

**Objective:**

- I. To ensure that a notice of denial is initiated when requested benefits are not available per contract, when requested services are not medically indicated, or adequate clinical information is not available to make a determination according to Tuality Health Alliance (THA) Health Plan policy or criteria. THA members include Oregon Health Plan (OHP) and Providence Health Plan (PHP)-THA. Members and Practitioners are notified of the denial in writing.
- II. To ensure that when an action is taken that may limit prior authorizations of requested covered services in an amount, duration, or scope that is less than requested, or is a reduction, suspension, discontinuance or termination of a previously authorized service the member is notified timely.
- III. To ensure that providers and members receive sufficient information to understand and decide about appealing a decision to deny care or coverage.

**Policy:**

- I. The THA Medical Director determines denials based on medical appropriateness.
  - A. THA Medical Director is available by telephone to discuss determinations based on medical necessity. Information on how to contact the Medical Director is included in the denial letter as an attachment.
  - B. Denials are documented in the Denial Log that is reviewed at the Utilization Management Committee.
  - C. Practitioners are notified by telephone or fax of a denial decision the same day of the decision. Practitioners may appeal the decision on the member's behalf.
  - D. Written notification is sent to members and practitioners, and includes the reason for each denial, including the specific utilization review criteria, benefit provisions, protocol or similar criterion used in the determination. The correspondence is sent the same day as the

- decision and includes appeal rights specific to each delegated health plan.
- E. Members and practitioners may obtain criteria used to make decisions by contacting THA Medical Management. Telephone numbers are enclosed with each denial notice sent.
- II. The written notification follows the following guidelines:
- A. Denial language is specific and easily understood.
  - B. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.
  - C. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
  - D. Description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
  - E. Explanation of the appeal process including the right to member representation and time frames for deciding appeals.
  - F. If a denial is an urgent pre-service or urgent concurrent denial, description of the expedited appeal process is included.
  - G. The member's right to have benefits continue pending resolution of an appeal is included as well as how to request those benefits and the circumstances under which the member may be required to pay the cost of services.
- III. For termination, suspension or reduction of previously authorized Oregon Health Plan covered services, the following time frames apply:
- A. The Notice of action must be mailed at least 10 calendar days before the date of the Action except in the following circumstances:
    - 1. THA or the practitioner receives a clear written statement signed by the member the he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying the information.
    - 2. The member's whereabouts are unknown and the post office returns the member's mail indicating no forwarding address.

3. THA establishes the fact that another State, territory or commonwealth has accepted the member for Medicaid services.
  4. A change in the level of medical care is prescribed by the member's practitioner.
  5. Information confirming the death of the member
- IV. Behavioral health issues are not delegated. For OHP Chemical Dependency denials the following are required:
- A. The specific reasons for the denial, in easily understandable language. The specific OAR will be documented.
  - B. A reference to the benefit provision, guideline, protocol or medical necessity criteria on which the denial decision was based.
  - C. Notification that the member may obtain a copy of the actual benefit provision, guideline, protocol or medical necessity criteria on which the denial decision was based, upon request.
  - D. Written notification of the denial contains the following appeal information:
    1. Description of the appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
    2. Explanation of the appeal process, including the right to member representation and time frames for deciding appeals. 3. If a denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process is included.
- V. Providence Health Plan does not delegate appeals to THA. Upon receiving a verbal or written appeal from a Providence member, THA will forward any information to the appropriate contact at the health plan the same day as the appeal is received.
- VI. Practitioners are notified of this policy by THA's policy manual which is available via THA's website, the provider manual, monthly provider newsletters and quarterly Office Manager and Clinical Nursing meetings.

**Subject: Denials**

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**THA Plan Director**

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**THA Medical Director**