demonstrated that Beacon consistently used nationally recognized UR criteria (InterQual and ASAM) and followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider.

NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all of the required information. In most cases involving a medical necessity review, NHP offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. Board-certified psychiatrists reviewed all medical necessity denials for 24-hour level of care. A psychiatrist or Doctor of Philosophy (PhD)-level psychologist reviewed medical necessity denials for outpatient care. Administrative denials were also reviewed by a physician or psychologist. In two records, HSAG did not find evidence that the requesting providers were offered a peer-to-peer review with a medical director for medical necessity denials. HSAG recommended that the Department work with NHP to evaluate documentation protocols to ensure accuracy.

# Appendix C. Colorado Department of Health Care Policy and Financing
# FY 2020–2021 Utilization Management Monitoring Tool
# for Colorado Access RAE 3

| | |
|---|---|
| **Review Period:** | May 1–October 31, 2020 |
| **Date of Review:** | December 1–January 31, 2020 |
| **Reviewer:** | Barbara McConnell |
| **Category of Service:** | Inpatient and Outpatient |
| **File #:** | Aggregate |

| Requirements | M/A | Comments |
|---|---|---|
| Date of initial request: Aggregate | | The records HSAG reviewed consisted of:<br>• 10 inpatient (four adults, six children/adolescents)<br>• 10 outpatient (eight adults, two children/adolescents)<br>Requests for service included inpatient acute care, Acute treatment unit, residential treatment, intensive outpatient program (MH and SUD), partial hospitalization, and psychological testing. |
| Service requested/indication: | | Covered diagnoses included impulse control/oppositional defiant disorders, depressive/mood disorders, ADHD, adjustment disorder, PTSD, bipolar disorder, and schizophrenic spectrum disorders.<br>Non-covered diagnoses included SUD, ASD, and substance-induced psychosis.<br>Presenting symptoms included anxiety, psychosis, suicidal ideations, homicidal ideations, paranoia, and aggression toward property and others. |
| Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N) | Y | All 20 records demonstrated that the services requested were all subject to prior authorization requirements per the RAE's prior authorization list. |
| Type of request (Standard [S], Expedited [E], or Retrospective [R]) | | The sample consisted of 11 standard requests, seven urgent concurrent requests, and two expedited preservice 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/A | Comments |
|---|---|---|
| Reason for the denial: | | |
| Medical necessity? (Y/N) | 14 | Fourteen denials were related to not meeting medical necessity. |
| Not a covered benefit/diagnosis? (Y/N) | 6 | Four denials were related to the primary diagnosis of SUD (one of these members also had a diagnosis of ASD). Two denials were related to the primary diagnosis of ASD. One was related to the child being in DHS custody. |
| Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N) | 2 | Two denials were related to the primary diagnosis of ASD. |
| Out-of-network provider? (Y/N) | 0 | No denials were related to the requesting provider being out of network. |
| Other (describe): (Y/N) | 1 | One denial was related to a child in DHS custody and a request for residential treatment. |
| Followed internal policies related to the prior authorization list and the reason for denial? (M/N)* | 20/20 | In all cases, HSAG found that COA followed policies and procedures related to which services require prior authorization and followed nationally recognized UM criteria. |
| Were both the provider and member notified (member in writing)? (M/NM)* | 20/20 | Members received a written NABD. Providers received a copy of the NABD and, in most cases, a phone call as well. |
| Date notice of adverse benefit determination (NABD) sent: | | |
| Was the notice sent within required time frame? (M or NM)* (S = 10 calendar days after; E = 72 hours after; T = 10 calendar days advance notice)? | 20/20 | In all cases reviewed, the NABD was sent within the required time frame. |
| If extended, was extension notification sent to the member with the required content? (M/NM/NA)* | NA | No determinations were extended. |
| Did the NABD include the required content? (M/NM)* | 20/20 | All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and addressed the reason for the denial. |

| Requirements | M/A | Comments |
|---|---|---|
| Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)* | 20/20 | In all cases reviewed, a medical director made the final denial determination, even those that were considered administrative denials, such as those due to a non-covered diagnosis. |
| 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. There was no response. |
| If the MCE has a peer-to-peer review policy/procedure/process, was it followed? (M/NM/NA)* | 20/20 | All records reviewed contained evidence that the peer-to-peer review was offered. |
| Was the decision based on established authorization criteria? (M/NM)* | 20/20 | All records contained evidence that COA based determinations on nationally recognized criteria (InterQual) and the RAE contract/benefit package. |
| Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)* | 20/20 | In all records reviewed, the NABDs were written in easy to understand language. |
| **Total Applicable Elements** | **161** | |
| **Total Met Elements** | **161** | |
| **Score (Number Met / Number Applicable) = %** | **100%** | |

***Scored Elements**

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

**A =** Applicable

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

## Summary

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

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

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

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

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

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) after the sixth visit if provided within a primary care group
- Psychological/neurological testing
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment
- Out-of-network services (except emergency/crisis care)

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

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) when provided by a non-primary care group
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

COA accepted requests for authorization via fax and by telephone. COA did not use an electronic authorization system. Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, HSAG found that, while COA reported the use of a separate code for non-covered diagnoses, the "non-covered benefit code" included the non-covered diagnoses of SUD (for inpatient requests) and developmental disability diagnoses, as well as cases in which the member was in DHS custody and requested RTC services. The records reviewed for COA RAE 3 demonstrated that COA consistently used nationally recognized UR criteria (InterQual) and followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider.

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

# Appendix D. Colorado Department of Health Care Policy and Financing
# FY 2020–2021 Utilization Management Monitoring Tool
# for Health Colorado, Inc. RAE 4

| | |
|---|---|
| **Review Period:** | May 1–October 31, 2020 |
| **Date of Review:** | December 1–January 31, 2020 |
| **Reviewer:** | Barbara McConnell |
| **Category of Service:** | Inpatient and Outpatient |
| **File #:** | Aggregate |

| Requirements | M/A | Comments |
|---|---|---|
| Date of initial request: Aggregate | | The records HSAG reviewed consisted of:<br>• 10 inpatient (seven adults, three children/adolescents)<br>• One outpatient (adult)<br>Requests for service included inpatient acute care, residential treatment, acute treatment unit, and psychological testing. |
| Service requested/indication: | | Covered diagnoses included impulse control/oppositional defiant disorders, conduct disorder, ADHD, depressive/mood disorders, bipolar disorder, and obsessive compulsive disorder.<br>Non-covered diagnoses included SUD, substance-induced depression, and encephalopathy.<br>Presenting symptoms included psychosis, paranoia, disorganized thinking, depression, suicidal ideations, homicidal ideations, and aggression toward property and others. |
| Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N) | Y | All 11 records demonstrated that the services requested were all subject to prior authorization requirements per the RAE's prior authorization list. |
| Type of request (Standard [S], Expedited [E], or Retrospective [R]) | | The sample consisted of four standard requests and seven urgent concurrent requests. |
| Type of denial: (Termination [T], New Request [NR], or Claim [CL]) | | All denials were related to new requests for service; either preservice requests or requests for additional days based on the authorization ending. |

| Requirements | M/A | Comments |
|---|---|---|
| Reason for the denial: | | |
| Medical necessity? (Y/N) | 7 | Seven denials were related to not meeting medical necessity. |
| Not a covered benefit/diagnosis? (Y/N) | 4 | The "not a covered diagnosis" reason category was related to primary SUD diagnoses. |
| Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N) | 0 | No denials were related to the primary diagnosis of developmental disability. |
| Out-of-network provider? (Y/N) | 0 | No denials were related to the requesting provider being out of network. |
| Other (describe): (Y/N) | 0 | |
| Followed internal policies related to the prior authorization list and the reason for denial? (M/N)* | 11/11 | In all cases, HSAG found that RAE 4 followed policies and procedures related to which services require prior authorization and followed nationally recognized UM criteria. |
| Were both the provider and member notified (member in writing)? (M/NM)* | 11/11 | Members received a written NABD. Providers received both a phone call and a copy of the NABD. |
| Date notice of adverse benefit determination (NABD) sent: | | |
| Was the notice sent within required time frame? (M or NM)* (S = 10 calendar days after; E = 72 hours after; T = 10 calendar days advance notice)? | 11/11 | All NABDs were sent within the required time frames. |
| If extended, was extension notification sent to the member with the required content? (M/NM/NA)* | NA | No determinations were extended. |
| Did the NABD include the required content? (M/NM)* | 11/11 | All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and 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)* | 11/11 | In all cases a qualified clinician made the determination, including those related to a non-covered diagnosis. |

| Requirements | M/A | Comments |
|---|---|---|
| If denied for lack of information, was the requesting provider contacted for additional information or consulted (as applicable)? (M/NM/NA)* | NA | No services were denied for lack of documentation from the provider. |
| If the MCE has a peer-to-peer review policy/procedure/process, was it followed? (M/NM/NA)* | 9/10 | In one record reviewed, HCI staff members did not clearly document in the system notes that a peer-to-peer review was offered to the requesting provider. In one case, a peer-to-peer review was not applicable as the request was for a member with a non-covered medical diagnosis. |
| Was the decision based on established authorization criteria? (M/NM)* | 11/11 | All records contained evidence that the RAE based determinations on nationally recognized criteria (InterQual or ASAM) and the RAE contract/benefit package. |
| Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)* | 11/11 | All NABD letters contained language at an easily understood reading level. |
| **Total Applicable Elements** | **87** | |
| **Total Met Elements** | **86** | |
| **Score (Number Met / Number Applicable) = %** | **99%** | |

***Scored Elements**

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

**A =** Applicable

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

## Summary

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

HCI did not delegate UM activities. HCI was in partnership with Beacon. HCI staff members reported that HCI UM staff members are Beacon employees. During the review period, HCI used InterQual UR criteria for MH decisions and ASAM level of care criteria for SUD determinations. HCI required its UM staff members to pass interrater reliability testing annually with a minimum score of 80 percent. HCI's prior authorization list, policies, and procedures stated that the following inpatient services were subject to prior authorization and concurrent review requirements during the review period:

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

HCI did not use an observation code.

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

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) after the 25th visit
- Psychological/neurological testing (as of January 1, 2021, this no longer requires prior authorization)
- Assertive community treatment
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment

- Out-of-network services (except emergency/crisis care)
- Half-day psychosocial rehabilitation
- Multisystemic therapy

The only outpatient services that did not require prior authorization/concurrent review during the review period were routine psychotherapy initial evaluations and psychotherapy (30-minute, 45-minute, and 60-minute sessions) for the first 12 sessions.

HCI accepted requests for authorization electronically through a website, via fax, and by telephone. The website allowed the upload of medical record documentation but was not an automated review/approval system. Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, HSAG found that HCI used a separate code for non-covered diagnoses, which included SUD (for inpatient requests) and developmental disability diagnoses. The records reviewed for HCI RAE 4 demonstrated that HCI consistently used nationally recognized UR criteria (InterQual and ASAM) and followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider.

NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all of the required information. In all except one request reviewed that involved a medical necessity review, HCI offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. Board-certified psychiatrists reviewed all medical necessity denials for 24-hour level of care. A psychiatrist or PhD psychologist reviewed medical necessity denials for outpatient care. Administrative denials were also reviewed by a physician or psychologist. In one record, HSAG did not find evidence that the requesting provider was offered a peer-to-peer review with a medical director for a medical necessity denial. HSAG recommended that the Department work with HCI to evaluate documentation protocols to ensure accuracy.

# Appendix E. Colorado Department of Health Care Policy and Financing
# FY 2020–2021 Utilization Management Monitoring Tool
# for Colorado Access RAE 5

| | |
|---|---|
| **Review Period:** | May 1–October 31, 2020 |
| **Date of Review:** | December 1–January 31, 2020 |
| **Reviewer:** | Barbara McConnell |
| **Category of Service:** | Inpatient and Outpatient |
| **File #:** | Aggregate |

| Requirements | M/A | Comments |
|---|---|---|
| Date of initial request: Aggregate | | The records HSAG reviewed consisted of:<br>• 10 inpatient (four adults, six children/adolescents)<br>• 10 outpatient (eight adults, two children/adolescents)<br>Requests for service included inpatient acute care, Acute treatment unit, residential treatment, intensive outpatient program (MH and SUD), and partial hospitalization. |
| Service requested/indication: | | Covered diagnoses included impulse control/oppositional defiant disorders, depressive/mood disorders, ADHD, bulimia, PTSD, bipolar disorder, and schizophrenic spectrum disorders.<br>Non-covered diagnoses included SUD, ASD, and substance-induced psychosis.<br>Presenting symptoms included anxiety, psychosis, suicidal ideations, homicidal ideations, and aggression toward property and others. |
| Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N) | Y | All 20 records demonstrated that the services requested were all subject to prior authorization requirements per the RAE's prior authorization list. |
| Type of request (Standard [S], Expedited [E], or Retrospective [R]) | | The sample consisted of 10 standard requests, three urgent concurrent requests, and seven expedited preservice 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/A | Comments |
|---|---|---|
| Reason for the denial: | | |
| Medical necessity? (Y/N) | 13 | Thirteen denials were related to not meeting medical necessity. |
| Not a covered benefit/diagnosis? (Y/N) | 7 | Five denials were related to the primary diagnosis of SUD. Two denials were related to the primary diagnosis of ASD. |
| Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N) | 2 | Two denials were related to the primary diagnosis of ASD. |
| Out-of-network provider? (Y/N) | 0 | No denials were related to the requesting provider being out of network. |
| Other (describe): (Y/N) | 0 | |
| Followed internal policies related to the prior authorization list and the reason for denial? (M/N)* | 20/20 | In all cases, HSAG found that COA followed policies and procedures related to which services require prior authorization and followed nationally recognized UM criteria. |
| Were both the provider and member notified (member in writing)? (M/NM)* | 20/20 | Members received a written NABD. Providers received a copy of the NABD and, in most cases, a phone call as well. |
| Date notice of adverse benefit determination (NABD) sent: | | |
| Was the notice sent within required time frame? (M or NM)* (S = 10 calendar days after; E = 72 hours after; T = 10 calendar days advance notice)? | 20/20 | In all cases reviewed, the NABD was sent within the required time frame. |
| If extended, was extension notification sent to the member with the required content? (M/NM/NA)* | NA | No determinations were extended. |
| Did the NABD include the required content? (M/NM)* | 20/20 | All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and 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)* | 20/20 | In all cases reviewed, a medical director made the final denial determination, even those that were considered administrative denials, such as those due to a non-covered diagnosis. |
| 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. |

| Requirements | M/A | Comments |
|---|---|---|
| If the MCE has a peer-to-peer review policy/procedure/process, was it followed? (M/NM/NA)* | 20/20 | All records reviewed contained evidence that the peer-to-peer review was offered. |
| Was the decision based on established authorization criteria? (M/NM)* | 20/20 | All records contained evidence that COA based determinations on nationally recognized criteria (InterQual) and the RAE contract/benefit package. |
| Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)* | 17/20 | In three denial records, there were conflicting statements regarding the denial. In these cases, the denial was a partial denial. The initial statement about the denied services stated that they were denied as they were not medically necessary. In a subsequent paragraph, the letter stated the number of visits that were approved. COA may want to customize the language in a partial denial letter for clarity, or develop a partial denial/partial approval template. |
| **Total Applicable Elements** | **160** | |
| **Total Met Elements** | **157** | |
| **Score (Number Met / Number Applicable) = %** | **98%** | |

***Scored Elements**

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

**A =** Applicable

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

## Summary

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

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

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

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

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

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) after the sixth visit if provided within a primary care group
- Psychological/neurological testing
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment
- Out-of-network services (except emergency/crisis care)

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

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) when provided by a non-primary care group
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

COA accepted requests for authorization via fax and by telephone. COA did not use an electronic authorization system. Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, HSAG found that, while COA reported it used a separate code for non-covered diagnoses, the "non-covered benefit code" included the non-covered diagnosis of SUD (for inpatient requests) and developmental disability diagnoses. The records reviewed for COA RAE 5 demonstrated that COA consistently used nationally recognized UR criteria (InterQual) and followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider.

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

HSAG found that in three denial records there were conflicting statements regarding the denial. In these cases, the denial was a partial denial. The initial statement about the denied services stated that they were denied as they were not medically necessary. In a subsequent paragraph, the letter stated the number of visits that were approved. HSAG recommended that the Department work with COA to determine whether customizing the language in each partial denial letter for clarity or developing a partial denial/partial approval template would be best.

# Appendix F. Colorado Department of Health Care Policy and Financing
# FY 2020–2021 Utilization Management Monitoring Tool
# for Colorado Community Health Alliance RAE 6

| | |
|---|---|
| **Review Period:** | May 1–October 31, 2020 |
| **Date of Review:** | December 1–January 31, 2020 |
| **Reviewer:** | Barbara McConnell |
| **Category of Service:** | Inpatient and Outpatient |
| **File #:** | Aggregate |

| Requirements | M/A | Comments |
|---|---|---|
| Date of initial request: Aggregate tool | | The records HSAG reviewed consisted of:<br>• 10 inpatient (six adults, four children/adolescents)<br>• 10 outpatient (six adults, four children/adolescents)<br>Requests for service included inpatient acute care, residential treatment, intensive outpatient program (MH and SUD), partial hospitalization, multisystemic therapy, and psychological testing. |
| Service requested/indication: | | Covered diagnoses included impulse control/oppositional defiant disorders, depressive/mood disorders, PTSD, and schizophrenic spectrum disorders.<br>Non-covered diagnoses included SUD, ASD, and substance-induced psychosis.<br>Presenting symptoms included psychosis, suicidal ideations, and aggression toward property and others. |
| Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N) | Y | All 20 records demonstrated that the services requested were all subject to prior authorization requirements per the RAE's prior authorization list. |
| Type of request (Standard [S], Expedited [E], or Retrospective [R]) | | The sample consisted of five standard requests, two urgent preservice requests, 12 urgent concurrent requests, and one retrospective denial (denying residential treatment center pass days). |
| 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/A | Comments |
|---|---|---|
| Reason for the denial: | | |
| Medical necessity? (Y/N) | 11 | Eleven denials were related to not meeting medical necessity. |
| Not a covered benefit/diagnosis? (Y/N) | 10 | The "not a covered benefit" reason category included non-covered diagnoses (ASD), reaching the 15 day IMD benefit limitation, and pass days from RTC exceeding 24 hours. |
| Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N) | 6 | Six of the "not a covered benefit" reason category cases were related to the primary diagnosis of ASD. |
| Out-of-network provider? (Y/N) | 0 | No denials were related to the requesting provider being out of network. |
| Other (describe): (Y/N) | 4 | Three of the "not a covered benefit" reason category cases were due to reaching more than 15 days in an IMD. One was due to denying 24-hour pass days from the RTC. |
| Followed internal policies related to the prior authorization list and the reason for denial? (M/N)* | 20/20 | In all cases, HSAG found that CCHA followed policies and procedures related to which services require prior authorization and followed nationally recognized UM criteria. |
| Were both the provider and member notified (member in writing)? (M/NM)* | 20/20 | Members received a written NABD. Providers received both a fax and a copy of the NABD.<br>In one case, a copy of the member letter was not available. CCHA staff members reported that the letter had been corrupted by the system; however, the system notes contained the date the letter was sent, and the verbiage provided in the letter. Therefore, HSAG scored this case as compliant for the letter having been sent and scored the content and readability in the below fields. |
| Date notice of adverse benefit determination (NABD) sent: | | |
| Was the notice sent within required time frame? (M or NM)* (S = 10 calendar days after; E = 72 hours after; T = 10 calendar days advance notice)? | 13/20 | In four expedited and three standard determinations, HSAG found that the notice to the member was sent after the required time frame had expired. |

| Requirements | M/A | Comments |
|---|---|---|
| If extended, was extension notification sent to the member with the required content? (M/NM/NA)* | NA | No determinations were extended. |
| Did the NABD include the required content? (M/NM)* | 20/20 | All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and addressed the reason for the denial. Reasons were, in some cases, unclear or found by HSAG to not be easily understood. These issues were scored and addressed related to the requirement that the reason is easily understood by the member. |
| Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)* | 10/10 | In 10 records, the service was administratively denied by a non-physician UM professional, consistent with the RAE's policies and procedures. |
| 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-to-peer review policy/procedure/process, was it followed? (M/NM/NA)* | 10/10 | The 10 applicable records contained evidence that the peer-to-peer review was offered, consistent with CCHA's UM program description. The program description stated that peer-to-peer reviews are not available for administrative denials. |
| Was the decision based on established authorization criteria? (M/NM)* | 20/20 | All records contained evidence that the RAE based determinations on nationally recognized criteria (MCG) and the RAE contract/benefit package. |
| Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)* | 5/20 | The reason for the denial was found to be easy to understand in only five of the 20 NABDs reviewed. HSAG found that when the reason category was "not a covered benefit," the member was referred to page 24 of the Health First Colorado Member Handbook with little other explanation. In these cases where the "not a covered benefit" reason category was due to a non-covered diagnosis or due to reaching the IMD limitation of 15 days and the service requested was inpatient hospitalization or another covered |

| Requirements | M/A | Comments |
|---|---|---|
| | | benefit, stating that the service is not covered and referring the member to a list of covered services is very confusing.<br>In NABDs related to lack of medical necessity, CCHA often copied the full description of the MCG criteria into the letter and did not adequately describe the specific member's symptoms that did not meet medical necessity. These reason statements were cumbersome and difficult to follow. |
| **Total Applicable Elements** | **140** | |
| **Total Met Elements** | **118** | |
| **Score (Number Met / Number Applicable) = %** | **84%** | |

***Scored Elements**

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

**A =** Applicable

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

## Summary

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

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

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

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

The following outpatient services required prior authorization/concurrent review:

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

The only outpatient services that did not require prior authorization/concurrent review were routine psychotherapy services (initial evaluation, 30-minute, 45-minute, and 60-minute sessions).

CCHA accepted requests for authorization electronically through an automated online system, via fax, and by telephone. CCHA did not delegate UM activities. CCHA was in partnership with Anthem. CCHA staff members reported that CCHA UM staff members are Anthem employees. During the review period, CCHA used MCG UR criteria for both MH and SUD determinations. CCHA required its UM staff members to pass interrater reliability testing annually with a minimum score of 90 percent.

Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, HSAG found that the reason category of "not a covered benefit" was included when the member had a non-covered diagnosis of ASD and when a member reached 15 days in an IMD in a single month. When a member reached 15 days in an IMD within the same month, CCHA retroactively denied payment for the full inpatient stay.

The records reviewed for CCHA RAE 6 demonstrated that CCHA consistently used nationally recognized UR criteria (MCG for both MH and SUD) and followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider. All requesting providers were offered a peer-to-peer review with a medical director for medical necessity denials.

The CCHA RAE 6 score of 84 percent was largely driven by the reasons for the denials depicted in the NABDs being unclear or confusing. In addition, seven NABDs were sent to the members after the required time frames for NABDs outlined in the Code of Colorado Regulations (CCR) 2505-10.209 and in the RAE contract with the Department. HSAG recommended that the Department work with CCHA to ensure that CCHA:

- Provides each member with the specific reason for the denial rather than the reason category, such as "not a covered benefit," particularly when the service being denied is a covered benefit but denied for an administrative reason.
- Clarifies and determines the level of specificity needed when the member does not meet medical necessity or takes other steps to improve the readability level of the reason for the denial within NABDs.
- Develops staff training and an internal monitoring process to ensure timeliness of NABDs sent to members.

# Appendix G. Colorado Department of Health Care Policy and Financing FY 2020–2021 Utilization Management Monitoring Tool for Colorado Community Health Alliance RAE 7

| | |
|---|---|
| **Review Period:** | May 1–October 31, 2020 |
| **Date of Review:** | December 1–January 31, 2020 |
| **Reviewer:** | Barbara McConnell |
| **Category of Service:** | Inpatient and Outpatient |
| **File #:** | Aggregate |

| Requirements | M/A | Comments |
|---|---|---|
| Date of initial request: Aggregate tool | | The records HSAG reviewed consisted of:<br>• 10 inpatient (seven adults, three children/adolescents)<br>• 10 outpatient (three adults, seven children/adolescents)<br>Requests for service included inpatient acute care, residential treatment, intensive outpatient program (MH and SUD), partial hospitalization, and psychological testing. |
| Service requested/indication: | | Covered diagnoses included impulse control/oppositional defiant disorders, depressive/mood disorders, ADHD, PTSD, bipolar disorder, borderline personality disorder, and schizophrenic spectrum disorders.<br>Non-covered diagnoses included SUD, ASD, substance-induced psychosis, and one other general medical diagnosis.<br>Presenting symptoms included psychosis, suicidal ideations, homicidal ideations, paranoia, and aggression toward property and others. |
| Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N) | Y | All 20 records demonstrated that the services requested were all subject to prior authorization requirements per the RAE's prior authorization list. |
| Type of request (Standard [S], Expedited [E], or Retrospective [R]) | | The sample consisted of nine standard requests, four urgent preservice requests, and seven urgent 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/A | Comments |
|---|---|---|
| Reason for the denial: | | |
| Medical necessity? (Y/N) | 12 | Twelve denials were related to not meeting medical necessity. |
| Not a covered benefit/diagnosis? (Y/N) | 8 | The "not a covered benefit" reason category included non-covered diagnoses (ASD, medical codes, and SUD), reaching the 15-day IMD benefit limitation, non-eligibility of the member, and "not responsible for payment due to youth in DHS custody." |
| Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N) | 1 | One of the "not a covered benefit" reason category cases was related to the primary diagnosis of ASD. |
| Out-of-network provider? (Y/N) | 0 | No denials were related to the requesting provider being out of network. |
| Other (describe): (Y/N) | 7 | Three of the "not a covered benefit" reason category cases were due to reaching more than 15 days in an IMD. One was due to a request for RTC for a member in DHS custody, one was related to a primary diagnosis of SUD, one was related to the member's ineligibility at the time of the service, and one was related to a medical diagnosis (stroke). |
| Followed internal policies related to the prior authorization list and the reason for denial? (M/N)* | 20/20 | In all cases, HSAG found that CCHA followed policies and procedures related to which services require prior authorization and followed nationally recognized UM criteria. |
| Were both the provider and member notified (member in writing)? (M/NM)* | 20/20 | Members received a written NABD. Providers received both a fax and a copy of the NABD.<br>In one case, a copy of the member letter was not available. CCHA staff members reported that the letter had been corrupted by the system; however, the system notes contained the date the letter was sent, and the verbiage provided in the letter. Therefore, HSAG scored this case as compliant for the letter having been sent and scored the content and readability in the below field. |

| Requirements | M/A | Comments |
|---|---|---|
| Date notice of adverse benefit determination (NABD) sent: | | |
| Was the notice sent within required time frame? (M or NM)* (S = 10 calendar days after; E = 72 hours after; T = 10 calendar days advance notice)? | 16/20 | In three expedited and one standard determination, HSAG found that the notice to the member was sent after the required time frame had expired. |
| If extended, was extension notification sent to the member with the required content? (M/NM/NA)* | NA | No determinations were extended. |
| Did the NABD include the required content? (M/NM)* | 20/20 | All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the RAE in filing, access to pertinent records, and addressed the reason for the denial. Reasons were, in some cases unclear or found by HSAG to be easily understood. These issues were scored and addressed related to the requirement that the reason is easily understood by the member. |
| Was the denial decision made by a qualified clinician not involved in a previous level of review? (M/NM)* | 12/12 | In eight records, the service was administratively denied by a non-physician UM professional, consistent with the RAE's policies and procedures. |
| 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-to-peer review policy/procedure/process, was it followed? (M/NM/NA)* | 8/12 | In four of the medical necessity reviews, there was no documentation in the system that indicated the provider was offered a peer-to-peer review as required by CCHA's policy. |
| Was the decision based on established authorization criteria? (M/NM)* | 20/20 | All records contained evidence that the RAE based determinations on nationally recognized criteria (MCG) and the RAE contract/benefit package. |
| Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)* | 4/20 | The reason for the denial was found to be easy to understand in only four of the 20 NABDs reviewed. HSAG found that when the reason category was "not a covered benefit," the member was referred to page 24 of the Health First Colorado Member Handbook with little other explanation. In these cases where the "not a covered benefit" reason category was due to a non-covered |

| Requirements | M/A | Comments |
|---|---|---|
| | | diagnosis or due to reaching the IMD limitation of 15 days and the service requested was inpatient hospitalization or another covered benefit, stating that the service is not covered and referring the member to a list of covered services is very confusing.<br>In NABDs related to lack of medical necessity, CCHA often copied the full description of the MCG criteria into the letter and did not adequately describe the specific member's situation that did not meet medical necessity. These reason statements were cumbersome and difficult to follow.<br>In two cases, the CCHA staff member used the wrong NABD template (for a new request, a concurrent template letter was used and for a medical necessity review, a "not a covered benefit" template letter was used), adding to the confusion. |
| **Total Applicable Elements** | **144** | |
| **Total Met Elements** | **120** | |
| **Score (Number Met / Number Applicable) = %** | **83%** | |

***Scored Elements**

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

**A =** Applicable

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

## Summary

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

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

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

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

The following outpatient services required prior authorization/concurrent review:

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

The only outpatient services that did not require prior authorization/concurrent review were routine psychotherapy services (initial evaluation, 30-minute, 45-minute, and 60-minute sessions)

CCHA accepted requests for authorization electronically through an automated online system, via fax, and by telephone. CCHA did not delegate UM activities. CCHA was in partnership with Anthem. CCHA staff members reported that CCHA UM staff members are Anthem employees. During the review period, CCHA used MCG UR criteria for both MH and SUD determinations. CCHA required its UM staff members to pass interrater reliability testing annually with a minimum score of 90 percent.

Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, HSAG found that the reason category of "not a covered benefit" was included when the member had a non-covered diagnosis (SUD [for inpatient requests], developmental disability diagnoses), and when a member reached 15 days in an IMD in a single month. When a member reached 15 days in an IMD within the same month, CCHA retroactively denied payment for the full inpatient stay.

The records reviewed for CCHA RAE 7 demonstrated that CCHA consistently used nationally recognized UR criteria (MCG for both MH and SUD) and followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider. In four records, HSAG did not find evidence that requesting providers were offered a peer-to-peer review with a medical director for medical necessity denials.

The CCHA RAE 7 score of 83 percent was largely driven by the reasons for the denials depicted in the NABDs being unclear or confusing. In addition, four NABDs were sent to the members after the required time frames for NABDs outlined in CCR 2505-10.209 and in the RAE contract with the Department. HSAG recommended that the Department work with CCHA to ensure that CCHA:

- Provides the member with the specific reason for the denial rather than the reason category, such as "not a covered benefit," particularly when the service being denied is a covered benefit but denied for an administrative reason.
- Clarifies and determines the level of specificity needed when the member does not meet medical necessity or takes other steps to improve the readability level of the reason for the denial within NABDs.
- Develops an internal monitoring process to ensure timeliness of NABDs sent to members and correct use of templates.
- Develops staff training to ensure consistency of documenting within the UM system.

# Appendix H. Colorado Department of Health Care Policy and Financing
# FY 2020–2021 Utilization Management Monitoring Tool
# for Denver Health Medical Plan MCO

| | |
|---|---|
| **Review Period:** | May 1–October 31, 2020 |
| **Date of Review:** | December 1–January 31, 2020 |
| **Reviewer:** | Barbara McConnell |
| **Category of Service:** | Inpatient and Outpatient |
| **File #:** | Aggregate |

| Requirements | M/A | Comments |
|---|---|---|
| Date of initial request: Aggregate | | The records HSAG reviewed consisted of:<br>• 10 inpatient (eight adults, two children/adolescents)<br>• 10 outpatient (all adults)<br>Requests for service included inpatient acute care, acute treatment unit, residential treatment, intensive outpatient program (MH and SUD), partial hospitalization, and psychological testing. |
| Service requested/indication: | | Covered diagnoses included impulse control/oppositional defiant disorders, depressive/mood disorders, PTSD, bipolar disorder, borderline personality disorder, and schizophrenic spectrum disorders.<br>Non-covered diagnoses included SUD and substance-induced psychosis.<br>Presenting symptoms included psychosis, suicidal ideations, homicidal ideations, paranoia, and aggression toward property and others. |
| Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N) | Y | All 20 records demonstrated that the services requested were all subject to prior authorization requirements per the MCO's prior authorization list. |
| Type of request (Standard [S], Expedited [E], or Retrospective [R]) | | The sample consisted of 12 standard requests, three urgent concurrent requests, and five urgent preservice 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/A | Comments |
|---|---|---|
| Reason for the denial: | | |
| Medical necessity? (Y/N) | 15 | Fifteen denials were related to not meeting medical necessity. |
| Not a covered benefit/diagnosis? (Y/N) | 5 | Five denials were related to the primary diagnosis of SUD. |
| Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N) | 0 | None of the denials were related to the primary diagnosis of intellectual, neurocognitive, or traumatic brain injury. |
| Out-of-network provider? (Y/N) | 0 | No denials were related to the requesting provider being out of network. |
| Other (describe): (Y/N) | 0 | |
| Followed internal policies related to the prior authorization list and the reason for denial? (M/N)* | 20/20 | In all cases, HSAG found that COA (DHMP's delegate), on behalf of DHMP, followed policies and procedures related to which services require prior authorization and followed nationally recognized UM criteria. |
| Were both the provider and member notified (member in writing)? (M/NM)* | 20/20 | Members received a written NABD. Providers received a copy of the NABD and, in most cases, a phone call as well. |
| Date notice of adverse benefit determination (NABD) sent: | | |
| Was the notice sent within required time frame? (M or NM)* (S = 10 calendar days after; E = 72 hours after; T = 10 calendar days advance notice)? | 20/20 | In all cases reviewed, the NABD was sent within the required time frame. |
| If extended, was extension notification sent to the member with the required content? (M/NM/NA)* | NA | No determinations were extended. |
| Did the NABD include the required content? (M/NM)* | 20/20 | All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from COA in filing, access to pertinent records, and 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)* | 20/20 | In all cases reviewed, a medical director made the final denial determination, even those that were considered administrative denials, such as those due to a non-covered diagnosis. |
| 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. |

| Requirements | M/A | Comments |
|---|---|---|
| If the MCE has a peer-to-peer review policy/procedure/process, was it followed? (M/NM/NA)* | 20/20 | All records reviewed contained evidence that the peer-to-peer review was offered. |
| Was the decision based on established authorization criteria? (M/NM)* | 20/20 | All records contained evidence that COA based determinations on nationally recognized criteria (InterQual) and the Colorado contract/benefit package. |
| Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)* | 20/20 | All NABDs were written in an easy to understand reading level. |
| **Total Applicable Elements** | **160** | |
| **Total Met Elements** | **160** | |
| **Score (Number Met / Number Applicable) = %** | **100%** | |

***Scored Elements**

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

**A =** Applicable

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

## Summary

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

DHMP delegated UM activities to COA. During the review period, COA used InterQual UR criteria for MH and SUD determinations. COA required its UM staff members to pass interrater reliability testing annually with a minimum score of 90 percent. COA's prior authorization list, policies, and procedures stated that the following inpatient services are subject to prior authorization and concurrent review requirements:

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

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

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

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) after the sixth visit if provided within a primary care group
- Psychological/neurological testing
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment
- Out-of-network services (except emergency/crisis care)

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

- Psychotherapy (30-minute, 45-minute, and 60-minute sessions) when provided by a non-primary care group
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

COA, on behalf of DHMP, accepted requests for authorization via fax and by telephone. COA did not use an electronic authorization system. The records reviewed for DHMP demonstrated that COA, on behalf of DHMP, consistently used nationally recognized UR criteria (InterQual) and followed its policies and procedures related to which services require prior authorization and providing notices to the member and the provider.

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

# Appendix I. Colorado Department of Health Care Policy and Financing
# FY 2020–2021 Utilization Management Monitoring Tool
# for Rocky Mountain Health Plans Medicaid Prime

| | |
|---|---|
| **Review Period:** | May 1–October 31, 2020 |
| **Date of Review:** | December 1–January 31, 2020 |
| **Reviewer:** | Barbara McConnell |
| **Category of Service:** | Inpatient and Outpatient |
| **File #:** | Aggregate |

| Requirements | M/A | Comments |
|---|---|---|
| Date of initial request: Aggregate | | The records HSAG reviewed consisted of:<br>• Nine inpatient (eight adults, one child/adolescent)<br>• 10 outpatient (all adults)<br>Requests for service included inpatient acute care, residential treatment, psychotherapy at 60 minutes, diagnostic evaluation from an out-of-network provider, and psychological testing. |
| Service requested/indication: | | Covered diagnoses included ADHD, depressive/mood disorders, bipolar disorder, adjustment disorder, PTSD, and schizophrenic spectrum disorders.<br>Non-covered diagnoses included SUD.<br>Presenting symptoms included psychosis, paranoia, suicidal ideations, anxiety, and aggression toward property and others. |
| Is prior authorization required per the managed care entity's (MCE's) policies and procedures/parity reporting? (Y/N) | Y | All 19 records demonstrated that the services requested were all subject to prior authorization requirements per the MCO's prior authorization list. |
| Type of request (Standard [S], Expedited [E], or Retrospective [R]) | | The sample consisted of 11 standard requests, one urgent preservice request, and seven urgent 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/A | Comments |
|---|---|---|
| Reason for the denial: | | |
| Medical necessity? (Y/N) | 13 | Thirteen denials were related to not meeting medical necessity. |
| Not a covered benefit/diagnosis? (Y/N) | 6 | The "not a covered benefit" reason category included reaching the 15-day IMD benefit limitation. |
| Co-occurring intellectual, neurocognitive, or traumatic brain injury diagnosis? (Y/N) | 0 | None of the denials were related to primary diagnoses of intellectual, neurocognitive, or traumatic brain injury diagnosis. |
| Out-of-network provider? (Y/N) | 2 | Two of the denials were due to the request being from an out-of-network provider. An MD reviewed both of these cases and determined that the services needed could be provided by providers already in the network. The reason category for these denials were "not medically necessary." |
| Other (describe): (Y/N) | 6 | All six of the "not a covered benefit" reason category cases were due to reaching more than 15 days in an IMD. |
| Followed internal policies related to the prior authorization list and the reason for denial? (M/N)* | 19/19 | In all cases, HSAG found that RMHP Prime followed policies and procedures related to which services require prior authorization and followed nationally recognized UM criteria. |
| Were both the provider and member notified (member in writing)? (M/NM)* | 19/19 | Members received a written NABD. Providers received both a phone call and a copy of the NABD. |
| Date notice of adverse benefit determination (NABD) sent: | | |
| Was the notice sent within required time frame? (M or NM)* (S = 10 calendar days after; E = 72 hours after; T = 10 calendar days advance notice)? | 19/19 | All 19 cases reviewed were in compliance with the required time frames. |
| If extended, was extension notification sent to the member with the required content? (M/NM/NA)* | 1/1 | RMHP Prime extended one determination to obtain additional medical records. An extension letter was sent to the member within the required time frame and it included the required content. |

| Requirements | M/A | Comments |
|---|---|---|
| Did the NABD include the required content? (M/NM)* | 19/19 | All NABDs were provided on a Department-approved template letter, which included the member's appeal rights, right to request an SFH following the adverse appeal resolution, how to request an expedited (fast) appeal, the availability of assistance from the MCO in filing, access to pertinent records, and 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)* | 13/13 | Six cases were processed as administrative denials that did not require a medical necessity review. |
| 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-to-peer review policy/procedure/process, was it followed? (M/NM/NA)* | 13/13 | In the six administrative denials a peer-to-peer review was not necessary. |
| Was the decision based on established authorization criteria? (M/NM)* | 19/19 | All records contained evidence that RMHP Prime based determinations on nationally recognized criteria (MCG and ASAM) and the MCO contract/benefit package. |
| Was correspondence with the member easy to understand? (i.e., did the NABD letter clearly describe what criteria were not met?) (M/NM)* | 19/19 | The reason for the denial was found to be easy to understand in all 19 NABDs reviewed. |
| **Total Applicable Elements** | **141** | |
| **Total Met Elements** | **141** | |
| **Score (Number Met / Number Applicable) = %** | **100%** | |

***Scored Elements**

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

**A** = Applicable

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

## Summary

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

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

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

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

The following outpatient services required prior authorization/concurrent review:

- Psychotherapy (60-minute sessions) after the 12th visit
- Psychological/neurological testing
- Partial hospitalization program
- Intensive outpatient program for MH and SUD
- BH day treatment
- Out-of-network services (except emergency/crisis care)

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

- Psychotherapy (initial evaluation, 30-minute and 45-minute sessions)
- Psychotherapy (60-minute sessions) for the first 12 visits
- Assertive community treatment
- Half-day psychosocial rehabilitation
- Multisystemic therapy

RMHP Prime accepted requests for authorization electronically through an "auto-auth" online system, via fax, and by telephone. RMHP Prime did not delegate UM activities. RMHP Prime was in partnership with United. RMHP Prime staff members reported that, previously, Optum (a subsidiary of United) staff members performed UM activities for RMHP Prime and that those individuals were brought into RMHP Prime's UM operations as RMHP Prime employees. During the review period, RMHP Prime used MCG UR criteria for MH determinations and ASAM levels of care criteria for SUD determinations. RMHP Prime required its UM staff to pass interrater reliability testing annually with a minimum score of 90 percent.

Based on review of 10 inpatient and 10 outpatient UR/denial records and associated documentation, HSAG found that RMHP Prime followed its prior authorization list and UM policies and procedures with regard to which services are subject to prior authorization and requirements for processing requests for services. NABDs were written at a reading level that was easy to understand and were provided on a Department-approved template that contained all of the required information. In all cases involving a medical necessity review, RMHP Prime offered requesting providers peer-to-peer reviews prior to finalizing a denial determination. Board-certified psychiatrists reviewed all medical necessity denials. An RN or master's level clinician made administrative denials. All administrative denials reviewed for RMHP Prime were due to the member reaching the limit of 15 days in an IMD. When a member reached 15 days in an IMD within the same month, RMHP Prime authorized payment for the first 15 days and denied payment on the 16th day and forward. In some cases involving requests for out-of-network care, an MD reviewed for medical necessity to ensure that an equivalent service was available from an in-network provider.

In two cases reviewed, the system documentation indicated that the request was a concurrent review, when the request was actually a new request for the service. HSAG recommended that the Department encourage RMHP Prime to evaluate documentation protocols to ensure accuracy.

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

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

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

| Service Type/Code | RMHP RAE 1 | NHP RAE 2 | COA RAE 3 | HCI RAE 4 | COA RAE 5 | CCHA RAE 6 | CCHA RAE 7 | DHMP | RMHP Prime |
|---|---|---|---|---|---|---|---|---|---|
| **Inpatient Services** | | | | | | | | | |
| Acute Hospitalization | 24-hour notification | Yes | Yes | Yes | Yes | Yes | Yes | Yes | 24-hour notification |
| Emergency Admissions | 24-hour notification | 24-hour notification | 24-hour notification | 24-hour notification | 24-hour notification | 24-hour notification | 24-hour notification | 24-hour notification | 24-hour notification |
| Observation | No | Do not use a code for this | No | Do not use a code for this | No | No, but subject to Med Nec review | No, but subject to Med Nec review | No | No |
| Acute Treatment Unit (ATU) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Residential Treatment Center (RTC) (Long and Short Term) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Crisis Stabilization Unit (CSU) | No | After the fifth visit per episode of care | No | After the fifth visit per episode of care | No | No | No | No | No |

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

| Service Type/Code | RMHP RAE 1 | NHP RAE 2 | COA RAE 3 | HCI RAE 4 | COA RAE 5 | CCHA RAE 6 | CCHA RAE 7 | DHMP | RMHP Prime |
|---|---|---|---|---|---|---|---|---|---|
| **Outpatient Services** | | | | | | | | | |
| Psychotherapy (P-Tx) (Initial evaluation) | No | No | No | No | No | No | No | No | No |
| P-Tx (60 minutes) | After the 12th visit | After the 25th visit | Only P-Tx billed by PCP after six visits | After the 25th visit | Only P-Tx billed by PCP after six visits | No | No | Only P-Tx billed by PCP after six visits | After the 12th visit |
| P-Tx (30 or 45 minutes) | No | After the 25th visit | Only P-Tx billed by PCP after six visits | After the 25th visit | Only P-Tx billed by PCP after six visits | No | No | Only P-Tx billed by PCP after six visits | No |
| Psychological/ Neurological Testing | Yes | Yes (No 01/01/21 and after) | Yes | Yes (No 01/01/21 and after) | Yes | Yes | Yes | Yes | Yes |
| Assertive Community Treatment (ACT) | No | Yes | No | Yes | No | Yes | Yes | No | No |
| Partial Hospitalization Program (PHP) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Intensive Outpatient Program (IOP) | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |

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

| Service Type/Code | RMHP RAE 1 | NHP RAE 2 | COA RAE 3 | HCI RAE 4 | COA RAE 5 | CCHA RAE 6 | CCHA RAE 7 | DHMP | RMHP Prime |
|---|---|---|---|---|---|---|---|---|---|
| Behavioral Health (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 |
| Services by Out-of-Network (OON) Provider | All services by OON providers (except emergency/crisis) (cover only if in-network provider unavailable) | | | | | | | | |
| **Criteria/Policies** | | | | | | | | | |
| Criteria Used | MCG ASAM | InterQual ASAM | InterQual | InterQual ASAM | InterQual | MCG | MCG | InterQual | MCG ASAM |
| Peer-to-Peer Review | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes | Yes |
| Interrater Reliability Testing/Passing Score | 90% | 80% | 90% | 80% | 90% | 90% | 90% | 90% | 90% |
| Delegation of UM | No brought in-house | Yes to Beacon | No | No Beacon/ Partner | No | No Anthem/ Partner | No Anthem/ Partner | Yes to COA | No brought in-house |
| Level of Reviewer for Medical Necessity Denial Determinations | MD/DO for all services | MD/DO for all services; PhD for non-24-hour level of care | MD/DO for all services | MD/DO for all services; PhD for non-24-hour level of care | MD/DO for all services | MD/DO for all services | MD/DO for all services | MD/DO for all services | MD/DO for all services |

| 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 |
|---|---|---|---|---|---|---|---|---|---|
| Level of Reviewer for Administrative Denials (Admin) | RN or clinician for all Admin | MD/DO for all services; PhD for non-24-hour level of care | MD/DO for non-covered services; Non-clinical for other Admin | MD/DO for all services; PhD for non-24-hour level of care | MD/DO for non-covered services; Non-clinical for other Admin | RN or clinician for all Admin | RN or clinician for all Admin | MD/DO for non-covered services; Non-clinical for other Admin | RN or clinician for all Admin |

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