414 – REQUIREMENTS FOR SERVICE AUTHORIZATION DECISIONS AND NOTICES OF ADVERSE BENEFIT DETERMINATION

EFFECTIVE DATES: 08/01/07, 11/01/12, 03/01/13, 06/01/13, 10/01/13, 01/01/14, 09/01/14, 07/01/16, 07/01/17 , 10/01/17, 12/20/18, 10/01/19, 10/01/22, 05/01/23, 06/27/24

APPROVAL DATES: 08/01/08, 10/01/09, 01/01/11, 10/11/12, 02/07/13, 05/24/13, 08/29/13, 10/29/13, 03/06/14, 08/07/14, 11/20/14, 04/21/16, 06/01/17, 09/27/18, 09/19/19, 04/21/22, 04/06/23, 05/02/24, 02/18/25

I. PURPOSE

This Policy applies to ACC, ACC-RBHA, ALTCS E/PD, DCS CHP (CHP), and DES DDD (DDD) Contractors. This Policy sets forth Contractor requirements for services authorization decisions and Notices of Adverse Benefit Determination. In addition, refer to AHCCCS Contract as well as state and federal rules for additional information and requirements regarding other types of Adverse Benefit Determinations relating to Title XIX/XXI.

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy.

III. POLICY

When the Contractor makes a decision to deny or limit an authorization request, or reduce, suspend, or terminate previously authorized services, the Contractor shall provide a written Notice of Adverse Benefit Determination to the member/Health Care Decision Maker (HCDM), and Designated Representative (DR) and provider as described in 42 CFR 438.404. Electronic notification to the provider is acceptable.

Pursuant to 42 CFR 438.400, an “adverse benefit determination” is defined to include "(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.” Adverse benefit determinations in this category include, but are not limited to, requests involving changes in service intensity, specialized provider or skilled care giver and requests for increased staffing ratios.

The Contractor shall use the AHCCCS developed member templates incorporated by reference in this Policy as specified in 42 CFR 438.10(c)(4)(ii). The templates shall not be altered except for those areas designated in the template that permit alteration and the removal of the header. Refer to Attachment A for the Notice of Adverse Benefit Determination template for service authorization requests.

The Contractor's Member Handbook shall inform members/HCDM, DR as specified in ACOM Policy 406, Attachment A:

1. Of their right to make a complaint to the Contractor about an inadequate Notice of Adverse Benefit Determination.

2. That if the Contractor does not resolve the complaint about the Notice of Adverse Benefit Determination to the member's satisfaction, the member/HCDM, DR may complain to AHCCCS, Medical Management (MM) at: MedicalManagement@azahcccs.gov.

3. That the Contractors and their providers are prohibited from taking punitive action against members/HCDM exercising their right to appeal.

A. RIGHT TO BE REPRESENTED

The Contractor shall acknowledge the member's right to be assisted by a third-party DR, including an attorney, during an appeal of an Adverse Benefit Determination. A list of legal aid services available to members are specified in Attachment B. The Contractor's appeals process shall register the existence of the third party and the Contractor shall ensure that the required communications related to the appeals process occur between the Contractor and the DR. The members' DR, upon request, shall be provided timely access to documentation relating to the decision under appeal. Consistent with federal privacy laws, the Contractor shall make reasonable efforts to verify the identity of the third party and the authority of the third party to act on behalf of the member. This verification may include requiring that the DR provide an authorization signed by the member/HCDM; however, if the Contractor questions the authority of the DR or the sufficiency of an authorization, it shall promptly communicate that to the DR.

B. NOTICE OF ADVERSE BENEFIT DETERMINATION CONTENT REQUIREMENTS

The Notice of Adverse Benefit Determination shall be written in an easily understood language and format as specified in ACOM Policy 404. For examples of easily understood Notice language, refer to the AHCCCS Guide to Language in Notice of Adverse Benefit Determination (NOA).

1. The Notice of Adverse Benefit Determination shall contain and clearly explain the information necessary for the member/HCDM and DR to understand the Adverse Benefit Determination, the reason for the Contractor's determination, such that the member/HCDM may make an informed decision regarding appealing the determination, and how to appeal the decision. If the reason for the Adverse Benefit Determination is due to the lack of necessary information, the member/HCDM and DR shall be clearly informed of that reason and be given the opportunity to provide the necessary information.

2. The Notice of Adverse Benefit Determination shall contain and clearly explain the following information and shall be consistent with 42 CFR 438.404:
   a. The requested service,
   b. The reason/purpose of the requested service,

c. The member-specific reasons for the Adverse Benefit Determination the Contractor made or intends to make (i.e., denial, limited authorization, reduction, suspension, or termination) with respect to the requested service consistent with 42 CFR 438.404(b)(1), which include an explanation of the specific facts that pertain to the decision,
d. The effective date of a service denial, limited authorization, reduction, suspension, or termination,
e. The right of the member/HCDM and DR to be provided, upon request and at no cost to the member, reasonable access to and copies of all documents, records, and other information relevant to the member's Adverse Benefit Determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits, and any documentation, records, and other information relevant to the member/HCDM and DR request as specified in 42 CFR 438.404(b)(2),
f. The legal basis for the Adverse Benefit Determination including the applicable statutes, rules, contractual provisions, policies, and procedures, if applicable reference to the general legal authorities alone is unacceptable,
g. Where members/HCDM and DR can find copies of the legal basis (e.g., the local public library and the web page with links to legal authorities). Reference to the benefit provision, guideline, protocol, or other criterion which the denial is based upon. When a legal authority or an internal reference to the Contractor's policy manual is available online, the Contractor shall provide the accurate URL site to enable the member/HCDM and DR to find the reference online,
h. A listing of legal aid resources,
i. The member's/HCDM's right to request an appeal and the procedures for filing an appeal of the Contractor Adverse Benefit Determination, including information on exhausting the Contractor's appeals process described in 42 CFR 438.402(b) and the right to request a State fair hearing consistent with 42 CFR 438.402(c), including if the Contractor fails to make a decision in a timely manner regarding the member's appeal request,
j. The procedures for exercising the member's rights as described in 42 CFR 438.404(b)(4),
k. The circumstances under which an appeal process can be expedited and how to request it,
l. Explanation of the member's right to have benefits continue pending the resolution of the appeal as specified in 42 CFR 438.420, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of continued services if the appeal is denied as specified in 42 CFR 438.420(d), and
m. A statement that the provider who requested the service authorization request has the option to request a peer-to-peer discussion with the Contractor's Medical Director. The Contractor must allow at least 10 business days from the date the provider has been made aware of the denial for the provider to request a peer-to-peer.

3. It is unacceptable to cite lack of medical necessity as a reason for denial unless the Notice of Adverse Benefit Determination also explains why the service is not medically necessary for the particular member in this instance. When citing lack of medical necessity, the Contractor shall also include potential alternative options for consideration that may address the member's condition, when appropriate. Failure to provide the reasons and explanation supporting the lack of medical necessity in the Adverse Benefit Determination will result in regulatory action by AHCCCS. The Contractor shall utilize a board-certified professional when citing lack of medical necessity and provide evidence of such upon AHCCCS request.
   For examples where medical necessity is appropriately used in denying/limiting services, or to find examples of potential alternatives refer to the AHCCCS Guide to Language in Notice of Adverse Benefit Determination (NOA).

4. The Notice of Adverse Benefit Determination shall state the reasons supporting the denial/reduction/limited authorization/suspension/termination. Notice of Adverse Benefit Determinations that do not provide explanation of why the service has been denied/reduced/limited/suspended/terminated and merely refer the member/HCDM and DR to a third party for more information are unacceptable. The Contractor may include a statement referring a member/HCDM and DR to a third party for more help when the third party can explain treatment alternatives in more detail.

C. EARLY PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

The Contractor shall cite EPSDT Federal law 42 USC 1396d(r)(5) when denying, reducing, limiting, suspending, or terminating a service for a Title XIX member who is younger than 21 years of age when these provisions are applicable. The Contractor shall explain in accordance with this Policy and AMPM Policy 430 the denial, reduction, limitation, suspension, or termination of the requested EPSDT service and shall specify the reason(s) why the service fails to correct or ameliorate defects or physical or behavioral health conditions or illnesses. In such circumstances, the Contractor shall specify why the requested service does not meet the EPSDT criteria and is not covered and shall also specify that EPSDT services include coverage of:

1. Screening services.
2. Vision services.
3. Dental services.
4. Hearing services and such other necessary health care.
5. Diagnostic services and treatment.
6. Other measures described in federal law to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the AHCCCS State Plan.

D. MEMBER COMPLAINTS REGARDING THE ADEQUACY AND/OR UNDERSTANDABILITY OF THE NOTICE OF ADVERSE BENEFIT DETERMINATION

If a member/HCDM or DR complains about the adequacy of a Notice of Adverse Benefit Determination, the Contractor shall review the initial Notice of Adverse Benefit Determination against the content requirements of this Policy. If the Contractor determines that the original Notice of Adverse Benefit Determination is inadequate or deficient, the Contractor shall issue an amended Notice of Adverse Benefits Determination consistent with the requirements of this Policy. Should an amended Notice of Adverse Benefit Determination be required, the timeframe for the member/HCDM to appeal and continuation of services shall start from the date of the amended Notice of Adverse Benefit Determination.

E. TIMEFRAMES FOR SERVICE AUTHORIZATION DECISIONS

All references to "days" in this Policy mean "calendar days" unless otherwise specified. When a service authorization request is submitted, the Contractor shall ensure completion and issuance of the service authorization decision within the following timeframes. Different timeframes apply depending upon whether the service authorization request is a standard request, an expedited request, and whether the service request relates to medications. The date/time the Contractor receives the request is considered the date/time of receipt, whichever is applicable. The date/time is used to determine the due date for completion of the authorization decision, depending on the timeframe applicable to the particular type of service request. The Contractor may use electronic date stamps or manual stamping for logging the receipt. If the Contractor subcontracts Prior Authorization (PA) to a delegated entity, the date or time the delegated entity receives the request, whichever is applicable, is used for establishing receipt of the request.

Standard and expedited authorization requests pertain to service requests that do not involve medications. Service authorization decisions pertaining to requests for medication shall be completed within the timeframe specified below and do not follow the standard or expedited timeframes used for other service authorization requests.

An expedited authorization request is a request for a service that is not a medication in which either the requesting provider indicates, or the Contractor determines, that following the standard timeframes for issuing an authorization decision could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. For expedited requests which meet these requirements, the authorization decision is prioritized and shall be completed no later than the 72-hour expedited timeframe as described below.

A standard authorization request is a request for a service that is not a medication, and which does not meet the definition of an expedited service authorization request. For standard service authorization requests, the date the Contractor receives the request is considered the date of receipt and is used to determine the due date for completion of the decision.
For service authorization requests lacking sufficient clinical information necessary to render the decision or that require clarification, the Contractor shall make sufficient attempts to obtain the information or clarification, and document all attempts.

For expedited service authorization requests and medication requests, the time the request is received is used to determine the completion time for the decision.

1. Service Authorization Decision Timeframe for Medications
   The Contractor shall issue service authorization decisions for medications no later than 24 hours from receipt of the submitted request for service authorization regardless of whether the due date for the medication authorization decision falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona. If the service authorization request lacks sufficient information for the Contractor to render a decision for the medication, the Contractor shall send a request for additional information to the prescriber no later than 24 hours from receipt of the request. For service authorization requests lacking information the Contractor shall make sufficient attempts to obtain the missing information and document such outreach attempts to the prescriber . The Contractor shall issue a final decision no later than seven working days from the initial date of the request as specified in 42 CFR 438.3(s).

2. Standard Authorization Decision Timeframe for Service Authorization Requests that do not pertain to Medications.

   The Contractor shall issue service authorization decisions which do not pertain to medications as expeditiously as the member's condition requires but no later than 14 calendar days from receipt of the request for the service, regardless of whether the 14th day falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona.

   For service authorization requests lacking sufficient information for the Contractor to make a decision regarding the service authorization request, the Contractor shall make sufficient attempts to obtain the missing information and document such outreach attempts to the provider. The Contractor shall allow the provider sufficient time for a peer-to-peer to occur before the Contractor issues its decision regarding the service authorization request. The Contractor may issue a Notice of Extension, as specified in 42 CFR 438.210(d)(2)(ii) utilizing Attachment C of this policy, of up to 14 additional calendar days, if the criteria for a service authorization extension are met as specified in Section G this Policy.

3. Expedited Service Authorization Decision Timeframe for Service Authorization Requests that do not pertain to Medications.

   The Contractor shall issue an expedited service authorization decision, as expeditiously as the member's health condition requires but no later than 72 hours from receipt of the request for service consistent with 42 CFR 438.210(d)(2)(i) and 438.404(c)(6) regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona.

   The following requests shall be treated as expedited:
   a. Behavioral Health Residential Facility (BHRF),
   b. Determination for member participation in a clinical trial shall be treated as an expedited request regardless of the geographic location or if the provider is in network, and

c. Requests for services when a member is awaiting disposition in the emergency department.

The Contractor may issue a Notice of Extension; utilizing Attachment C of this policy, of up to 14 additional calendar days if the criteria for a service authorization extension are met as specified in Section G this Policy.

4. Expedited Service Authorization Request Treated as a Standard Request
When the Contractor receives an expedited request for a service authorization and the service request fails to meet the requirements for expedited consideration, the Contractor may treat the expedited authorization request as a standard request. The Contractor shall have a process included in the Contractor's policy for service authorization that describes how the provider will be notified of the change to a standard authorization request and be given an opportunity to provide additional information. The requesting provider shall be permitted to send additional documentation supporting the need for an expedited authorization.

5. Service Authorization Decisions Not Reached Within the Timeframes
A service authorization decision that is not reached within the required timeframes for a standard, medication, or expedited request constitutes a denial. The Contractor shall issue a Notice of Adverse Benefit Determination denying the request on the date that the timeframe expires.

6. Service Authorization Decisions Not Reached Within the Extended Timeframes
A decision that is not reached within the timeframe noted in the Notice of Extension constitutes a denial. The Contractor shall issue a Notice of Adverse Benefit Determination denying the service request on the date that the timeframe expires as specified in 42 CFR 438.404(c)(5).

F. TIMEFRAMES FOR COMPLETING NOTICES OF ADVERSE BENEFIT DETERMINATIONS

The Contractor shall mail the Notice of Adverse Benefit Determination within the following timeframes:

For termination, suspension, or reduction of a previously authorized service, the Notice of Adverse Benefit Determination shall be mailed at least 10 calendar days before the date of the proposed termination, suspension, or reduction except for situations in 42 CFR 438.210 providing exceptions to advance notice as specified in 42 CFR 431.211 and 438.404 (c)(1) and as specified in Contract.

1. For Service Authorization decisions that deny or limit services, the Contractor shall provide a Notice of Adverse Benefit Determination:
   a. No later than 24 hours from the receipt of a request for authorization of a medication regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona. When the service authorization request for a medication lacks sufficient information to render a decision, the Contractor shall request additional information from the prescriber no later than 24 hours from the receipt of the request. A final decision and a Notice of Adverse Benefit Determination shall be rendered no later than seven working days from the initial date of the request,
   b. For a non-medication request for authorization, as expeditiously as the member's health condition requires but no later than 14 calendar days from the receipt of the request regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona, unless there is a Notice of Extension. For extension timeframes, refer to Notice of Extension Requirements as specified in this Policy, 42 CFR 438.404(c)(3) and (4), and 42 CFR 438.210(d)(1), and
   c. As expeditiously as the member's health condition requires but no later than 72 hours from receipt of an expedited service authorization request consistent with 42 CFR 438.210(d)(2) and 438.404(c)(6)] regardless of whether the due date falls on a weekend (Saturday and Sunday) or legal holiday as defined by the State of Arizona unless there is a Notice of Extension. For extension timeframes, refer to Notice of Extension Requirements in this Policy.

G. NOTICE OF EXTENSION REQUIREMENTS

Notice of Extension Timeframes:

1. The Contractor shall extend the timeframe for both standard and expedited services for up to 14 days when:
   a. The member/HCDM or provider (with written consent of the member/HCDM) affirmatively requests an extension, or
   b. The Contractor determines that there is not sufficient clinical information for the Contractor to make a service authorization decision within the applicable standard or expedited timeframes. In these circumstances, the Contractor shall issue an extension to obtain needed information. The Contractor shall not pursue the Notice of Extension until the Contractor has made sufficient attempts to first obtain the necessary information from the requesting provider within the standard or expedited timeframe, whichever is applicable. 42 CFR 438.404(c)(4) and 438.210(d). The Contractor shall document all attempts made to the requesting provider for the needed information.

2. For decisions involving issues of medical necessity, when a decision is not reached within the required timeframe or when there is insufficient or conflicting information regarding medical necessity, the Contractor shall extend the timeframe to render a decision, by up to 14 days, and shall document efforts to consult with the ordering provider or conduct a peer-to-peer, to obtain clinical information to assist in a decision. The Contractor shall allow the provider sufficient time for a peer-to-peer to occur before the Contractor issues its decision regarding the service authorization request. Obtaining an extension and peer-to-peer consultation in these circumstances is in the member's best interest. [42 CFR 438.210 (b)(2), 42 CFR 457.1260, 42 CFR 438.408(b)(1)-(3), and 42 CFR 438.408(c)(1)(i)-(iii)].

3. For Standard Service Authorization requests (requests that do not involve medications), the Contractor may extend the 14-calendar day timeframe to make a decision by up to an additional 14 calendar days, not to exceed 28 calendar days from the service request date regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

4. For Service Authorization requests involving medication refer to 'Timeframes for Completing Notices of Adverse Benefit Determinations' as specified in this Policy when the service authorization requests lack sufficient information from the prescriber.

5. For an expedited Service Authorization Request not involving medications, the Contractor may extend the 72-hour timeframe to make a decision by up to an additional 14 calendar days regardless of whether the due date falls on a weekend (Saturday and Sunday) or Legal Holiday as defined by the State of Arizona.

6. If the Contractor extends the timeframe to make a decision, in accordance with 42 CFR 438.210(d) the Contractor shall:
   a. Give the member/HCDM and DR written notice of the reason for the decision to extend the timeframe in easily understood language,
   b. Include what information is needed to make a determination,
   c. Inform the member/HCDM and DR of the right to file a grievance (complaint) if he or she disagrees with the decision to extend the timeframe as described in 42 CFR 438.210(d) and 438.404(c)(4)(i), and
   d. Issue and carry out the decision as expeditiously as the member's condition requires and no later than the date the extension expires consistent with 42 CFR 438.210(d) and 438.404(c)(4)(ii).

H. NOTICE OF ADVERSE BENEFIT DETERMINATION SELF-MONITORING REQUIREMENTS

1. The Contractor shall conduct quarterly Notice of Adverse Benefit Determination self-audits. The Contractor shall audit Notice of Adverse Benefit Determinations that they have issued as well as Notice of Adverse Benefit Determinations issued by their subcontractors, as outlined below:
    a. Utilizing the AHCCCS provided Reporting Form,
    b. Reporting Notice of Adverse Benefit Determinations issued within the quarter prior,
    c. Report by line of business:
        i. DDD shall submit Notice of Adverse Benefit Determinations issued for services provided by DDD, and
        ii. DDD's Subcontracted Health Plans shall report DDD as a line of business when submitting the Scores and Summary described below.
    d. The auditor shall not be a staff member that writes or issues the Notice of Adverse Benefit Determination,
    e. The sample shall include Notice of Adverse Benefit Determinations from each of the following categories: Medical, Dental, Pharmacy, and Behavioral Health. The Contractor will randomly select 30 Notice of Adverse Benefit Determinations from each of the categories. From the 30, eight Notice of Adverse Benefit Determinations will be randomly selected to be audited. If the initial eight Notice of Adverse Benefit Determinations are all found to be in compliance, 95% or above, the remaining 22 Notice of Adverse Benefit Determinations will not need to be audited. If any one of the eight Notice of Adverse Benefit Determinations issued are found to be out of compliance, the remaining 22 shall be audited, and
    f. The Contractor shall submit Attachment D to AHCCCS/Medical Management as specified Contract.

2. The Executive Summary shall include an analysis of the audit including but not limited to:
    a. A methodology for pulling the sample,
    b. Deficiencies,
    c. Plan of action to bring back into compliance,
    d. Staff members involved in audit and credentials or role in the organization, or
    e. Score sheet.

AHCCCS reserves the right to request specific Notice of Adverse Benefit Determinations and associated records for further review.