Subject: Denials

Objective:

I. To ensure that members and providers are notified expeditiously when requested benefits are not available per contract, when requested services are not medically indicated or adequate clinical information is not available to make a determination according to Tuality Health Alliance (THA) Health Plan policy or criteria. THA serves Oregon Health Plan (OHP) members.

II. To ensure that when an adverse action is taken that may limit a prior authorization of a requested covered service in an amount, duration, or scope that is less than requested; or is a reduction, suspension, discontinuance or termination of a previously authorized service, the member is notified timely.

III. To ensure that providers and members receive sufficient information to understand and make a decision about appealing a decision to deny care or coverage.

Policy:

I. Notification of Physician Reviewer Availability

A. The THA Medical Director makes decisions based on medical appropriateness and is available to discuss any denial decision based on medical appropriateness.

B. THA Case Managers and the Medical Director are available to the member or provider by telephone to discuss determinations based on medical necessity or guidelines that are used as part of the determination. Contact information is included in the denial letter as an attachment.

II. The process for issuing the written notification and the content of the notification incorporates the following guidelines and reflects the following format as required in 42 CFR 438.10 (c) and (d):

A. Denial language is specific and easily understood. Examples include but are not limited to:

1. The service or item requires pre-authorization and the service or item was not preauthorized.
2. The service or item is received in an emergency care setting and does not qualify as an Emergency Service under the prudent layperson standard.
3. The person was not a THA member at the time the service was rendered.
4. The provider is not on THA's participating panel and prior approval was not obtained.

B. A reference to the relevant section of the statutes and rules for each reason identified, benefit provision, guideline, protocol or other similar criterion used for the basis of the denial decision.

C. The written denial notice includes appeal and hearing rights specific to each delegated health plan.

D. Providers may appeal the decision on the member's behalf if they receive written permission from the member to act as their representative.

E. Members and providers may obtain a copy of the criteria, a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request by contacting THA Medical Management. Telephone numbers are included with each denial notice.

F. Member's right to file an appeal and how to file the appeal. (See Policy # V-10 – OHP Appeals.

III. For termination, suspension or reduction of previously authorized Oregon Health Plan covered services, the following time frames apply:

A. The Notice of action must be mailed at least 10 calendar days before the date of the Action, except in the following circumstances:

1. THA or the provider receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information.

2. The member has been confined or admitted to an institution where he or she is ineligible for covered services from THA
3. The member's whereabouts are unknown and the post office returns the member's mail indicating no forwarding address.
4. THA establishes the fact that another State, territory or commonwealth has accepted the member for Medicaid services.
5. A change in the level of medical care is prescribed by the member's practitioner.
6. The date of action will occur in less than 10 calendar days related to discharges or transfers and long-term care facilities.
7. Information confirming the death of the member
8. There is an adverse determination made with regard to the preadmission screening requirements for Long Term Patient Care (LTPC) admissions; and
9. The safety or health of individuals in the facility would be endangered, the member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required y the member's urgent medical needs, or a member has not resided in the LTPC for 30 days (applies only to adverse actions for LTPC transfers).

B. THA may shorten the period of advance notice to 5 calendar days before the date of action if THA has facts indicating that an action should be taken because of probable fraud by the THA member. These facts should be verified through secondary sources whenever possible.

IV. Notice of action letter is to be provided to members on all requests that are being denied:

A. For a denial of payment, at the time of any action affecting the claim.

B. For a standard prior authorizations that deny a requested service or authorize a service in an amount, duration, or scope that is less than requested, a Notice of Action must be provided by THA as expeditiously as the member's health condition requires and within 14 calendar day following receipt of the request for service.

. Plan may have an extension of up to 14 additional days if the member or the provider requests the extension; or if the plan justifies (to Health

Share upon request) a need for additional information and how the extension is in the member's interest.

V. If THA extends the timeframe of the NOA, the member must be given written notice and to include:
   i. the reason for the decision to extend the timeframe
   ii. the member's right to file a grievance if they disagree with the decision.

VI. THA must issue and carry out its prior authorization determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Prior authorization decisions not reached within the appropriate timeframes (which constitutes a denial and is thus an adverse action), the Notice of Action (NOA) shall be mailed on the date the timeframes expire.

VII. Expedited prior authorizations are done when THA determines (upon request from the member or the provider) documentation indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain or regain maximum function.

   i. THA must assure that punitive action is not taken against a provider who requests an expedited resolution.

VIII. Appeals

   A. The member has a right to file an appeal or Administrative Hearing Request.

   B. An explanation of the appeal/hearing process is included with the Notice of Action. A description of the appeal/hearing rights, including the right to submit written comments, member representation, timeframes or other information relevant to the appeal/hearing is included.

   C. If a denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal/hearing process is included and the circumstances under which an expedited appeal/hearing resolution is available

Subject: Denials

D. The member has a right to have benefits continue pending resolution of an appeal/hearing. This is included as well as how to request those benefits and the circumstances under which the member may be required to pay the cost of services.

IX. Practitioners are notified of this policy by THA's policy manual which is available via THA's website

Reference:
OAR 410-141-3260 thru OAR 410-141-3264
CFR 438.210 (b) (c)
CFR 438.404 (c) (1)-(6)
CFR431.210
CFR 483.12(a) (5) (ii)
ORS 183.415 (2) (c)
THA Policy V-10 OHP Appeals

Formulated:	January 1997
Reviewed:	July 2014
Revised	June 1998 June 1999 April 2000 September 2000 February 2002 March 2003 April 2004 February 2006 July 2007 September 2008 June 2010 June 2012 June 2016 November 2016