BEACON HEALTH OPTIONS			POLICIES AND PROCEDURES
Policy Number:	**CAD 101.3**	**Category: A**	**Page 1 of 4**
Policy Name:	**Adverse Determinations: Clinical, Administrative, and Benefit**		

Keyword Search:	**Adverse Determination Benefit Determination; Administrative Determination; Denial, Reconsideration**	**Reviewed** 1/19/16, 11/15/16, 1/17/17, 5/16/17	**Revised** 11/15/16, 5/16/17	**New**
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Historical Policies / Addenda	**VO C303**	

I. Policy

It is the policy of Beacon to follow a standardized process for issuing and documenting adverse clinical determinations, adverse administrative determinations, and adverse benefit determinations.

For Adverse Clinical Determinations:

- Initial clinical review staff is prohibited from making a denial decisions based on medical necessity.
- Peer Advisor reviews are conducted for all cases, by a properly qualified and credentialed behavioral health professional, where certification is not issued through the initial clinical review or initial screening processes.
- That staff who conduct clinical review have access to consultation with a 1) licensed health professional in the same licensure category as the ordering provider, or 2) health professional with the same clinical education as the ordering provider in clinical specialties where the licensure is not issued. That the treating provider/practitioner is offered the opportunity to engage in a Peer-to-Peer Conversation with the Peer Advisor when there is an adverse benefit determination made through a peer clinical review. A Peer-to-Peer Conversation is not a requirement for retrospective requests; a peer clinical review is sufficient.

For Adverse Administrative Determinations or Adverse Benefit Determinations

- Clinical or non-clinical staff can make these determinations, depending on the situation.
- Adverse Benefit Determinations are made based on the member's eligibility and the benefits as outline in the evidence of coverage (EOC) or Guide to Benefits (GTB).

II. Definitions

A. Adverse Clinical Determination – A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a requested service, that is based on not meeting medical necessity (including services not excluded in the EOC or GTB).

B. Adverse Administrative Determination– Often issued upon failure by a provider to adhere to guidelines for authorization procedures outlined in the provider manual or Provider Services Agreement (PSA) including but not limited to:

- Correct authorization procedures were not followed
- The request for services was submitted outside of the required timeframe from date of discharge
- A determination of an individual's eligibility to participate in a health benefit plan or insurance coverage (Note: Beacon is not responsible for determinations regarding rescissions of plan

coverage.).

C. Adverse Benefit Determination: Often issued due to a service not being a covered benefit, including but not limited to:
- Service requested is not covered by the member's mental health benefit for the plan (i.e. Medical) and/or is identified as a benefit exclusion.
- Testing outside the scope of diagnosis and state testing mandates
- The member's coverage was not in effect at the time the services was rendered
- The behavioral health request is in excess of the benefit limitations defined in the member subscriber agreement

The appeals process for an Adverse Benefit Determination could follow either a clinical appeal or an administrative appeal depending on the situation.

D. Medical Necessity - Medically necessary services are those which are:
- Intended to prevent, diagnose, correct, cure, alleviate or preclude deterioration of a diagnosable condition (most current version of ICD or DSM,) that threatens life, causes pain or suffering, or results in illness or infirmity.
- Expected to improve an individual's condition or level of functioning.
- Individualized, specific, and consistent with symptoms and diagnosis, and not in excess of patient's needs.
- Essential and consistent with nationally accepted standard clinical evidence generally recognized by mental health or substance abuse care professionals or publications.
- Reflective of a level of service that is safe, where no equally effective, more conservative, and less resource intensive treatment is available.
- Not primarily intended for the convenience of the recipient, caretaker, or provider.
- No more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency.
- Not a substitute for non-treatment services addressing environmental factors.

E. Peer Advisors / Peer Reviewers - Psychiatrists or doctoral level psychologists in a state or territory of the United States who render medical necessity opinions/determinations or appeal considerations and
1. Hold an active, unrestricted license to practice medicine and are
2. Board-certified OR are a
3. Licensed doctoral-level psychologist;

Peer Reviews are in a similar specialty as typically manages the medical condition, procedure, or treatment as mutually deemed appropriate.

For appeals, Peer Advisors,
1. Are neither the individual who made the original non-certification, nor the subordinate of such an individual; and
2. Are located in a state or territory of the United States when conducting appeal considerations

Note: Peer Clinical Review Staff for Medicare cases - Peer Clinical Reviewers for Medicare cases are physicians or other appropriate health care professionals with sufficient medical and other expertise, including knowledge of Medicare coverage criteria that are qualified, as determined by the medical or clinical director, to render a clinical opinion about the medical condition, procedures, and treatment under review.

III. Purpose

To standardize the process for categorizing and documenting adverse determinations.

IV. Committees/Departments Affected
- A. Care Management Staff
- B. Clinical Customer Service
- C. Claims Customer Service
- D. Account Services
- E. Quality Management Department
- F. Medical Department
- G. National Peer Advisor Services

V. Procedure

A. All adverse determinations and written notices are made after the receipt of all request/notice necessary information and within the appropriate timeframes and contain the content required by the contract, accreditation, and/or state and federal law standards as applicable for the contract (Please refer to CUR 143 Medical Necessity Requests, CAD 100 Content of Notifications, and CUR 100 Medical Necessity Request Determination Timeframes).

B. All adverse determinations are documented in the Information System (IS) record completely and retained as required by HIPAA and/or state law whichever is more stringent (Please refer to CO 15 Record Retention).

Adverse Clinical Determinations

A. When the clinician concludes from information provided by the treating clinician, or the treating clinician's designated representative that the requested treatment of a member does not appear to meet medical necessity criteria and cannot be medically certified:

1. The clinician documents his or her concerns and any efforts to reach agreement with the provider on any clinically appropriate alternatives; and consults with, or refers the case to, an appropriate Peer Advisor (i.e. Peer Clinical Reviewer); as described in CUR 141 Physician Advisor, Psychologist Advisor and Supervisory Review of Cases.
2. Notification, including notification of appeal rights and procedures, for all urgent care cases is given telephonically at the time the adverse benefit determination is made and then in writing to provider and member within: three (3) calendar days for prospective and 24 hours for concurrent of the request for services, or two (2) calendar days of the completed Peer-to-Peer Review. For all levels of care, written notification is sent to provider and member according to the timelines set forth in Clinical Policy and Procedure CUR 100 Medical Necessity Request Determination Timeframes.

B. If the provider has not been offered a Peer-to-Peer Conversation prior to the clinical adverse benefit determination, s/he can request such discussion within three (3) business days of receiving the notice of denial. The Peer Clinical Reviewer who issued the non-certification determination is made available to conduct the discussion within one (1) business day. If the original Peer Clinical Reviewer cannot be available during that time frame, another Peer Advisor is made available to conduct the reconsideration with the requestor. If the request for Peer-to-Peer Conversation is received after the time standard for requesting such, the provider is verbally notified by the Peer Advisor or designee that no further action will be taken and that the provider or patient may request a clinical appeal and the procedure to do so.

1. Based on information received during the conversation, the Peer Advisor makes a decision whether or not to alter the initial clinical adverse benefit determination within one (1) business day and documents the results in the IS record. At that time, the Peer Advisor may affirm the original clinical adverse benefit determination, or may modify it.
2. If the determination following the Peer-to-Peer Conversation is to affirm the initial clinical adverse benefit determination, the Peer Advisor notifies the provider of that fact verbally at the time of the conversation, if possible, but, in any case, within one (1) business day of the discussion, and that no additional notification will be issued.
3. If the determination is to modify initial clinical adverse benefit determination, in whole or in part, appropriate notification of the new adverse benefit determination is issued in accordance with CAD 100 Content of Notifications and CUR 100 Medical Necessity Request Determination Timeframes.

C. Reconsiderations are not available once an adverse clinical determination is issued subsequent to a Peer-to-Peer Review, or if the provider declines to conduct a peer to peer review prior to an adverse benefit determination, or if the provider fails to attend a scheduled peer to peer review prior to an adverse benefit determination. The provider is verbally notified by the Peer Advisor or designee that no further action will be taken and that the provider or patient may request a clinical appeal and the procedure to do so.

Adverse Administrative Determinations

A. To confirm an adverse administrative determination, the staff will validate the reason through the accepted contract specific procedure, as outlined in the provider manual or Provider Services Agreement (PSA).

B. If the reason for making the adverse administrative determination is substantiated, the staff will process accordingly.
C. If the reason for making the adverse administrative determination is not substantiated, the request will then follow the clinical review process for medical necessity.

Adverse Benefit Determinations

A. To confirm an adverse benefit determination, the staff will validate the reason through accepted Service Center/ Engagement Center (SC/EC) and company standard operating procedures. (For example, verify member's eligibility by contacting the appropriate internal or external eligibility entity or confirming member's benefit coverage.)
B. If the reason for making an adverse benefit determination is substantiated, the staff may discuss this with the requestor to determine if there is an alternate solution. If an alternate solution is not available, Beacon will verbally notify the requestor of the adverse benefit determination, if appropriate, and a written notification is issued.
C. If the reason for making an adverse benefit determination is not substantiated, then the staff will send the request to a clinician to review.
    a. If Beacon is not delegated benefit determinations/ exceptions, the clinician will forward to plan for review.
    b. If Beacon is delegated benefit determinations/exceptions, the clinician will review, following its procedure for medical necessity review.

VI. Attachments
A. CAD 101A Adverse Benefit Determination Process
B. CAD 101B Adverse Benefit Determinations Maryland Specific
C. CAD 101C Peer Advisor Adverse Determination Rhode Island Specific
D. CAD 101D Peer Advisor Adverse Determination Connecticut Specific
E. CAD 101E Pre-Adverse Determination Peer-to-Peer Communications Texas Specific
F. CAD 101F Peer Advisor Adverse Determination Jacksonville TRICARE Federal Specific
G. CAD 101G Peer Advisor Adverse Determination Vermont Specific
H. CAD 101H Peer Advisor Adverse Determinations Illinois Individual Care Grant (ICG) Specific
I. CAD 101I Peer Advisor Adverse Determinations New Jersey Specific
J. CAD 101J Non-Certification (Denial) Determinations Pennsylvania Specific
K. CAD 101K Adverse Determinations: Process for Administrative Denials and Appeals New York Specific
L. CAD 101L Adverse Determinations: Initial and Final Adverse Utilization Review Determinations for CHP FHP Medicaid New York Specific

VII. Referenced Policies
A. CAD 100 Content of Notifications
B. CUR 100 Medical Necessity Request Determination Timeframes
C. CUR 143 Medical Necessity
D. Clinical Appeals and Denials Policies
E. CO 15 Record Retention

VIII. URAC / NCQA Standards
A. UM 8 A
B. HUM 11
C. HUM 12
D. HUM 13
E. HUM 14 (a) - (d)
F. HUM 17
G. HUM 18 (a) & (b)

Other References:
A. MD CODE ANN [INS] §15-10B-07