

SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

DATE: August 28, 2019

BHRS POLICY: 19-03

SUBJECT: Expedited Pre-Service Organizational Determinations

AUTHORITY: Federal Medicaid Managed Care Regulations, Title 42, CFR Part 438; MHP Agreement with State of California; Delegation Agreements with the Health Plan of San Mateo

SUPERSEDES: New Policy

PURPOSE:

This policy explains procedures for issuing timely initial and continuing expedited organizational benefit determinations for services that a client is entitled to receive. It also explains what happens when these are not completed on time and other related information.

SCOPE:

This policy covers expedited pre-service and continuing authorization requests for all Health Plan of San Mateo (HPSM) covered services in the Mild-to-Moderate/Private Provider Network.

Expedited means that the requester believes that waiting for a decision under the standard (14 day) time frame could place the beneficiary's life, health, or ability to regain maximum function in serious jeopardy.

Please see Policy 19-02: Standard Pre-Service Organizational Determinations for the rules regarding standard (14 day) pre-service authorization requests.

DEFINITION OF ORGANIZATIONAL DETERMINATION:

An organizational determination is an evaluation and decision made in response to a request for BHRS services. This includes payment for urgently needed services and for services provided by non-contracted providers that are covered under Medicare or Medi-Cal.

RESPONSIBILITY AND AUTHORITY:

- The Medical Director or her or his designee is responsible for the overall Utilization Management Program.
- The ACCESS Call Center Clinical Services Manager manages the daily pre-service authorization process.

- Clinical staff are responsible for reviewing pre-service authorization requests.
- Administrative assistants are responsible for the receipt, and entry of pre-service authorization requests into AVATAR.
- The Medical Director or her or his designee is responsible for all denials and modifications of pre-service requests based on medical necessity.

PARTIES TO AN ORGANIZATIONAL DETERMINATION:

A member, a member’s provider, or a member’s authorized representative may request an organizational determination for an initial or continuing pre-service authorization. A request will not be considered until all the appropriate documentation is provided and for expedited requests additional or missing information must be requested within 24 hours of the initial request.

- Provider Submitted Requests

Provider submitted requests for organizational determinations are submitted on Authorization Request Forms. This form is completed by providers to request services that require prior authorization by BHRS. The Authorization Request Form may serve as an initial assessment and plan for treatment.

Non-Contract providers must request authorization prior to providing any services using the Authorization Request Form. BHRS staff will request any information needed from the non-contract provider to make an expedited organizational determination within 24 hours of receiving the initial request.

Providers submit the form to BHRS via mail or fax. Expedited requests can be faxed and should indicate the request is to be expedited by writing the same across the top of the first page. Expedited requests should be preceded or accompanied by a telephone call to confirm receipt.

Prior authorization is not required for members who request an initial assessment and/or emergency inpatient services.

- Member Submitted Requests

Member requests for initial or continued pre-service authorization may be submitted verbally or in writing to BHRS.

After receiving a member’s request for an initial or continuing pre-service authorization, ACCESS staff will request documentation from the member’s provider to support the request.

Member authorized representatives may submit the requests in the same way as the member.

TIMELINES FOR EXPEDITED INITIAL AND CONTINUING PRE-SERVICE AUTHORIZATIONS:

BHRS will make and provide both verbal and written notice of an initial or continuing pre-service organizational determination on an expedited authorization request as expeditiously as the member's health requires, but no later than 72 hours from receipt of the request.

If a request is determined to be ineligible for expedited review, BHRS shall provide immediate verbal notice of the determination and the send a written notice within 3 calendar days. BHRS automatically processes the request under the standard fourteen (14) day organizational determination process. The 14-day period starts when the request for an expedited determination was received. See Policy 19-xx Standard Pre-Service Organizational Determinations policy for more information.

DENIAL OF EXPEDITED REVIEW PROCEDURE:

Any decision to deny a request for an expedited review due to the lack of medical justification must be determined by the Medical Director or their physician designee.

The member is given prompt verbal notification of the denial for expedited review, including notification of the member's appeal rights. Clinical staff will document the date and time of verbal notification.

- Within three calendar days of the member's verbal notice, BHRS will mail a written notification of the determination with the "Notice of Right to an Expedited Grievance" that:
 - Explains that BHRS will automatically transfer and process the request using the fourteen (14) day time frame for standard determinations;
 - Informs the member of the right to file an expedited grievance if he/she disagrees with the decision not to expedite the determination;
 - Informs the member of the right to resubmit a request for an expedited determination that will automatically be approved if the member gets a physician's support indicating that applying the standard time frame could seriously jeopardize the member's life, health, or ability to regain maximum function; and
 - Provides instructions about the expedited grievance process and time frames.

APPROVED EXPEDITED REVIEW PROCEDURE:

If the request for expedited determination is approved the ACCESS Call Center clinician will process the request and notify the member and provider of the organizational determination as expeditiously as the enrollees' health condition requires, but no later than 72 hours after receiving the request. The clinician will notify the member verbally of the approval and document the date and time of notification. Providers are also notified verbally of the approval with the time noted and by fax on the day of approval.

- If additional information is required to make a determination, BHRS must request the information within twenty-four (24) hours of receiving the request for expedited review.
- BHRS may extend the seventy-two (72) hour time frame up to fourteen (14) calendar days under the following circumstances:

- If the member requests the extension, or
 - If BHRS identifies and can justify the need for additional information. In this case, documentation showing how the extension is in the best interest of the member is needed; or
 - The request has been made by a non-contract provider.
- If BHRS extends the time frame for making the expedited organizational determination, it will provide the member and provider with a written “Notice of Extension of Expedited Review” that includes:
 - Reason for the extension.
 - Information about the member’s right to file an expedited grievance if the member disagrees with BHRS’s decision to extend the time frame.

MEMBER AND PROVIDER NOTIFICATION:

Members are notified verbally and in writing of BHRS’s initial determination to modify, deny, or approve an expedited pre-service request. The ACCESS call center clinician documents the date and time of the verbal member notification.

Any decision to partially or fully deny a request for lack of medical necessity must be determined by the Medical Director or physician designee. Notice of a decision to modify or deny a request for initial or continuing pre-service authorization must include the following information with approved Medicare and/or Medi-Cal language:

- The specific reason for the denial that considers the member’s presenting medical condition, disabilities, and special language requirements, if any;
- Information regarding the member’s right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the member’s behalf;
- For initial and continuing pre-service authorization denials, a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process;
- For post-service authorization denials, a description of the standard reconsideration process and time frames, and the rest of the appeals process; and
- The member’s right to submit additional evidence in writing or in person.

Providers are notified verbally and in writing of BHRS’s initial determination to modify, deny, or approve an expedited pre-service request. The ACCESS call center clinician documents the date and time of the verbal provider notification. Providers receive a written copy of each member notice via fax; if no fax is available, a copy is mailed to their address.

REVIEW OF DECISIONS:

The Utilization Management Program Policy (18-03) explains in detail how organizational determinations are reviewed regularly for consistency and appropriateness of care. Please see that policy for more detail.

