HEALTH PLANS
UNIVERSITY OF UTAH

Administrative Policy

Clinical Reconsideration of Organizational Determinations

Policy ADMIN-005

Origination Date: 02/28/2024

Reviewed/Revised Date: 02/28/2024

Next Review Date: 02/28/2025

Current Effective Date: 04/28/2024

Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial, CHIP and Healthy U (Medicaid). Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.

Description:

Health Plans have certain Services which require pre-approval (prior authorization) before they are eligible for coverage. In some instances, these requests are denied coverage (an adverse determination). In these instances, the requesting provider may disagree with the determination and feel additional information is available that may alter the decision and was not provided during the initial review. In these circumstances, they may appeal the decision with inclusion of the new information. In this instance, the information will be reviewed by an appropriate different reviewer.

Alternatively, in limited circumstances, the initial clinical determination may be 'reconsidered' by the Health Plan. These clinical reconsiderations are performed as a courtesy by the Health Plan and are not mandated by federal or state regulation. The purpose of a clinical reconsideration is to reduce unnecessary administrative burden and delay in provision of services in certain circumstances felt to perhaps not require the complete appeals process.

Policy Statement and Criteria

1. Commercial Plans/CHIP

U of U Health Plans will allow for a 'Clinical Reconsideration' determination in limited circumstances defined by the Plan when specific criteria are met.

Criteria Requirements for Allowance of 'Clinical Reconsideration' Determinations:

A. Request is derived from one of the following situations:
    i. Peer to Peer discussion in which new information regarding the case has been brought forward during the peer-to peer discussion and U of U Health Plans representative has agreed to a Clinical Reconsideration during the conversation;
    ii. Inpatient admissions in which substantive additional information felt to demonstrate continued hospitalization warranted is provided and request is made within 48 hours of the adverse determination triggering the request.
B. Denial of the Service is for medical necessity reasons only
C. Provider has specific new information pertinent to the reason for denial provided in the initial service denial
D. Requesting Provider/Entity has completed the U of U Health Plans Clinical Reconsideration form
E. Appeal has not yet been initiated

Clinical Reconsiderations are allowed completely at U of U Health Plans discretion.

If a Clinical Reconsideration is granted, communication regarding the Clinical Reconsideration will occur via U of U Health Plans standard utilization management process.

Clinical Reconsiderations are performed as a courtesy and are outside the standard Appeals Process and do not substitute or replace the Member/Provider appeals rights.

2. **Medicaid Plans**
Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at: https://medicaid.utah.gov/utah-medicaid-official-publications/ or the Utah Medicaid code Look-Up tool

CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.

Clinical Rationale

Prior Authorization (also known as "Pre-Certification") is a process through which a clinician seeks advanced approval from a health plan to ensure that a service or treatment is covered, medically

necessary, and not duplicated. It's an important tool health plans use to ensure the services, drugs and devices that members receive are supported by current, credible medical evidence.

Expensive tests and procedures are often ordered that may not be supported by the most recent medical evidence. The vast majority of Services do not require prior authorization with some estimates suggesting no more than 4-6% of Services typically are subject to prior authorization

Without prior authorization, health care premiums would increase. In fact, a recent study by Milliman concluded that removing prior authorization altogether could result in premium increases in the commercial market nationally totaling between $43 billion and $63 billion, or $240-$360 annually per member additional premiums. The report also estimated higher out of pocket costs for members if prior authorization was removed.

In some instances, the information provided is insufficient to approve the request but the necessary information is readily available of simple in character (e.g. single lab or x-ray result). In most instances the provider will need to do a formal appeal of the determination. In other instances, a clinical reconsideration might be provided.

Clinical reconsideration refers to a less formal process than appeals that involves requesting the payer to reevaluate the case that was denied. It is typically used as an initial step before pursuing a full appeal. Clinical reconsideration allows the provider to engage in dialogue with the payer to address any missing information and provide additional documentation that could potentially lead to authorization of the Service. A clinical reconsideration is typically only done due to the absence of missing information that is readily available and not a re-adjudication of the case.

Clinical reconsiderations are an optional service provided by health plans intended to reduce administrative burden on provider office and any potential delays in care that may occur from use of a formal appeals process. It is a courtesy which requires collaboration between the provider office and the plan. Clinical reconsiderations do not replace or eliminate the member/provider appeals rights.

Applicable Coding

CPT Codes

All Codes Requiring Prior Authorization as listed on the published Plan Prior Authorization List

HCPCS Codes

All Codes Requiring Prior Authorization as listed on the published Plan Prior Authorization List

References:

1. Eleanor D. Kinney, Tapping and Resolving Consumer Concerns about Health Care, 26 AM. J.L. & MED. 335 (2000).
2. Consumer Problems with Prior Authorization: Evidence from KFF Survey Karen Pollitz, Kaye Pestaina, Lunna Lopes, Rayna Wallace, and Justin Lo Published: Sep 29, 2023
3. Salzbrenner SG, Lydiatt M, Helding B, Scheier LM, Greene H, Hill PW, McAdam-Marx C. Influence of prior authorization requirements on provider clinical decision-making. Am J Manag Care. 2023 Jul;29(7):331-337. doi: 10.37765/ajmc.2023.89394. PMID: 37523751; PMCID: PMC10403277.
4. Potential impacts on commercial costs and premiums related to the elimination of prior authorization requirements; Frederick (Fritz) Busch and Stacey V. Muller; 30 March 2023, https://www.milliman.com/en/insight/potential-impacts-elimination-of-prior-authorization-requests

explanation of benefits, or a contract. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

U of U Health Plans makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. U of U Health Plans updates its Coverage Policies regularly, and reserves the right to amend these policies and give notice in accordance with State and Federal requirements.