

## Utilization & Clinical Medical Policy Frequently Asked Questions

### 1. What criteria are used for authorization decisions?

- Neighborhood Health Plan of Rhode Island (Neighborhood) applies Managed Care Appropriateness Protocol (MCAP), developed by The Oak Group, as the review criteria for hospital stay reviews and alternative level of care review (i.e. home care, acute inpatient rehab, outpatient rehab, skilled nursing home stays).
- Neighborhood's Clinical Medical Policies are applied to "conditional" benefits such as: breast reduction surgery, gastric bypass surgery, etc., and uses of medical technology which require medical necessity determination.

### 2. What is the process for medical review?

- Medical review is conducted by nurses to confirm the medical necessity of the treatment and the appropriateness of the care setting.
- The nurses gather all pertinent clinical information from the treating practitioners and staff and review against the Neighborhood criteria.
- The criteria and Clinical Medical Policies provide a guideline, but individual consideration and clinical judgment is always used when determining medical necessity.
- If the nurse is able to confirm the medical necessity and care setting appropriateness, the requested service is authorized.

### 3. What happens if the criteria are not met?

- When the Medical Review Nurse is not able to confirm the medical necessity and appropriateness of care setting, the case is referred to a Neighborhood physician reviewer for a decision.
- Decisions to make an adverse medical necessity determination ("denial") are only made by a physician reviewer who is a similarly licensed practitioner as the ordering physician.

### 4. What is the turn-around time for decision making?

Depending on the type of request, regulatory requirements dictate specific timelines for decision making:

- Prospective (precert) services (not yet rendered, and non-urgent) - due within 15 calendar days from receipt the request and prior to the date of service.
- Urgent requests - within 72 hours of receipt of the request and prior to the date of service.
- Inpatient hospital (also known as "concurrent") - within 24 hours. This can be extended to 72 hours if no clinical information made available to the health plan.
- Retrospective (services already rendered) – within 30 calendar days of the request.

**5. Is the turn-around time affected if the request requires a Neighborhood physician review?**

No. The timelines above apply to the entire process.

**6. How is the decision communicated to the provider?**

*Authorizations*

- Hospitals receive “Update” reports that indicate what level of care the Medical Review Nurse has approved.
- For other urgent requests, the ordering practitioner and/or provider receive a phone call
- For all other requests the providers receives a faxed request or report, with detail on what services were approved

*Adverse Decisions (Denials):*

- The ordering practitioner is notified by phone and given the opportunity to discuss with the Neighborhood Physician Reviewer, and
- A letter is sent, detailing reason for the denial.

**7. If an Adverse Decision (Denial) letter is sent, what other information is in the letter?**

- The specific rationale as to why the services could not be approved
- Which criteria was used for the decision-making process
- Contact information for the Neighborhood physician reviewer should the ordering practitioner wish to discuss further
- Member appeal rights and information on how a member can appeal

**8. Can providers appeal on behalf of the member, if an adverse decision was made by a Neighborhood physician reviewer?**

Yes. These are “clinical appeals.” There are two levels: the first appeal should be received by Neighborhood within 90 days of the denial, and if a second appeal is necessary, it should be received within 60 days of the level I appeal decision letter.

**9. What is the turn-around time for appeal decisions?**

- Decisions are due within 15 calendar days from receipt of the request to appeal.

**10. If the service required is “emergent” what is the turnaround time?**

Emergent is defined as the “sudden onset of a medical condition that the absence of immediate medical attention could reasonably be expected by a prudent layperson, to result in placing the member’s life or health in serious jeopardy.”

- A decision will be rendered within 1 business day of request, if all information received.
- If information is insufficient, decision will be no later than 72 hours from request.

**11. Who do I call if I want more information or have questions?**

Utilization Management Department at 401-459-6060