New Mexico Health Connections Policy and Procedure		
Section: Medical Management	**Number**	**UM 002B**
Title: Administrative Decisions	**Effective Date**	**01/2017**
Page 1 of 6	**Review/Revised Date**	
	Next Review Date	**01/2018**

Purpose:
The purpose of this policy and procedure is to ensure efficient and timely management of healthcare service requests when a provider has failed to follow prior authorization requirements. This policy also describes the process used to manage healthcare service requests in which the provider fails to follow authorization requirements set forth in the Provider Contract or Plan requirements.

Policy:
New Mexico Health Connections (NMHC) is committed to ensuring that UM decisions and subsequent notification to members and practitioners are timely and consistent in order to accommodate the clinical urgency of the situation. These determinations apply to non-behavioral health and behavioral health utilization decisions, as well as urgent and non-urgent requests. NMHC's ability to provide timely utilization managements services hinges upon the clinical information that providers submit with requests for healthcare services as well as provider compliance with prior authorization requirements, plan requirements and provider contracts.

Definitions:

Administrative Decision**:** A decision to deny payment for services when a provider has failed to follow the requirements set forth in the Provider Contract or Plan requirements or when certain administrative criteria are not met, i.e., a member is ineligible on a requested date of service or the requested service is not covered or excluded by the member's Plan. Administrative decisions are based on reasons other than a lack of medical necessity.

UM staff may issue an administrative decision for any of the following reasons:

a. A contracted provider fails to follow plan rules including but not limited to verification of eligibility and prior authorization requirements. According to contractual arrangements, members cannot be billed for rendered services due to the failure of the provider to follow plan rules;

b. A contracted provider fails to obtain prior authorization for an elective service, procedure or admission. According to contractual arrangements, members cannot be billed for rendered services due to the failure of the provider to obtain prior authorization.

c. Duplicate prior authorization requests;

d. Failure to submit clinical documentation for services that require prior authorization in order for the Plan to review if authorization criteria are met.

e. Services are not a covered benefit and not subject to medical necessity review.

Adverse Determination**:** A decision made by a Medical Director, or other physician designee, to deny payment for a requested service based on NMHC's definition of medical necessity, in conjunction with the member's benefits, applicable state laws and state and federal regulations, the Medical Director's medical expertise, medical necessity criteria, and/or published peer-review literature. At the discretion of the Medical Director, in accordance with applicable laws, regulations or other regulatory and accreditation requirements, input to the decision may be obtained from participating board certified physicians from an appropriate specialty. The Medical Director or physician designee makes the final decision.

The Medical Director, or physician reviewer, makes all adverse determinations for clinical reasons. Only a physician may issue a denial for medical necessity.

Urgent Review**:** Any request for medical care or treatment including pharmaceuticals with respect to which the application of the time periods for making non-urgent care determinations could result in the following circumstances:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Non-urgent Review**:** Any request for medical care or treatment including pharmaceuticals for which the application of the time period for making a decision does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Concurrent Review**:** Any request for coverage of medical care, pharmaceutical services or other services made while a member is in the process of receiving the requested medical care, pharmaceutical or other services, even if the organization did not previously approve the earlier care.

Defined Timeframes:

Non-urgent Requests: In order for the Plan to complete a review and issue a determination within 5 business days of receipt of the request, **s**ufficient clinical information must be received from the provider. When there is a lack of necessary clinical information to make a determination for non-urgent requests the provider will be notified and will have 2 business days to provide the information.

Urgent Requests: In order for the Plan to complete the review and issue a determination within 24 (twenty-four) hours, sufficient clinical information must be received from the provider upon initial notification or 24 (twenty-four) hours before the expiration of the approved current course of treatment or the anticipated discharge date if continued stay is requested. Continued stay reviews are considered urgent concurrent requests. When there is a lack of necessary clinical information for urgent pre-service decisions, NMHC will notify the provider and allow 2 business days to receive the required information. When there is a lack of necessary clinical information for concurrent review requests, NMHC will notify the provider and allow 2 business days to receive the required information.

Weekends and Holidays: For hospital admissions that occur after regular business hours, notification of the admission must be received on the next business day and supporting clinical information must be received on the subsequent day.

Procedures:

1. A request for healthcare services is received in the UM department by the UM technician.

2. Requests for which an authorization shell will not be created (i.e., ineligible member or duplicate request), an administrative decision is made on the request by the UM technician and the requesting provider is provided faxed notification of the administrative decision.

3. The UM technician enters a Member Note in the care management system that describes the type of request and rationale for the administrative decision.

4. For requests for which an authorization shell is created (i.e., no supporting clinical submitted, requested service is not a covered benefit, failure of a provider to obtain prior authorization for an elective request), the UM technician verifies patient eligibility and uploads all submitted documentation into the created authorization shell in the care

management system. For requests received without supporting clinical, the UM technician faxes a request to the provider requesting the clinical information within 2 business days.

5. The authorization shell along with the submitted clinical information is assigned to a clinical UM staff member in the care management system for processing depending on the type of request: in general, inpatient hospitalizations, home health and hospice requests are assigned to registered nurses; outpatient requests are assigned to licensed vocational nurses.

6. The authorization shell and all submitted clinical information is reviewed in total by the assigned nurse to determine provider compliance with plan rules and regulations.

7. If the nurse reviews the request and determines that it is appropriate for administrative decision, a note is entered into the care management system that includes:
    a. The specific type of services requested and the length of treatment
    b. The services are subject to an administrative decision
    c. The rationale for the administrative decision

8. The nurse then faxes notification to the provider notifying them of the administrative decision and rationale.

9. The authorization request is then finalized in the care management system.

10. If clinical is received within 5 business days of the original received date, a new detail is created within the original authorization request and it is sent to the nurse for review. The normal review process is then followed. If the member is still in the hospital (evidenced by no discharge date) an administrative decision is issued for the dates for which clinical was not received and the provider is educated to submit clinical with initial notification in the future.

11. If the clinical is received more than 5 business days from receipt of the original request the provider will be notified that the request will not be processed as information was not submitted in a timely manner and a new authorization request will need to be submitted for a pre-service request. If the member is still in the hospital (evidenced by no discharge date) an administrative decision is issued for the dates for which clinical was not received and the provider is educated to submit clinical with initial notification in the future.

12. Notification to a provider of the following types of administrative decisions are communicated via fax with the corresponding category selected on the fax form:

☐ NMHC has received a request for prior authorization of a service that does not require prior authorization. As such, your request will not be processed. Please refer to the provider manual for a list of services that do require prior authorization and department contact information. Any issues with payment post-service should be directed to the claims department.

☐ This member is not currently eligible for coverage by New Mexico Health Connections. Please verify member's eligibility. If you have additional questions, please contact Customer Service at 1-855-7MYNMHC (1-855-769-6642).

☐ No specified diagnosis, procedure description or clinical information to complete a review of the request has been provided. Please fax the information to 1-866-446-3774 or submit the information through the provider portal within 2 business days.

☐ This is a duplicate service request of one previously received. To check status of the authorization, please call 1-855-7MY-NMHC (1-855-769-6642), option 3 or check status on the provider portal.

☐ (Contracted providers only) Prior authorization must be obtained for an elective service, procedure or admission prior to the rendering of services. The submission received by NMHC is for services already rendered without obtaining authorization. An administrative decision has been made by NMHC to deny payment for this request. The member may not be billed for this service. A request for reconsideration may be submitted upon claim denial.

☐ (Contracted providers only) Notification was not received by NMHC within 1 business day for observation or inpatient admission. The member may not be billed for this service. For inpatient admissions the member may not be billed for dates for which clinical information was not received. A request for reconsideration may be submitted upon claim denial.

13. Notification to a provider and member of administrative decisions with a formal denial letter will occur for the following:

☐ The requested service is not a covered benefit and is not subject to medical necessity review.

☐ Clinical information was not received by NMHC within 2 business days of notification.

☐ (Non-contracted providers only) Prior authorization must be obtained for an elective service, procedure or admission prior to the rendering of services. The submission received by NMHC is for services already rendered without obtaining authorization. An administrative decision has been made by NMHC to deny payment for this request.

☐ (Non-contracted providers only) Notification was not within 1 business day for observation and inpatient admission. An administrative decision has been made by NMHC to deny payment for this request for those days when no clinical information was received.