HEALTH PLANS
UNIVERSITY OF UTAH

Administrative Policy

Dismissal: Failure to Follow Filing Procedures

Related Policies:
Admin-022 Retrospective Service Reviews
Admin-023 Administrative Denials

Policy ADMIN-021

Origination Date: 05/26/2021

Reviewed/Revised Date: 05/29/2024

Next Review Date: 05/29/2025

Current Effective Date: 05/29/2024

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) plans. 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:

Prior Authorization or preauthorization is a process used by U of U Health Plans to assure health benefits are administered as designed, that members receive treatments that are safe and effective for the condition being treated and that the treatments used have the greatest value. Prior Authorizations require the contracted provider to receive pre-approval for coverage of a particular treatment in order for the service to be covered by the U of U Health Plans benefit.

U of U Health Plans dismisses a prior authorization request for failure to follow filing procedures when U of U Health Plans is unable to move forward with the medical necessity review because the requester did not provide sufficient information to start a review.

In some instances prior authorization requests are submitted which do not follow filing procedures. These circumstances do not allow ascertaining of medical necessity as certain minimal information is necessary to determine medical necessity. In these instances, actions taken by U of U Health Plans are considered a dismissal rather than a denial of coverage for services.

Policy Statement and Criteria

1. Commercial Plans/CHIP

U of U Health Plans dismisses prior authorization requests when filing procedures are not followed as part of the prior authorization request, and elements necessary to complete a medical necessity review are not provided.

Essential elements necessary to be submitted with prior authorization requests include **ALL** of the following:

A. Completed request form*

B. Clinical Documentation supporting the requested services *(including but not limited to)*:

   i. Medical History (include treatment, diagnostic tests, examination data).

   ii. Description of treatment plan and treatment to date

   iii. Diagnostic/Laboratory/Radiology results

   iv. Clinical notes necessary to certify medical necessity

*The appropriate forms and instructions for submission are found at: https://uhealthplan.utah.edu/for-providers/prior-authorization.php

U of U Health Plans requires prior authorization of all elective inpatient admissions. Requests for authorization will be dismissed only if information comes from admission notification or census report with no other clinical information provided.

A retrospective review failing to meet the standards established in Admin-022 Retrospective Service Reviews, will be considered a dismissal.

A dismissed request is not a denial and therefore has no appeal rights.

A request for prior authorization will be reconsidered at the initial review level, if the requester resubmits for prior authorization with a completed form and accompanying clinical documentation.

Dismissed requests will follow the following notification rules:

A. For urgent preservice and concurrent decisions, U of U Health Plans notifies the practitioner (member's authorized representative) or member within 24 hours of receiving the request for services. Notification may be verbal, unless the practitioner or member requests written notification.

B. For nonurgent preservice decisions, U of U Health Plans notifies the practitioner or member within 5 calendar days of receiving the request for services.

2. Medicaid Plans

U of U Health Plans dismisses prior authorization requests when filing procedures are not followed as part of the prior authorization request, and elements necessary to complete a medical necessity review are not provided.

Essential elements necessary to be submitted with prior authorization requests include **ALL** of the following:

A. Completed request form*

B. Clinical Documentation supporting the requested services *(including but not limited to)*:

   i. Medical History (include treatment, diagnostic tests, examination data).

   ii. Description of treatment plan and treatment to date

   iii. Diagnostic/Laboratory/Radiology results

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Clinical Rationale

U of U Health Plans has established policies and procedures governing prior authorization and notification requirements, medical necessity review, and submission of clinical documentation.

To obtain prior authorization, the requester should submit a current copy of the appropriate request form and all relevant clinical documentation related to the requested services. A request form is considered complete when U of U Health Plans has sufficient information to move it to review. This includes member information, requesting and servicing provider information, contact information, and requested services. Illegible forms, or forms with insufficient information to attach it to a member in our UM platform will be returned to sender with a request to resubmit. Without both a completed request form and accompanying clinical, U of U Health Plans is not able to move the request forward for medical necessity review.

Denying the request results in the loss of a level of clinical assessment as part of the prior authorization for the member when no legitimate clinical review is possible. In these instances rather than denying the case for failing to demonstrate medical necessity, these cases will be dismissed for failure to follow filing procedures.

The requester may resubmit for prior authorization (PA) with a completed form and accompanying clinical documentation. Upon receipt of the resubmitted request, U of U Health Plans staff reviews the PA request to determine if the service is covered and if the service is medically necessary. The date in which a complete request, with the required clinical documentation being received, will be the date posted for the PA request.

Applicable Coding

CPT Codes

Too numerous to list

HCPCS Codes

Too numerous to list

References:

1. NCQA 2021 HP Standards and Guidelines UM Standards and Elements - UM 5: Timeliness of UM Decisions for Non BH, BH, and Rx decisions. See p. 266-267, 272, 279.