HEALTH PLANS
UNIVERSITY OF UTAH

Administrative Policy

Administrative Denials

Related Policies:
Admin-021 Dismissal: Failure to Follow Filing Procedures
Admin-022 Retrospective Service Reviews

Policy ADMIN-023

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 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. The prior approval process is called pre-authorization, or prior authorization (PA).

In some instances, denial of coverage for services is based on reasons other than a lack of medical necessity or for being considered investigational. In these instances the denial is considered an administrative denial and does not require a qualified health care provider review.

Policy Statement and Criteria

1. Commercial Plans/CHIP

U of U Health Plans considers the following circumstances administrative denials and does NOT cover the services:

A. Pended claims in which the only information provided are CPT and/or ICD-10 codes on the claim.

B. A request for authorization in which a request for additional information has been formally made and the appropriate time has passed consistent with regulatory or administrative requirements without any response from the provider. This is applicable for pre and post service review requests.

C. Request for services in which the only information provided are CPT and/or ICD-10 codes on which identify the request to be for services never covered by benefit.

D. In the instance of services requested which require a prior authorization, and no preservice authorization was obtained.

E. Prior authorization request received for services specifically excluded in the member's plan documents.

F. Services requested by a non-participating provider for services that are available by network providers (If the request specifically asks for consideration of a benefit exception, U of U Health Plans would review the request for the exception).

U of U Health Plans considers failure to provide all necessary information to complete a medical necessity review in the following circumstances an administrative denial (All Must Be Present):

A. Clinical information necessary to determine medical necessity

B. U of U Health Plans representatives have contacted provider and requested specific information needed to complete the review

C. U of U Health Plans does not receive any of the requested information within the plan specific timeline.

2. Medicaid Plans

U of U Health Plans considers the following circumstances administrative denials and does NOT cover the services:

A. Pended claims in which the only information provided are CPT and/or ICD-10 codes on the claim.

B. A request for authorization in which a request for additional information has been formally made and the appropriate time has passed consistent with regulatory or administrative requirements without any response from the provider. This is applicable for pre and post service review requests.

C. Request for services in which the only information provided are CPT and/or ICD-10 codes on which identify the request to be for services never covered by benefit.

D. In the instance of services requested which require a prior authorization, and no preservice authorization was obtained.

E. Prior authorization request received for services specifically excluded in the member's plan documents.

F. Services requested by a non-participating provider for services that are available by network providers (If the request specifically asks for consideration of a benefit exception, U of U Health Plans would review the request for the exception).

U of U Health Plans considers failure to provide all necessary information to complete a medical necessity review in the following circumstances an administrative denial (All Must Be Present):

A. Clinical information necessary to determine medical necessity

B. U of U Health Plans representatives have contacted the provider and requested specific information needed to complete the review

C. U of U Health Plans does not receive any of the requested information within the plan specific timeline.

Clinical Rationale

Medical necessity review is a process to consider whether services that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. Medical necessity review requires consideration of the member's circumstances, relative to appropriate clinical criteria and U of U Health Plans policies. Instances, however, may arise in which a complete lack or near complete lack of information is provided which disallows any possibility of application of appropriate clinical criteria or U of U Health Plans policies to determine medical necessity of requested or performed services in the case of post-service review.

In these circumstances, medical necessity review cannot be performed. As no clinical judgement is required in these circumstances, determination does not require review by a qualified health care professional and is excluded from medical necessity review requirements by NCQA. NCQA HP Standards and Guidelines Effective for Surveys Beginning UM Standards and Elements – UM1 Program Structure state:

Decisions about the following do not require medical necessity review:

1. Services in the member's benefits plan that are limited by number, duration or frequency;
2. Extension of treatments beyond the specific limitations and restrictions imposed by the member's benefits plan;
3. Care that does not depend on any circumstances;
4. Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living (ADL).

As an affirmative determination would never be covered because medical necessity cannot be established due to "care that does not depend on any circumstances", medical necessity review is not

required and determination does not require an appropriate licensed qualified health care provider to review.

In addition, since prior authorization requires appropriate filing of information to allow for medical necessity review, NCQA standards allow for a determination to occur. UM 5: Timeliness of UM Decisions for Non BH, BH, and Rx decisions. See p. 266-267, 272, 279 states:

- *Failure to follow filing procedures.* If the member (or the member's authorized representative) does not follow U of U Health Plans reasonable filing procedures for requesting preservice or urgent concurrent services, U of U Health Plans notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting services.
- *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.
- *For nonurgent preservice and post-service decisions*, U of U Health Plans notifies the practitioner or member within 5 calendar days of receiving the request for services.

As medical necessity review requires proper filing of information, this would be considered an administrative denial.

Applicable Coding

CPT Codes

All CPT Codes

HCPCS Codes

All HCPCS

ICD-10 Codes

All ICD-10 Codes

References:

1. NCQA 2021 HP Standards and Guidelines UM Standards and Elements – UM1 Program Structure,
2. 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.
3. 29 CFR 2560-503-1 Claims Procedure