Policy and Standards

Policy Number:	**CO.272.20**
Policy Name:	**Benefit Certification & Appeal General Guidelines** (formerly UM: General Guidelines)
Review Type:	Substantive (Material changes or initial documentation of current processes)
Contract or Regulatory Reference: (include citation if applicable)	*N/A*

Product Applicability: *(For Health Insurance Marketplaces, policies and procedures are the same, unless contractual requirements dictate a more stringent variation in which case customized documents are created.)*

Commercial
Medicaid
Medicare Part: C (Medicare Advantage)
Federal (Applies to Magellan Federal, Magellan Healthcare, non-Medicaid or Medicare, Federal contracts)

Business Division and Entity Applicability:

Magellan Healthcare

Magellan Healthcare (Behavioral)

Policy Statement

The properly licensed affiliates and subsidiaries of Magellan Health, Inc. (Magellan) conduct the utilization management (UM) program(s) as delegated by the plan or state agency with the goal of optimizing the use of healthcare resources. State regulations and/or account contractual requirements that are more stringent or that provide an additional aspect to one or more of the standards in this policy will be addressed in a customized version of this policy or in an addendum attachment.

Purpose

To describe the general guidelines applicable to the UM program activities relevant to benefit certification including appeal and provider dispute of the certification determination.

Policy Terms & Definitions Glossary

Key Terms *(as used in this policy)*

Benefit

Health care benefit per the insured's health insurance plan. These benefits are used toward the payment of healthcare services. *Synonymous term includes: coverage*. Health benefits may have one or more provisions that need to be met before the health benefit can be paid. Benefits and any provisions, as well as services excluded for benefit coverage, are described in the member's health plan policy, also called a certificate of coverage or summary of benefits.

Benefit Certification before Service is Delivered

A health benefit provision which requires requesting benefit pre-approval before the health service is delivered (rendered) or initiation of inpatient service. *Synonymous terms include: authorization; pre-certification/authorization; prior-certification/authorization; pre-service review; organization determination used by Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage (Part C) program and inpatient continued stay or concurrent requests. Federal Department of Labor ERISA regulations define concurrent request for benefits during a course of treatment.*

Benefit Determination of Payment after Service is Delivered

A claim requesting payment of the benefit after the health service has been delivered. *Synonymous terms: post-service or retrospective request.* There are health insurance industry standard forms (paper or electronic versions) with coded elements (location, type of service, procedure, etc.) for this type of request. Processing of a claim (adjudication for payment) includes checking to assure any benefit provisions, such as certification was met.

Business Days

Are counted by the number of days between two dates excluding weekends and holidays, with the starting day excluded and the last day included (unless it falls on a weekend or holiday).

Calendar Days

Are counted by the number of days between two dates with the starting day excluded and the last day included.

Insured

The individual with a health insurance policy with health insurance benefits. *Synonymous terms include: beneficiary, consumer, enrollee, insured, member and recipient.*

Notice of Admission

In certain markets and for specific services, Magellan processes a benefit certification request as a notification of admission. As with all admissions, pre-screening is conducted in order to determine the member's benefits and eligibility. Magellan determines the levels of care which require notification of admission based on provider and plan characteristics. Member and provider notifications of determinations meet all state and plan requirements.

Additional *Policy Terms & Definitions* are available should the reader need to inquire as to the definition of a term used in this policy.

To access the *Policy Terms & Definitions Glossary* in C360, click on the below link: *(internal link(s) available to Magellan Health employees only)*

Policy Terms & Definitions Glossary

Standards

I. Benefit Certification Determination

A. The outcome of a benefit certification request, or a claim for payment of benefits after services have been delivered, is called a 'benefit determination'.

B. Benefit certification determination outcomes consist of the following:

1. Approve – The benefit requested can be applied toward the specific service requested. *Synonymous terms include: certified; authorized; and favorable*.

2. Adverse – The benefit requested cannot be applied toward the specific service requested. *Synonymous terms include: action (used by Centers for Medicare & Medicaid Services (CMS) for Medicaid managed care program; not approved; not certified; not authorized; not favorable; and partially favorable*.

3. Inactive – Procedures, including any notice to the insured, are implemented based on regulation or contract. *Synonymous term includes withdrawn*. Examples of inactive/withdrawn requests are as follows:

a) Mutually agreed alternative – The service being requested for application to a benefit results in the ordering/rendering provider agreeing to a difference in or /alternative service to be applied to the benefit and the agreed upon benefit is approved. The initial service as requested is considered inactivated by the requestor.

b) Voluntarily inactivate the request - At any time during the benefit certification process the requestor may voluntarily inactivate the benefit request.

c) Benefit request not covered – Requestor found the request was made in error because benefit certification is not a provision of the benefit.

C. Benefit determination outcomes resulting from a claim for a benefit payment consist of the below:

1. Approved for payment or paid; or

2. Not approved for payment or payment denied.

D. Appeal of Adverse Benefit Determination or Claim for Benefit Payment

1. Disagreements with the adverse benefit determination, or claim payment denial, may be initiated by invoking the applicable member appeal rights.
   a) Appeal process outcome is a decision to uphold (not change) or to overturn (change) the benefit determination at the time of certification or the claim payment request.
   b) Synonymous term includes: Reconsideration, as used by CMS to describe the Medicare Advantage (Part C) enrollee appeal process.
2. There are significant differences between the insured invoking the right to appeal and a provider appealing on behalf of themselves for payment of service. See the chart below for some differences:

Key Aspects	Insured invoking right to appeal	Provider dispute for payment
Governed by Federal regulation	Yes	No
State regulation for initiating	Yes	States that have regulations for provider disputes with/without Peer To Peer (PTP) conversation frequently use the terms "reconsideration" or "provider appeal" in the regulation.
State regulation for time to process	Yes	
State regulation for notification of decision to insured	Yes	
Provider acting as authorized representative of the insured individual.	Yes. MHS or state law may require a signed authorization from the insured individual.	No
Regulation includes E/IRO review	Yes	No
Requestor	Insured individual or their authorized representative which in most cases is the ordering /treating provider	Ordering and/or rendering provider
Included in appeal case files for accreditation survey?	Yes URAC and National Committee for Quality Assurance (NCQA) accreditation survey this as part of the benefit/coverage	No .

Key Aspects	Insured invoking right to appeal	Provider dispute for payment
	certification determination process.	
Requested after unfavorable benefit/coverage certification determination.	Yes	Yes
Requested after non-payment of a claim submitted for reimbursement.	Yes	Yes
How many levels are available?	MHS company may be contractually delegated to perform the regulatory allowed number of internal mandatory appeal levels and any plan specific internal voluntary appeal levels.	Some states view the PTP as an appeal. Most states allow for one level of provider dispute appeal. . It is possible that a state or customer might require a two-level appeal process for providers. State law and customer contract should be consulted.

II. Health Benefit Certification and Appeal General Principles

A. The actual delivery of healthcare services to a member remains under the authority and responsibility of an ordering and/or rendering healthcare provider regardless of the health benefit determination.

B. Benefit certification requests and appeal processing, i.e., who can request, time-to-process, notification and other relevant aspects, in this policy and each companion product line specific benefit certification and appeal policy, are described in accordance with the applicable federal agency that regulates the health insurance product line:

1. Commercial or private insurance (including ACA marketplace plans) – Department of Labor, Employee Retirement Income Security Act of 1974 (ERISA);
2. Medicare Advantage (Part C) insurance program – CMS; and/or
3. Medicaid managed care insurance program – CMS.

C. This policy and each companion product line specific benefit certification and appeal policy may include additions and/or modifications based on one or more of the following:

1. State agency that regulates health insurance product(s) or Medicaid and Children's Health Insurance Program (CHIP) plans;
2. Managed care industry accreditation entity[1] standards; or

[1] NCQA and URAC.

3. Specific health insurance policy requirements for decisions including pre-existing condition provisions when the insurance plan or agency is allowed by regulation to not cover pre-existing care or services.

D. Time to Process

1. Is cited as the maximum timeframe and includes any allowable extensions.
2. To support the timely delivery of service, each benefit (certification and appeal) request is to be completed by:
   a) Using thoughtful consideration of the member's clinical condition and location (e.g., is the member in a health care setting) at the time of the coverage request; and
   b) Reminding the ordering and/or rendering provider of timely delivery of service consideration when additional clinical information is needed to decide the medical necessity.
3. Standard *(synonymous term: non-urgent)* processing timeframe is applied except when the member's clinical situation and location require the expedited *(synonymous terms: urgent or fast)* timeframe. Although regulators have different language to describe when to apply the expedited timeframe[2], the member's clinical situation at the time of the request is taken into account to decide if the standard timeframe would seriously jeopardize the member's life, health, or ability to regain maximum function.
4. Processing timeframe starts with the request, verbal or written, (written may be required in situations such as a claim appeal) by the member or a valid representative of the member.
5. Processing timeframe ends, is completed, with notification to the member, and/or requestor on behalf of the member, when applicable.

E. Benefit Certification and Appeal Notice Guidelines

1. Verbal notice is allowed for expedited determinations or appeal decisions and approved determinations when written notice is not mandated by regulation, accreditation or contract.
   a) Verbal notice of an expedited benefit determination and appeal is only required to be made to the ordering and/or rendering provider requesting the benefit acting on the member's behalf unless state law requires that the insured be notified.
   b) Non-English language, verbal/oral, service is made available to assist customers and members in answering questions in any applicable non-English language and providing assistance with requesting benefit certification, filing a claim and appeals (including external review) in any applicable non-English language.
   c) Voice mails are not considered evidence of verbal notifications.
2. Written notice is required for all adverse benefit determination and appeal decisions and is provided to the member and the ordering and/or rendering provider in easily understood language.

[2] FROM REGS – DOL/ERISA-expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires; MEDICAID-as soon as possible, taking into account the medical exigencies; MA - request for expedited determination must make its determination and notify the enrollee (and the physician involved, as appropriate) of its decision, whether adverse or favorable, as expeditiously as the enrollee's health condition requires.

a) A provision of the Patient Protection and Affordable Care Act (ACA) requires written notices to be provided in a "culturally and linguistically appropriate manner".

i. This accommodation is met when the English version of the notice includes a prominently displayed statement on how to access non-English language services provided by the plan or issuer. The applicable non-English language for the statement is selected based on the county of the member's address, where 10% or more of the county population is literate only in the same non-English language.

ii. The 10% threshold is based on the American Community Survey (ACS) data published by the United States Census Bureau and is updated annually. The Department of Health and Human Services has issued the current list of Culturally and Linguistically Appropriate Services (CLAS) County Data for the counties where 10% or more of the population is literate only in the same non-English language.

iii. Written notices for commercial populations contain a non-English language statement on how to access language services in Spanish, Tagalog, Chinese and Navajo unless the 10% threshold data ~~has~~ indicates a different language or the contractor directs to change one or more of the statements. Upon request, notices will be provided in any applicable non-English language.

iv. Some customer health plans subject to Section 1557 of the ACA wish to continue providing the notices called for in that Rule despite its repeal. If directed by a customer to do so, written notices will be provided with the *Notice of Nondiscrimination* and taglines in at least the top 15 languages spoken by limited English proficient speakers in the state or, where appropriate, the aggregate languages for multiple plan states or nationwide. If requested by a customer, these taglines and the *Notice of Nondiscrimination* will also be on any web content that contains information that is critical for coverage or access to services.

b) Written notices for Medicare and Medicaid populations are also provided in a "culturally and linguistically appropriate manner" by containing a non-English language statement on how to access language services in the four (4) languages of Spanish, Tagalog, Chinese and Navajo, or the 10% threshold in the current CLAS County Data or per the contracting entity/agency.

c) When permitted by federal and/or state regulators, the notice to the member may not be required when the adverse benefit determination is the result of a:

i. Benefit request for an inpatient stay course of treatment since the facility is acting on behalf of the member (synonymous terms: continued stay or concurrent); or

ii. Benefit request made after the service has already been rendered and the member is not at financial risk, excluding benefit co-pay and/or deductible.

3. The notice to the member also contains information based on regulatory requirements that the member may request access to and copies of all documents relevant to their appeal free of charge.

4. A written summary of the procedures from the appeal policy is available, upon request, to any insured individual, provider, or facility rendering service (as required by applicable accreditation standards).

F. Basis of a Benefit Certification Determination and Appeal Decision

1. Clinical criteria are applied using the available clinical information to decide the medical necessity of the benefit request. *Synonymous term: clinical based benefit certification determination*.
   a) Applied consistently for similarly situated insured individuals;
   b) Uses clinical information obtained during the benefit certification or appeal; and
   c) Clinical criteria are not applied for Notifications of Admissions.
2. An exception to a benefit certification being decided with medical necessity is when necessary clinical information to apply the clinical criteria for medical necessity is not made available during the benefit certification process applied to the benefit request. This is called an administrative-based decision of a benefit request.
   a) The benefit certification process is designed to identify clinical information needed to decide the medical necessity of the benefit requested early in the process.
   b) When clinical information is lacking, the ordering/rendering provider, and the member, if the member is the requestor, or if state law requires member notification, is notified immediately, verbally, and in writing if required by regulation, of the clinical information needed to decide medical necessity and the timeframe within which the provider has to submit the clinical information as well as in what manner the information may be submitted, i.e., verbally and/or in writing.
   c) The length of time the provider is given to submit the needed clinical information is dependent on the regulatory maximum allowable timeframe, including any allowable extensions as described in each product line benefit certification policy.
   d) Written notices about lack of information based benefit certification determination are issued to the member and ordering and/or rendering provider within the maximum allowable timeframe being applied to the benefit certification request as described in each product line benefit certification policy. The notice includes the clinical information that was needed to show medical necessity. A verbal notification within the timeframe may also be given to the requestor.
   e) When an administrative based benefit certification and/or appeal is disallowed by regulation or contract, a medical necessity decision must be rendered using the available clinical information.

G. Behavioral Health Discharge Planning

1. Magellan's Transition of Care Coordinator (TOC) or Care Manager (CM) may reach out to the facility prior to the last covered day for discharge and transition of care planning.
2. Minimally a discharge and transition of care plan contains the following components.
   a) Target date of discharge;
   b) Place of discharge;
   c) A scheduled post discharge provider appointment (the TOC or CM will assist the facility in scheduling a post discharge appointment if necessary); and
   d) Assessment of member for Magellan's care management program

3. If the provider indicates that additional services are needed for a successful transition of care, the initial authorization may be extended administratively. If a transition of care plan is not progressing or is inadequate, a Magellan Physician Reviewer will review the details of the transition of care plan and may discuss with the member's attending physician.

H. Emergency Service Waiver of Benefit Certification Provision

1. Each of the product line regulators has regulations for emergency service waiver.
2. These are the common aspects of emergency service benefit certification waivers:
   a) When the insured is seeking emergency services for immediate medical attention that is furnished by a provider qualified to provide emergency services (e.g., facility crisis unit or emergency room/department) when such services are needed to evaluate and/or stabilize an emergency clinical situation; and
   b) An emergency clinical situation is when an insured's clinical disorder is manifesting itself through one or more acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to place the individual's life or health in serious jeopardy or cause the individual bodily impairment and/or dysfunction[3].

I. No Surprises Act

1. Applies to individual plans, small group plans, large group plans, self-funded plans, church plans, grandfathered and grand mothered plans, nonfederal government plans, student plans and Federal Employees Health Benefits (FEHBP).
2. Applies when a member receives emergency services from an out of network provider or facility, when a member receives non-emergency services from an out of network provider at an in-network facility, and when a member receives out of network air ambulance services.
3. Emergency services include medical screening exams, the ancillary services needed to evaluate the member's condition, further treatment to stabilize the member, and post stabilization services.
4. Emergency services include those provided in an emergency room, a freestanding emergency room and an urgent care center if the center is appropriately licensed by the state to provider emergency care.
5. Post stabilization services include services regardless of where in a hospital those services are provided. These include outpatient observations and inpatient or outpatient stays that are provided together with emergency services.
6. Emergency services must be provided:
   a) Without prior authorization;
   b) Without regard for if the provider is a participating provider or participating emergency facility; and
   c) In a manner such that any services provided by a non-participating provider or non-participating emergency facility are provided without imposing any requirements or limits more restrictive than there would be for par providers.
7. Non-Emergency Services performed by a non-participating provider at participating facilities need to be provided in accordance with the guidance above as well unless

[3] Adapted from EMTALA; 42CFR § 438.114 (a); and 42CFR § 422.113 (b) (1) (i) emergency condition definitions.

the notice and consent requirements are provided as outlined in Magellan claims policies.

J. Similarities in regulatory language to define the application of expedited timeframe and emergency service waiver of benefit certification may make it difficult to discern which to apply. Processors of benefit certification requests should initially consider application of the emergency service waiver when the insured is in a clinical situation that requires immediate emergency medical attention.

K. Requests for Excluded, Unproven, Experimental, or Investigational Services per ERISA

1. When a policy or account contract explicitly states that services are a benefit exclusion (not a benefit) and names the excluded services in the member's contract, the request for named services is processed as a request for an ineligible benefit.
2. When a request is for services that Magellan or the account consider to be experimental or investigational services, the benefit certification process is initiated to decide the medical necessity of the requested benefit based upon the approved clinical criteria.
3. For health plans subject to ERISA, if appealed, experimental/investigational treatments are reviewed by a physician in accordance with the state law or external/independent review organization procedures.
4. For Medicaid and Medicare accounts, experimental and investigations services are handled in accordance with the customer contract.

L. Requests for Benefit Certification after the Delivery of Service

1. There are two situations in which this occurs:
   a) A late certification request is when the benefit, policy, contract or state agency does not allow a grace period to request benefit certification after the delivery or initiation of inpatient service and a claim for payment has not been submitted; or
   b) A claim for payment has been submitted for a benefit that has a certification provision and the certification was not requested.
2. Per Department of Labor/ERISA regulations for commercial insurance, these requests are required to be completed (a benefit certification determination notice issued) within thirty (30) calendar days of the receipt of the late request or claim for payment. Although CMS does not include post-service as part of the benefit certification regulation for Medicare Advantage (Part C) and Medicaid managed care, the thirty (30) day timeframe is applied. when NCQA and/or URAC accreditation is being sought or exists.
   a) These requests are initially researched administratively for any applicable state or contract waiver in place or a reasonable cause for the certification not being obtained before the service was delivered.
   b) If a waiver is not in place and a reasonable cause was not found to exist, the request is completed based on the administrative reason.
   c) If a waiver is in place or a reasonable cause is determined, the benefit certification process is followed.

M. Non-Incentive Compensation Statements

1. Employees or contracted personnel that perform one of the benefit certification and appeal process roles are not provided any financial incentives or rewards to withhold or reduce coverage determination based upon clinical criteria, administrative

reasons, or coverage eligibility. This company policy is distributed to each employee, contractor, provider, and when contracted, directly to members.

2. Action will not be taken with respect to a member or health care provider that is intended to penalize such member, the member's authorized representative, or the member's health care provider for, or to discourage such member, representative, or provider from, undertaking a provider on behalf of provider dispute resolution, invoking formal appeal rights given to the member or judicial review of an adverse coverage determination.

3. Magellan does not enter into contracts with financial incentives or rewards related to the reduction in approved coverage.

N. Amending an existing certification of coverage is not done for reasons other than correcting an error or for one or more specific coverage provisions, such as when a provider terminates from the network or if there is fraud.

III. Clinical Criteria for Medical Necessity Decision

A. Established objective and evidence-based clinical criteria make up the decision support tool that constitutes the basis of a medical necessity decision.

B. For behavioral health business, Magellan Care Guidelines are used. Magellan Care Guidelines include: Milliman Care Guidelines (MCG) for higher levels of care; Magellan Medical Necessity Criteria for specialty outpatient services; American Society of Addiction Medicine (ASAM) for Substance Use Disorder (SUD) services where required by state or account; the Level of Care Utilization System (LOCUS®), Children's Level of Care Utilization System (CALOCUS®), and Early Childhood Service Intensity Instrument (ECSII®) when required by state or account; and other state or account mandated criteria. .

C. The Medical Director's office oversees the development and/or adoption and annual review of the clinical criteria.

D. Providers are notified of how to access the criteria used to make specific determinations via correspondence, web site, newsletter, handbook, and/or alerts. New providers are supplied with this notice upon receipt of their handbook.

E. Annual and interim review of Magellan Care Guidelines involves:

1. Appropriately licensed, actively practicing physicians, with current clinical knowledge and expertise in applicable specialties, who are preferably board certified, and participate in the development and annual review process.

2. Information gathered as part of the development and annual review is assessed in order to maintain objective clinical criteria based on clinical evidence as well as guidance for applying the clinical criteria. Information can be from sources such as:

a) Latest scientific research published since the previous annual review;

b) Results of the consistency in which the clinical criteria are applied (inter-rater reliability); and

c) Solicited or unsolicited input received from providers:

i. Solicited input such as from participation on advisory committees, meetings, or provider surveys, and

ii. Unsolicited comments or feedback.

F. Annual and interim draft content updates for Magellan Care Guidelines are also assessed for consistency against current utilization management (UM) policies, system scripting or algorithms, adopted clinical practice guidelines and CMS Medicare's coverage determinations[4].

1. Recommendations for content updates to the clinical criteria, which may include updates to application of clinical criteria, are presented to the corporate committee that is designated oversight for approval.
2. Following committee approval, the clinical criteria are finalized.
3. Criteria is then filed with state regulators as required. Customer approval, where required, is sought at this time as well.
4. After necessary approvals are received, the criteria are distributed to all UM staff who will receive notice as to the revisions.
5. The website is updated with the criteria once all approvals are received and prior to the effective date of the criteria.

G. State or local regulations and/or account contractual requirements may dictate the use of other clinical criteria for one or more types of coverage. This may be a modified version of the approved clinical criteria or alternative clinical criteria such as national, local or account proprietary clinical criteria.

1. An account's request to use a modified version of the clinical criteria is reviewed by the Medical Director's office to assess the modifications for consistency with good clinical practice, to convey findings and to make any recommendations prior to use.
2. At the time of contracting with the account, the Medical Director's office reviews any non-state law required alternative clinical criteria to assess if it is consistent with good clinical practice, to convey findings and to make any recommendations prior to use. Any recommendations made as a result of subsequent annual reviews are forwarded in writing to the account.

H. Consideration is given to the following items when applying clinical criteria to a covered service:

1. Applicable coverage;
2. Individual member needs such as age (e.g.: address a child or adolescent's individual need), environmental factors, and clinical features such as the specific disorder progression and co-morbid conditions; and
3. Resources in the local/regional service delivery area including availability of services and any applicable alternative service.

I. The degree to which clinical UM staff consistently applies the clinical criteria (inter-rater reliability) is evaluated annually using performance measurements approved by the corporate Medical Director and designated committee. When measurement results are determined to be below performance expectations, a quality improvement activity is initiated to improve consistency in which the clinical criteria are applied and/or make recommendations for revision to the criteria.

IV. Initiating the Benefit Certification Process

[4] cms.gov national and local coverage determinations (NCD and LCD)

A. Members are provided information about what coverage requires certification and how to request coverage from the policy issuer via the member ID card, manual, handbook and/or web site.

B. Requests for coverage may be initiated, processed and completed verbally via telephone or in writing via mail, facsimile, or other approved and secure transmission mode such as a designated web portal. Language assistance and TDD/TTY services for hearing or speech impaired members are available for members to discuss benefit certification or other UM program needs.

C. The benefit certification process is not conducted face-to-face on-site, unless it is deemed an exception and approved by the designated Medical Director. If face-to-face on-site is approved, the UM staff must carry a picture ID displaying their full name and the name of the company. The UM staff must schedule the clinical record review at least one (1) business day in advance, unless otherwise agreed, and follow rules and reasonable procedures of the facility, including checking in with designated personnel.

D. The member, or a representative designated by the member, can initiate a benefit certification process query or request for coverage. Due to the level of clinical information needed for medical necessity decision and processing timeframes the ordering or rendering provider with current knowledge of the member's clinical condition acting as the member's representative should initiate the request for benefit certification process if possible. Where required by state law or customer contract, for benefit certification requests that do not require an expedited timeframe, a consent form signed by the member for an individual to act as a representative may be required.

E. Contact in which it is expressed or stated that the caller is seeking coverage which requires certification initiates the benefit certification process. The following are <u>not</u> considered a request for coverage:

   1. An inquiry in which general information is sought, including general questions about coverage (may include questions about past coverage certifications or general question about current coverage); and

   2. Contacts from providers seeking advice or direction about applicability of the member's coverage of healthcare or healthcare related service.

F. General Administrative Communication Protocols

   1. Magellan can be contacted via web portal, toll-free telephone, interactive voice response (IVR) where available and in writing (mail or facsimile) for inquiries about UM services, participating providers and request for coverage.

   2. To address telephonic contacts in which the caller self-reports they are in an emergent clinical situation and not in a healthcare setting, an emergency option is the first statement of live answer or the automated attendant. Voice recognition technology or an auto transfer for non-responses will route rotary telephone callers to staff. Staff can assist callers found to be in an emergent clinical situation by advising the caller to call 9-1-1 or in some situations, the staff may contact 9-1-1 for the member.

   3. Incoming calls are answered in a professional and timely manner and directed to appropriately qualified staff.

   4. Telephonic access performance is measured using approved metrics and frequency and is overseen by a designated committee.

G. Communication Protocols Specific to Benefit Certification and Appeal

1. When communicating (inbound or outbound) directly with members or providers, UM staff identify themselves by name, job title and company name.
2. Designated UM staff are available for inbound benefit certification and appeal process communications, including questions, from members and providers via the toll-free number at least eight (8) hours during normal business days. UM staff are also made available to receive inbound calls after business hours and on non-business days when required by state regulation or account.
3. Response to a benefit inquiry is made no later than one (1) business day after receipt of the contact. Response to an inquiry from a provider is conducted during reasonable and normal business hours for providers, unless otherwise mutually agreed.
4. UM staff will attempt to verbally inform the member, ordering and/or rendering provider of specific benefit certification process requirements and procedures, upon request.

V. Role of Staff in the Benefit Certification and Appeal Process

A. Required qualifications relevant to an individual's role in UM are identified in job descriptions and contractor agreements which include minimum requirements for education, experience, skills, and clinical licensure.

B. Licensure and other applicable credentials of licensed or certified individuals are verified upon hire or contracting and at least every three (3) years thereafter when the individual is part of the UM staff. If there is an adverse change in licensure or certification status, the individual must notify the applicable department(s) in a timely manner.

C. Employees and contracted physician reviewers with a role in UM must complete initial orientation and ongoing annual training, which includes: relevant benefit certification and appeal process policies; principles and procedures based on applicable industry accreditation standards; federal regulations and privacy and information security principles. Employee and contractor performance is appraised at least annually.

VI. Processing of Benefit Certification and Appeal

A. Initial Administrative Review

1. Information collected at this step can be obtained by phone or secure electronic portal. When the information is obtained by phone, it is performed by a non-healthcare professional in a consumer assistance role. One of the job titles for this role is Customer Service Associate (CSA). Administrative staff performing this step have access to licensed health professionals who can answer questions and provide guidance as needed.
    a) General information (i.e., demographics, requestor and coverage requested); and
    b) Structured clinical related data via system prompts or algorithms which do not require evaluation or interpretation of clinical information such as provider reported disorder type, findings, results and claim code.
2. Outcome of this level of review is:
    a) A certification approval is issued; or
    b) A referral to a provider if one has not been identified; or
    c) The request cannot be certified and is forwarded for initial clinical review.

B. Initial Clinical Review

1. Performed by a healthcare professional, possessing an active license or certification to practice as a health professional in a state or territory of the United States; and with a scope of practice that is relevant to the clinical area(s)/ specialty, who performs review of the clinical aspects of the requested benefit/ coverage against the approved and established clinical criteria. Job titles for staff performing this role are Initial Clinical Reviewer (ICR) Care Manager (CM) or Utilization Review (UR) Nurse.
2. Reviewers have access to employed or contracted licensed physicians in the same licensure category as the ordering and/or rendering provider to answer questions and provide guidance as needed.
3. Reviewers collect information in addition to the data collected during initial review and review the request for medical necessity using the appropriate approved clinical criteria.
4. Reviewers use the same clinical criterion for the requested level of care throughout the member's episode of care and appeal, if applicable. If the specific criteria that is utilized for the respective member's health plan changes, modified or amended in any way while the member is in a specific level of care, the criteria that was applied upon the admission request will be utilized throughout that level of care until discharge or moving to an alternative level of care. If the member is moving to an alternative level of care, the new Medical Necessity Criterion will be utilized.
5. Outcome of this level of review is:
    a) The requestor is notified of additional information needed in order to perform medical necessity and any allowable timeframe extension. Extension time is started upon notice to requestor; or
    b) A certification approval is issued; or
    c) The request cannot be certified and is forwarded for peer clinical review.

C. Peer Clinical Review

1. Peer clinical review of a benefit certification or appeal request cannot be conducted on a U.S. military base, vessel, or embassy located outside of the United States or its territories.
2. The review is performed by a healthcare practitioner who holds an unrestricted current and valid license or certification to practice medicine in a state or territory of the United States; in the same licensure category as the ordering and/or rendering provider and, unless expressly allowed by state or federal law or regulation, are located in a state or territory of the United States when conducting a peer clinical review.
    a) When allowed by regulation and appropriate to the benefit undergoing certification, a peer reviewer may be a non-physician such as a pharmacist or doctoral-level clinical psychologist who holds an unrestricted current and valid license to practice in the U.S.
    b) When the peer reviewer is a physician, active board certification is preferred except for peer clinical review of appeals when board certification is required by law.
3. Other job titles for a peer clinical reviewer can be a Physician Clinical Reviewer (PCR) or Physician Advisor (PA) or Utilization Review (UR) Physician.

4. The peer clinical reviewer may consult with another licensed physician that is board certified in the specialty relevant to the request.
5. If the peer clinical reviewer feels more clinical information, in addition to the data collected during the initial administrative and clinical reviews, would provide a more comprehensive view of the case from the ordering/rendering providers point of view in deciding the medical necessity, the peer clinical reviewer:
    a) May apply allowable extension timeframes, if not started during the initial clinical review; and/or
    b) Has the option to initiate a peer–to–peer (PTP) discussion with the requesting ordering/rendering provider prior to completing the peer clinical review.
    c) For MEDICARE: may provide the treating provider opportunity to discuss prior to the decision.
        i. Magellan does not use peer-to-peer discussions to solicit substantive modification to pending prior authorization (organization determination) requests to improve likelihood for approval (e.g., a peer-to-peer discussion suggesting the physician or prescriber modify a pending organization determination request to a lower level of service to receive an approval).
        ii. Magellan must render an organization determination on the initial service and the frequency and/or number of services requested even when an alternative level of care or less frequent and/or number of services is accepted by the requesting provider.
        iii. Coverage and medical necessity decisions are initial organization determinations subject to notification and appeal requirements.
        iv. Magellan may not interfere with an enrollee's right to receive an organization determination or obstruct the enrollee's access to the appeal process by any means.
6. The outcome of a peer clinical review is a medical necessity decision resulting in an approved certification or adverse benefit determination. An adverse certification determination can also be the result of an administrative reason if the peer clinical reviewer cannot render a medical necessity decision with the available clinical information.
7. If the peer clinical review results in an adverse benefit determination, the benefit notice is issued to the member and requesting provider. The requesting provider is also notified in a timely manner of available provider dispute options and member appeal rights.

D. Peer to Peer discussions may occur as follows:
1. The requesting ordering/treating provider is offered a PTP discussion with the peer clinical reviewer if he/she did not speak to a peer clinical reviewer prior to the adverse benefit determination.
    a) The PTP may be offered verbally and/or by letter.
2. The PTP discussion must be with the ordering, attending or treating provider.
3. When the ordering, attending or treating provider is not available for a timely PTP with a peer reviewer for the requested benefit, the ordering, attending or treating provider may appoint a designee who is a health care professional with knowledge of

the claimant's medical condition and involved in the direct care of the claimant, to conduct the PTP review on their behalf.

4. PTP discussions only involve health care professionals on the clinical team as described above.
5. Individuals who are not health care professionals on the clinical team are prohibited from participating in the PTP discussion unless otherwise required by law.
6. Magellan peer clinical reviewers discontinue the PTP discussion upon learning of the attendance of a third party before or during a PTP discussion. In these instances, the peer clinical reviewer may offer the ordering, attending or treating provider another time for the PTP discussion to take place without the attendance of the third party but this is at the discretion of the clinical peer reviewer.
7. If the ordering/rendering provider requests a PTP discussion, the PTP is conducted within one (1) business day from the date of the request unless an alternate date is agreed to by the ordering, attending or treating provider and as permitted by state regulation and/or customer contract.
    a) The PTP discussion takes place at the appointed time prior to the benefit certification timeframe with the assigned peer clinical reviewer or another peer clinical reviewer if the assigned peer clinical reviewer is unavailable for the scheduled PTP discussion.

E. The appeal process can begin with an administrative or clinical peer review as noted above. The review level is chosen based upon the following:

1. The basis of the adverse benefit determination;
2. When the appeal request was made before or after services rendered;
3. Other relevant appeal information at the time of appeal request; and/or
4. State regulatory or contract requirements.

F. Additional requirements for the role of a peer clinical reviewer when performing medical necessity for an appeal:

1. Active board certification is preferred except for peer clinical review of an appeal when board certification is required by law;
2. Appointment of a new person to review the appeal who was not involved in the initial denial determination and is not a subordinate of the individual who made the initial denial determination;
3. The peer clinical reviewer must have the scope of licensure or certification that typically manages the clinical disorder/condition/issue, procedure or treatment and current relevant experience and/or knowledge related to the benefit/coverage determination under appeal; as well as current experience and/or knowledge relevant to the member's clinical situation. The peer clinical reviewer meets (a) scope of licensure or certification that typically manages the clinical disorder/condition, procedure, treatment, or issue under review; and (b) current, relevant experience and/or knowledge to render a determination for the case under review;
4. Considerations to match a peer clinical reviewer for medical necessity review of an appeal may include ordering and /or rendering provider specialty (example child psychiatry, addictions, etc.);
5. If the assigned peer clinical reviewer finds that he/she does not have the experience and/or knowledge of the member's clinical situation to perform as the peer clinical

reviewer for medical necessity review of the appeal then, he/she may recuse him/herself. The appeal is then referred to the Medical Director for assignment to an appropriate peer clinical reviewer; and

6. The peer clinical reviewer that accepts and conducts the medical necessity review of the appeal must acknowledge in the record that he/she meets scope of licensure or certification that typically manages the clinical condition, procedure, treatment, or issue under appeal, and has the current, relevant experience and/or knowledge to render the medical necessity decision for the appeal.

VII. Information Collected and Documented During Benefit Certification and Appeal Process

A. Administrative and clinical information collected by UM staff is recorded in the designated computerized system which has identification protocols for system security including user and password login. The system also allows need-to-know staff to view collected information to assist with seamless and unduplicated certification coverage processes.

B. Information obtained for the certification and appeal process can be submitted from any reasonable reliable source prior to the end of processing timeframe; collected verbally and/or in writing; and is recorded in the designated system, which contains prompts to assist with collection of specific information.

C. The system is able to auto-populate some administrative information such as basic demographics from eligibility records and provider system.

D. Aspects for coverage certification and appeal entered in the system include but are not limited to:

1. Contact aspects such as date, time, origin/location of insured at time of request;
2. Identification of requestor and verification of authorized representative, as applicable;
3. Basic member identifiers (e.g., name, plan ID);
4. Basic ordering and/or rendering provider identifiers;
5. Requested covered service for application of benefit, including frequency and duration, as applicable;
6. Anticipated/scheduled date of service if required by account;
7. Date and time of medical necessity decision, peer-to-peer attempts and outcome, coverage determination rendered and issuance;
8. Name, title and credential of UM staff conducting the UM review process;
9. Specific clinical criteria set/criterion applied to request;
10. Request and receipt of any medical records, entirely or sections, specific to the UM certification review;
11. Coverage determination elements (outcome of UM coverage certification review, when approved the specific service(s), type, duration and frequency. Non-certifications include offering of appeal rights and response to appeal rights if notified verbally); and
12. As applicable in the case of a referral, results of provider search and name of provider selected by member including any member's preference (e.g., provider gender, ethnicity, language, distance).

E. Clinical information that is collected and entered into the system for assessing minimal filing requirements, deciding medical necessity for coverage and providing referral, as applicable, include but are not limited to:

1. Clinical status/condition/disorder/symptom(s) prompting need for service; and
2. Other bio-psychosocial information (e.g., clinical history, current biomarkers, and co-occurring disorders) minimally necessary to support application of coverage per clinical criteria; and
3. Specific service transaction codes (e.g., Healthcare Common Procedure Coding System (HCPCS), including Current Procedural Terminology (CPT), applicable version of International Classification of Diseases (ICD) codes) relevant to service for consideration of coverage, as available, but not routinely required unless required by regulation.

F. Medical records are not routinely requested. However, one or more sections of the medical record may be requested as evidence for deciding medical necessity of the coverage under review.

G. Non-system generated documentation such as letters and copies of medical record section(s) have their receipt date recorded and are maintained in the individual member's paper or electronic file. Relevant elements about the document received, including but not limited to, source, type, and specifics relevant to the case, are entered in the system for tracking purposes.

Cross Reference(s)

Provider Dispute of Benefit/Coverage Determination; Commercial Benefit Certification Determination; Medicaid: Action Appeal; Medicaid: Service Authorization Determination; Medicare Advantage: Organization Determination; Medicare Advantage: Reconsideration; Medicare Advantage: Re-opening of an Adverse Organization Determination; Commercial Appeal; Nondiscrimination and Language Access

Corporate Policy Life History

Date of Inception: December 29, 2010	**Previous Review Date:** November 22, 2021	**Current Review Date:** March 06, 2023
Previous Corporate Approval Date: December 15, 2021	**Current Corporate Approval Date:** March 06, 2023	**Unit Effective Date:** April 06, 2023

Associated Corporate Forms & Attachments *(internal link(s) available to Magellan Health employees only)*

None

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Addendum Attachment (AA)

Corporate Policy Name: Benefit Certification & Appeal General Guidelines

AA Number: CO.272.20.NM.AA.03

Compliant with Requirements of the: State of New Mexico

Addendum Attachment

A. Re: Key Terms *Per NM SB 273, Section 14*:

Generally Recognized Standards

Standards of care and clinical practice established by evidence-based sources, including clinical practice guidelines and recommendations from mental health and substance use disorder care provider professional associations and relevant federal government agencies, that are generally recognized by providers practicing in relevant clinical specialties, including psychiatry, psychology, social work, clinical counseling, addiction medicine and counseling, or family and marriage counseling.

Mental Health or Substance Use Disorder Services

Professional services, including inpatient and outpatient services and prescription drugs, provided in accordance with generally recognized standards of care for the identification, prevention, treatment, minimization of progression, habilitation and rehabilitation of conditions or disorders listed in the current edition of the American psychiatric association's Diagnostic and Statistical Manual of Mental Disorders, including substance use disorder; or Professional talk therapy services, provided in accordance with generally recognized standards of care, provided by a marriage and family therapist licensed pursuant to the Counseling and Therapy Practice Act."

B. Add as Standard I.E. ***per NM SB 273, Sections 6,19 30 & 40***: Prohibited Exclusions of Coverage for Mental Health or Substance Use Disorder Service. Magellan will not exclude court ordered treatment.

C. Re: Standard II.D.: Health Benefit Certification and Appeal General Principles. Time to Process

1. ***Per NMAC 13.10.22.9.D(3):*** All determinations shall be made on a timely basis as required by the exigencies of the situation and in accordance with sound medical principles, which, in any event, shall not exceed twenty-four (24) hours for emergency care and seven (7) days for all other determinations. If Magellan is unable to complete a referral within ten (10) days due to unforeseen circumstances, Magellan shall inform the covered person in writing about the reasons for the delay and when a decision may be expected.

2. Replace language of Standard II.D.4. with ***Per N.M.S.A. § 59A-22B-5 B:*** Prior authorization shall be deemed granted for determinations not made within seven (7) days; provided that:

(1) A determination shall be made within twenty-four (24) hours, or shall be deemed approved if not made within twenty-four (24) hours, when a member's ordering or rendering provider requests an expedited prior authorization and submits to Magellan a statement that, in the health care professional's opinion that is based on reasonable medical probability, delay in the treatment for which prior authorization is requested could seriously jeopardize the member's life or overall health; affect the member's ability to regain maximum function; or subject the member to severe and intolerable pain; and

(2) The processing timeframe shall commence with the request, verbal or written, (written may be required in situations such as a claim appeal) by the member or a valid representative of the member, but after Magellan receives all necessary and relevant documentation supporting the prior authorization request.

D. Re: Standard II.E.2 Health Benefit Certification and Appeal General Principles. Benefit Certification and Appeal Notice Guidelines. ***Per NMAC 13.10.22.9.D(5):***

1. An enrollee's notice shall contain the reasons why coverage or authorization was denied, and shall be subject to review in accordance with the specific grievance procedures outlined in NMAC 13.10.17.
2. The written notice shall advise the covered person that review of the Magellan's denial of coverage or authorization is available. In addition, the notice shall describe the procedures necessary for commencing an internal review as outlined in 13.10.17 NMAC.

E. Add as Standard II.F.1.d) Basis of a Benefit Certification Determination and Appeal Decision, ***per NM SB273, Sections 5B, 18B, 28B & 39B:*** Magellan will apply criteria in accordance with generally recognized standards of care.

F. Add as Standard II.F.3, ***per NM SB 273, Sections 5A, 18A, 29A & 39A:*** Magellan will, at least monthly, review and update its UR process to reflect the most recent evidence and generally recognized standards of care.

G. Add as Standard II.F.4, ***per NM SB 273, Sections 7, 20, 31 & 41:*** Level of Care Determinations for the Provision of Mental Health or Substance Use Disorder Services.

1. Magellan shall provide coverage for all in-network mental health/substance use disorder services, consistent with generally recognized standards of care, including place a member into a medically necessary level of care.
2. Changes in level and duration of care will be determined in consultation with the member's provider.
3. Level of care determinations will include placement of a member into a facility that provides detoxification services, a hospital, an inpatient rehabilitation treatment facility, or an outpatient treatment program.
4. Level of care services for a member with a mental health/substance use disorder will be based on the mental health/substance use disorder needs of the member rather than arbitrary time limits.

H. Re: Standard IV. Initiating the Benefit Certification Process B.: ***Per NMAC 13.10.31.9.A(9):*** Magellan will maintain an electronic portal system for the secure electronic transmission of prior authorization requests on a twenty-four-(24) hour, seven (7) day-a-week basis.

I. Re: Standard V.: Role of Staff in the Benefit Certification and Appeal Process

1. ***Per NMAC 13.10.22.9.A:*** The utilization management program will be under the direction of a medical director who is a licensed physician in New Mexico.
2. ***Per N.M.S.A. § 61-6-6 (J)(6) & 13.10.22.9.D(1):*** All determinations to authorize an admission, service, procedure, or extension of stay shall be rendered by either a physician, registered professional nurse, or other qualified health professional licensed in New Mexico.
3. ***Per N.M.S.A. § 61-6-6 (J)(6) & 13.10.22.9.D(2):*** All determinations to deny or limit an admission, service, procedure or extension of stay shall be rendered by a physician licensed in New Mexico, either after application of uniform criteria established by the plan in consultation with specialists acting within the scope of their license or after consultation with specialists acting within the scope of their license.

J. Re: Standard VI.: Processing of Benefit Certification and Appeal

1. Add as Standard VI. B. Initial Clinical Review 6. ***Per N.M.S.A. § 59A-22B-5 E.:*** An auto-adjudicated prior authorization request based on medical necessity that is pended or denied shall be reviewed by a health care professional who has knowledge or consults with a specialist who has knowledge of the medical condition or disease of the covered person for whom the authorization is requested.
2. Add as Standard VI.C. Peer Clinical Review 8.: ***Per N.M.S.A. § 59A-22B-5 E.:*** The health care professional shall make a final determination of the request. If the request is denied after review by a health care professional, notice of the denial shall be provided to the covered person and covered person's provider with the grounds for the denial and a notice of the right to appeal and describing the process to file an appeal.

Associated Forms & Attachments

None

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