HEALTH PLANS
UNIVERSITY OF UTAH

Administrative Policy

Reopening of Organizational Determinations for Medical Review

Policy ADMIN-005

Origination Date: 02/28/2024

Reviewed/Revised Date: 8/28/2024

Next Review Date: 08/28/2025

Current Effective Date: 10/28/2024

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.
5. Provisions and terms of the provider contract may supersede 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 requester may resubmit with the missing clinical information to be reviewed. A clinical reopening is performed as a courtesy by the Health Plan and are not mandated by federal or state regulation. The purpose of allowing for the submission of the missing information and a clinical reopening 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 reopening of a coverage determination and a re-review of additional information in limited circumstances defined by the Plan when specific criteria are met.

Criteria Requirements for allowance of reopening a clinical determination:

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 reopening of a determination during the conversation;

   ii. For inpatient members: Member is currently admitted to a facility and continued hospitalization has been determined to in a denied status with substantive additional information felt to demonstrate continued hospitalization is warranted and **ALL** of the following:

      a) Request must be made within 48 hours of denial;

      b) Member must still be admitted. Once discharged the provider must appeal;

      c) Denial is for medical necessity reasons only.

   iii. For outpatient Service requests: Provider believes denial was based on incomplete clinical information and has specific new information pertinent to the reason for denial and **ALL** of the following:

      a) Request must be made within 14 calendar days of pre-service denial;

      b) Denial is for medical necessity reasons only;

      c) If the services have already been provided, the provider must appeal.

B. Requesting Provider/Entity has completed the U of U Health Plans Clinical Reopening's form

   i. Reopening requests for inpatient admission without **ALL** of the following will be dismissed:

      a) A completed reopening's form *(located here: https://doc.uhealthplan.utah.edu/providers/request-to-reopen-organizational-determination.pdf)*;

      b) New or additional documentation is provided.

   ii. Reopening requests for outpatient services without **ALL** of the following will be dismissed:

a) A completed reopening's form *(located here: https://doc.uhealthplan.utah.edu/providers/request-to-reopen-organizational-determination.pdf)*;

b) Submission of new or additional documentation.

C. Appeal has not yet been initiated

D. Claim has not been received

Only one reopening will be allowed for each clinical circumstance.

If the provider disagrees with the reopening decision, they will be asked to follow the appeals process.

In circumstances in which additional records have been received after the patient has been discharged from the hospital and reopening is requested, reopening will not be granted and the requesting entity will be asked to follow the Appeals process.

Reopening of case determinations are allowed completely at U of U Health Plans discretion.

If a reopening of a case determination is granted, communication regarding the re-determination will occur via U of U Health Plans standard utilization management process.

Reopening of a case is performed as a courtesy and is outside the standard Appeals Process and does 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 reopening might be provided.

Reopening 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. Reopening a case determination 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 reopening is typically only done due to the absence of missing information that is readily available and not a re-adjudication of the case.

A reopening is 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. A clinical reopening does 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. Consumer Problems with Prior Authorization: Evidence from KFF Survey Karen Pollitz, Kaye Pestaina, Lunna Lopes, Rayna Wallace, and Justin Lo Published: Sep 29, 2023
2. Eleanor D. Kinney, Tapping and Resolving Consumer Concerns about Health Care, 26 AM. J.L. & MED. 335 (2000).
3. 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
4. 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.

Disclaimer:
This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an 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. Provisions and terms of the provider contract may supersede this 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.

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