

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

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I. PURPOSE

This Policy applies to ACC, ALTCS E/PD, DCS/CMDP (CMDP), DES/DDD (DDD), and RBHA Contractors. This Policy sets forth Contractor requirements for services authorization decisions and Notices of Adverse Benefit Determination (NOA) relating to Title XIX/XXI coverage and authorization of services.

II. DEFINITIONS

ADVERSE BENEFIT DETERMINATION	The denial or limited authorization of a service request, or the reduction, suspension or termination of a previously approved service.
APPEAL	A request for review of an Adverse Benefit Determination .
CALENDAR DAYS	Includes every day of the week including weekends and holidays.
COMPUTATION OF TIME IN CALENDAR DAYS	Computation of time in calendar days begins the day after the act, event, or decision and includes all calendar days and the final day of the period. For purposes of computing, if the final day of the period is a weekend or legal holiday, the period is extended until the end of the next day that is not a weekend (Saturday or Sunday) or a legal holiday. The first day of the “count” always begins on the day after the event.

LEGAL HOLIDAYS

Legal holidays as defined by the State of Arizona are:

- New Year's Day – January 1,
- Martin Luther King Jr./Civil Rights Day – 3rd Monday in January,
- Lincoln/Washington Presidents' Day – 3rd Monday in February,
- Memorial Day – Last Monday in May,
- Independence Day – July 4,
- Labor Day – 1st Monday in September,
- Columbus Day – 2nd Monday in October,
- Veterans Day – November 11,
- Thanksgiving Day – 4th Thursday in November,
- Christmas Day – December 25.

When a holiday falls on a Saturday, it is recognized on the Friday preceding the holiday and when a holiday falls on a Sunday, it is recognized on the Monday following the holiday.

**NOTICE OF ADVERSE
BENEFIT
DETERMINATION
(NOA)**

The written notice provided to the member/Health Care Decision Maker, and designated representative which explains the reasons for the Adverse Benefit Determination made by the Contractor regarding the service authorization request and includes the information required by this Policy.

**NOTICE OF EXTENSION
(NOE)**

The written notice to a member/Health Care Decision Maker, and designated representative to extend the timeframe for making either an expedited or standard authorization decision by up to fourteen days if criteria for a service authorization extension are met.

**SERVICE
AUTHORIZATION
REQUEST**

A request by the member/Health Care Decision Maker, and designated representative or a provider for a physical or behavioral health service for the member which requires Prior Authorization (PA) by the Contractor.

WORKING DAYS

“Working Day” as defined in A.A.C. R9-34-202. Monday, Tuesday, Wednesday, Thursday, or Friday unless:

- A legal holiday falls on one of these days; or
- A legal holiday falls on Saturday or Sunday and a Contractor is closed for business the prior Friday or following Monday.

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

NOA to the member/Health Care Decision Maker, and designated representative as described in 42 CFR 438.404.

The Contractor shall use the AHCCCS developed member NOA 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 NOA template for service authorization requests.

The Contractor's Member Handbook shall inform members/Health Care Decision Makers:

1. Of their right to make a complaint to the Contractor about an inadequate NOA.
2. That if the Contractor does not resolve the complaint about the NOA to the member's satisfaction, the member/Health Care Decision Maker may complain to AHCCCS Division of Health Care Management (DHCM), Medical Management (MM) at: MedicalManagement@azahcccs.gov.
3. That the Contractors and their providers are prohibited from taking punitive action against members/Health Care Decision Makers 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 designated representative, including an attorney, during an appeal of an Adverse Benefit Determination. A list of legal aid services available to members as 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 designated representative. The member's designated representative 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 designated representative provide an authorization signed by the member/Health Care Decision Maker; however, if the Contractor questions the authority of the designated representative or the sufficiency of an authorization, it shall promptly communicate that to the designated representative.

B. NOTICE OF ADVERSE BENEFIT DETERMINATION CONTENT REQUIREMENTS

The NOA shall be written in an easily understood language and format as specified in ACOM Policy 404.

1. The NOA shall contain and clearly explain the information necessary for the member/Health Care Decision Maker, and designated representative to understand the Adverse Benefit Determination, the reason for the Contractor's determination such that the member/Health Care Decision Maker may make an informed decision

- regarding appealing the determination, and how to appeal the decision. If the reason for the denial of a service authorization request is due to the lack of necessary information, the member/Health Care Decision Maker, and designated representative shall be clearly informed of that reason in order to be given the opportunity to provide the necessary information.
2. The NOA 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 reasons for the Adverse Benefit Determination the Contractor has 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),
 - d. The effective date of a service denial, limited authorization, reduction, suspension, or termination,
 - e. The right of the member/Health Care Decision Maker, and designated representative to be provided, upon request and free of charge, 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 as specified in 42 CFR 438.404(b)(2),
 - f. The legal basis for the Adverse Benefit Determination,
 - g. Where members/Health Care Decision Maker, and designated representatives can find copies of the legal basis (e.g. the local public library and the web page with links to legal authorities). 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/Health Care Decision Maker, and designated representative to find the reference online,
 - h. A listing of legal aid resources,
 - i. The member's/Health Care Decision Maker'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),
 - 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, and
 - 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 (42 CFR 438.420(d)).
 3. It is unacceptable to cite lack of medical necessity as a reason for denial, unless the NOA also provides a complete explanation of why the service is not medically

necessary. 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. For examples where medical necessity is appropriately used in denying/limiting services, refer to the 'Guide to Language in Notices of Adverse Benefit Determination', on the AHCCCS website, under resources.

4. The NOA shall state the reasons supporting the denial/reduction/limited authorization/suspension/ termination. NOAs that do not provide explanation of why the service has been denied/reduced/ limited/suspended/terminated and merely refer the member/Health Care Decision Maker, and designated representative to a third party for more information are unacceptable. The Contractor may include a statement referring a member/Health Care Decision Maker, and designated representative to a third party for more help when the third party can explain treatment alternatives in more detail.

C. EPSDT

The Contractor shall cite Early Periodic Screening, Diagnosis and Treatment (EPSDT) Federal law 42 U.S.C. 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. 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:

- a. Screening services,
- b. Vision services,
- c. Dental services,
- d. Hearing services and such other necessary health care,
- e. Diagnostic services, treatment and
- f. 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/Health Care Decision Maker complains about the adequacy of a NOA, the Contractor shall review the initial NOA against the content requirements of this Policy. If the Contractor determines that the original NOA is inadequate or deficient, the Contractor shall issue an amended NOA consistent with the requirements of this Policy. Should an amended NOA be required, the timeframe for the member/Health Care Decision Maker to appeal and continuation of services shall start from the date of the amended NOA.

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 or not 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 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 in 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 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 PA 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 prior 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. The Contractor shall

issue a final decision no later than seven working days from the initial date of the request. Refer to 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.

The Contractor may issue a NOE; utilizing Attachment D 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); 42 CFR 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.

All authorization requests for BHRF services shall be treated as expedited requests.

The Contractor may issue a NOE; utilizing Attachment D 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 a 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 Prior Authorization (PA) that describes how the individual 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 NOA 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 NOE constitutes a denial. The Contractor shall issue a NOA denying the service request on the date that the timeframe expires [42 CFR 438.404(c)(5)].

F. TIMEFRAMES FOR COMPLETING NOTICES OF ADVERSE BENEFIT DETERMINATIONS

The Contractor shall mail the NOA within the following timeframes:

1. For termination, suspension, or reduction of a previously authorized service, the NOA 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 [42 CFR 431.211, 42 CFR 438.404 (c)(1)],
2. For Service Authorization decisions that deny or limit services, the Contractor shall provide an NOA:
 - 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 prior 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 an NOA 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 an NOE. For extension timeframes, refer to NOE Requirements in this Policy [42 CFR 438.404(c)(3) and (4), 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)(i), 42 CFR 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 an NOE. For extension timeframes, refer to NOE Requirements in this Policy.

G. NOTICE OF EXTENSION REQUIREMENTS

1. NOE Timeframes:
 - a. The Contractor may extend the timeframe to make a Service Authorization Decision for both standard and expedited service authorization requests when the member/Health Care Decision Maker or provider (with written consent of the member/Health Care Decision Maker) requests an extension, or when the Contractor justifies the need for additional information is in the member's best interest. The NOE shall not be sent until the Contractor has made sufficient

- attempts to obtain the necessary information from the requesting provider. [42 CFR 438.404(c)(6), 42 CFR 438.210(d)(2)(ii)],
- b. 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,
 - c. For Service Authorization requests involving medication, refer to ‘Timeframes for Completing Notices of Adverse Benefit Determinations’ as specified in this Policy when the PA requests lack sufficient information from the prescriber,
 - d. 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
 - e. Refer to Computation of Time in Calendar Days under “Definitions” for further information regarding when the end date falls on a weekend or legal holiday
 - f. If the Contractor extends the timeframe in order to make a decision, in accordance with 42 CFR 438.210 (d)(1) the Contractor shall:
 - i. Give the member/Health Care Decision Maker, and designated representative written notice of the reason for the decision to extend the timeframe in easily understood language,
 - ii. Include what information is needed in order to make a determination,
 - iii. Inform the member/Health Care Decision Maker, and designated representative 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)(1)(ii); 42 CFR 438.404(c)(4)(i), and
 - iv. 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)(1)(ii); 42 CFR 438.404(c)(4)(ii), and
 - v. For examples of easily understood NOA language, refer to the ‘Guide to Language in Notices of Adverse Benefit Determination’, on the AHCCCS website, under resources.

H. NOA SELF-MONITORING REQUIREMENTS

1. The Contractor shall conduct quarterly self-audits as outlined below:
 - a. Utilizing the AHCCCS provided Reporting Form,
 - b. Reporting NOA’s issued within the quarter prior,
 - c. Report by line of business,
 - i. DDD shall submit NOA’s issued for services provided by DDD,
 - 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 the staff member that writes or issues the NOA,
 - e. The sample shall include NOAs from each of the following categories: Medical, Dental, Pharmacy, and Behavioral Health. The Contractor will randomly select 30 NOAs from each of these categories. From the 30, eight NOAs will be

randomly selected to be audited. If the initial eight NOAs are found to be in compliance, the remaining 22 NOAs will not need to be audited. If any of the eight NOAs issues are found to be out of compliance, the remaining 22 must be audited, and

- f. The Contractor shall submit a Notice of Adverse Benefit Self-Audit Scores and Executive Summary to DHCM/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 member involved in audit and credentials or role in the organization, and
 - e. Score sheet.

AHCCCS reserves the right to request specific NOAs and associated records for further review.