Seaside Health Plan Policies and Procedures	**Effective Date:** May 17, 2013 **Note: For origination date see History at the end of Policy**
SUBJECT: NOTIFICATION TO DENY, DEFER, MODIFY, DELAY AND TERMINATE REQUEST FOR MEDICAL SERVICES	**Approval Signature:** Barry Smith, MD Chief Medical Officer
Manual: Utilization Management **Policy/Procedure #** UM-180 **Section:** UM Program	**Sponsor Signature:** Kimberly Ward, RN Director, Utilization Management
☒ **COMMERCIAL** ☒ **HEALTHY FAMILIES** ☒ **MEDI-CAL** ☒**MEDICARE**	

AUTHORITY
Title 22, CCR, sections 51014.1 and 53894

POLICY
When Seaside Health Plan denies, defers, modifies, delays or terminates a request by a provider for medical services, Seaside Health Plan notifies Members and Providers in a consistent and timely manner,

Providers are involved in development and/or adoption of criteria used for modifying, deferring or denying requested services. Providers are encouraged to participate in Seaside Health Plan's Utilization Management (UM) meetings when UM guidelines (Milliman Care) are discussed.

The UM Process and criteria utilized in making UM decisions are disclosed to the enrollee, provider, person designated by the enrollee and public upon request.

Commercial Members who have exhausted benefits will receive a denial letter notifying him/her of the cessation of benefits prior to the actual date of termination.

Medicare Members will receive a NOMNC letter when certain long term benefits have been exhausted, or are terminated based on lack of medical necessity.

If a patient is in the hospital, and it is determined that hospitalization should be terminated based on lack of continued justification for the stay, a letter of notification will be sent 24 hrs. prior to termination, 48 hours prior for Medicare Members.

SB 59: Care shall not be discontinued until the enrollee's treating provider has been notified of the Plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

DEFINITION
Termination of Services: An authorization is approved for a certain period of time, then extended based on medical necessity.

PROCEDURE

I. Seaside Health Plan has set timeframes for notification to deny, defer, modify, delay and terminate request for medical services. Refer to Policy and Procedure: UM-100

II. The prior authorization decision to deny, modify, defer, delay and terminate requested services is always made by the Medical Director or physician designee.

III. **LA CARE REQUIREMENT**: for Healthy Families/Healthy Kids: notification for approvals, denials, modification, or termination of referral requests: Seaside Health Plan shall provide required notification to beneficiaries and the representatives in accordance with timeframes set forth in Title 22, CCR, sections 51014.1 and 53894. Such notice shall be deposited with the USPS in time for pick up no later than the third working day after the decision is made not to exceed 30 calendar days from the receipt of the original request.

IV. **LA CARE REQUIREMENT:** for Healthy Families deferral timeliness standards: Seaside Health Plan's UM Program Plan indicates non-urgent pre-service authorization requests can be deferred for up to 45 calendar days if additional information is requested. **Seaside Health Plan will comply with LA Care allowance of 30 days for deferrals when requesting additional information**.

V. This Procedure shall be followed when all of the following conditions exist:

    A. The request is made by a Seaside Health Plan provider who has a formal arrangement with Seaside Health Plan to provide services to enrollees.

    B. The beneficiary for whom the request is made is eligible and is enrolled as a Seaside Health Plan Member.

    C. The request is made by the provider through Seaside Health Plan formal prior authorization procedures.

    D. The service for which prior authorization is requested is a covered service for which Seaside Health Plan has established a prior authorization requirement.

VI. Requirements for contents of the Notice:

    A. Seaside utilizes the CMS mandated Notice of Denial of Medical Coverage (NDMC) for Non-Behavioral and Behavioral (BH) and the supplemental CMS Region IX approved template letters for Medicare members.

    B. The scope of this policy is limited to those Behavioral Health Denials which are the responsibility of the health plan and where Seaside has not been delegated

for. Seaside Health Plan complies with Health plan requirements of contracted Health Plans and refers all Behavioral Health requests to the responsible Health Plan.

C. The Notice of Action for any denial, delay, deferral, modification or termination of a request for authorization of a medical service or BH service is mailed by a Utilization Review representative to the member, beneficiary and/or requesting provider. Seaside Health Plan utilizes ICE approved template letters. The letter must include:

1. Service(s) being denied, delayed , deferred, modified or terminated

2. The reason(s) for the action taken (denial) in easily understandable language

3. Pended notification must include a description with the following reasons: specific information needed; time frame for submitting the information; expected date of decision and type of expert reviewer required, if applicable [CA health & Safety Code 1367.01].

4. A citation of the Seaside Health Plan authorization procedures or specific regulations supporting the action.

5. A reference to the benefit provision, guideline, protocol or other similar criteria on which the denial decision is based.

6. Notification that the Member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial was based, upon request. Seaside Health Plan shall provide required notification to beneficiaries and the representatives in accordance with the timeframes set forth in Title 22, CCR, Sections 51014.1 and 53894. Such notice shall be deposited in the USPS in time for pick up.

7. Disclosure of the actual benefit provision, guideline, protocol or other similar criterion upon which the denial was based shall be accompanied by the following notice: The following disclosure statement:

   "*The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract*." CAHSC §1361.5(c).

   The Member may obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion upon which the denial decision was based, upon request.

8. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal, and;

9. The Member's right to, and method of obtaining, a fair hearing, to contest the denial, deferral, or modification action and the decision the delegate has made.

10. Provision of the name and address of the delegate and the State toll-free telephone number for obtaining information on legal service organization for representation

11. Member may speak for him/herself at the State Hearing or have someone else speak for the member, including a relative, friend or attorney. The member must get the other person him/herself. Member may be able to get free legal help. Member may call the Health Consumer Center of Los Angeles at 1-800-896-3203. Member may also call the local legal Aid Society in Los Angeles County at 1-800-399-4529

12. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.

13. An explanation of the Member's right to call the State Medi-Cal Managed Care 'Ombudsman Office' for answering questions or help in appealing decision

14. An explanation if the member does not agree with this decision, member may:

    1. Ask for a 'State Hearing"

    2. File a grievance with your health plan

    3. Ask for an "Independent Medical Review (IMR)

15. Member's right to have benefits continue pending the resolution of the appeal and how to request continued benefits.

16. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care and ongoing treatment.

17. Upon request by a member, the identity of expert reviewers will be provided

18. Practitioners are notified of the policy for making an appropriate Practitioner Reviewer available to discuss any UM denial decision is communicated via the Seaside Health Plan website and on fax cover sheets used for all denials, modifications and deferrals. Statement on how to contact a Practitioner Reviewer is also communicated via the approval authorization form.

History: New

Origination Date: May 17, 2013