Public Policy Statement on Managed Care, Addiction Medicine and Parity: Supplement for Physicians and Others

The Step-by-Step Utilization Review Process: Authorizations, Denials, and Appeals

Overview

Utilization Review (UR) is the process developed by Managed Care Organizations (MCOs) to authorize or deny payment for treatment. Employers and other large purchasers of health insurance (unions, governments, employers) attempt to limit health insurance expenses by purchasing benefits that require such a ‘gate keeper’ UR process. Reviews serve to verify a match between a patient’s presenting symptoms (their Severity of Illness, or SI), an individualized and targeted treatment plan, and the appropriate treatment, level of care, and length of time needed to accomplish the treatment (together, the Intensity of Service, or IS).

In the Utilization Review process, a healthcare professional presents a synopsis of clinical information justifying a treatment plan, and the treatment is authorized and paid for, in concert with patient deductibles and co-pays, by the managed care company. The MCO must verify a patient’s benefit eligibility and ensure that the requested treatment is medically necessary.

A general definition of medical necessity is:

1. Services requested are needed to identify or treat an illness that has been diagnosed or suspected.
2. Treatment services are consistent with:
   a. the diagnosis and treatment of the condition (‘experimental treatments’ are disallowed)
   b. the standards of good medical practice
3. Treatment services required are for other than convenience.
The Utilization Review Procedure

Authorization requests for treatment are made by a provider to an MCO intake employee (often with a Bachelor’s degree and unlicensed), most often via telephone or occasionally in writing (e.g., via fax). The treatment provider calls the toll-free Utilization Review or Insurance Authorization telephone number on the back of the patient’s insurance card.

1. The MCO intake employee first verifies that an individual patient has behavioral health insurance benefits through that company and that the benefits are current (have not expired) and have not been exhausted (benefit maximum reached).
2. The intake employee transfers the call to a Case/Care Manager (CM), a licensed behavioral professional, who next verifies that the treatment requested is a covered benefit. (For example, the treatment provider requests a residential level of chemical dependency care -- ASAM Patient Placement Criteria Level III. The question is whether this is a covered benefit under this patient’s insurance policy.)
3. Finally, the CM verifies that the patient’s presenting symptoms meet medical necessity guidelines for the specific level of care requested.

Authorizations

The provider gives clinical information to the CM that justifies the requested treatment services and/or medication. The focus should be on answering the question: “What in the patient’s current clinical symptoms, symptom history, and/or prior treatment necessitates the requested medication(s) and/or level of care treatment services for the requested number of sessions?” A one to three minute patient presentation with pertinent clinical information speaking to medical necessity is in order. Specific patient behaviors observed or verbalizations that can be quoted are ideal.

Note that a focus only on historical data does not equate to current severity of illness unless there is also “here and now” severity and dysfunction in that assessment dimension. The patient’s ‘severity of illness’ should be summarized by the requesting provider (or provider’s agent, such as a UR specialist working for a hospital, an addiction treatment center, clinic, or private practice).

Using the six dimensions of illness from the ASAM Patient Placement Criteria (ASAM PPC-2R) may make the communication with/to the MCO CM more focused. (For example, the initial communication could be structured around the question, “What are the problems described, using the six assessment dimensions in the ASAM PPC, that require services, the dose and intensity of which can only safely be delivered via the ASAM PPC level of care being requested?”)

Note that all medical necessity level of care criteria are publicly available on the MCOs’ Internet websites, whether these are consistent with or at variance with the ASAM PPC.

---

It is prudent for the provider to become familiar with the MCO’s criteria and cite specific patient symptoms that meet the criteria for the specific level of care requested during the UR process: satisfying medical necessity criteria, or not, is the rationale for authorization or denial. **An MCO may defer an authorization decision for up to 24 hours after an emergency level of care authorization request, and up to 3 – 5 days after a non-emergency level of care authorization request, although these allowable time lags may differ depending on an individual state’s regulations.**

If authorization is granted, typically 3-7 days/sessions are approved, and further authorization for treatment requires the treatment provider to telephone or otherwise communicate with the CM for a Continuing Care UR request several days/sessions before the last authorization has been used up. The corollary question for the provider to address during a Continuing Care UR request is: “What in the patient’s current clinical symptoms, symptom history, and/or prior treatment necessitate the requested continued medication(s) or continued level of care treatment services for the requested number of sessions?” If the provider’s answer to this question is challenged, s/he should immediately be prepared to answer a second question: “Why will an alternative medication, lower level of care, and/or less number of sessions be ineffective for this patient at this time?”

**It is prudent for a provider not to request authorization for a patient’s entire anticipated length of stay during the first UR call.** One reason is that a patient’s symptoms and condition likely will change during the course of treatment, and it cannot be accurately predicted at the onset of the treatment episode what the appropriate length of stay should be. Generic treatment plans (e.g., every CD patient needs a 30-day residential stay, 18 Partial Hospitalization sessions, or 24 Intensive Outpatient Treatment sessions) harken back to an earlier treatment era that was not evidence-based, perhaps unnecessary, or provided inefficiently, and may undermine the provider’s clinical integrity in the eyes of managed care.

**Denials**

**Only an MCO Medical Director (MD) -- and never an MCO Case Manager (CM) -- is allowed by state laws to deny a request for treatment.** A provider may come away from a utilization review telephone exchange, having talked to a CM, with the impression that the CM has denied his/her request for authorization of treatment. In fact, this perception is a common occurrence and many providers close the conversation prematurely, incorrectly convinced their treatment request is denied and the matter is ended. Specifically, a CM may tell a provider that the treatment requested is “not authorized.” “Not authorized” is technically, and legally, by state regulatory standards, not the same as “denial.” The CM’s statement is not an official denial because s/he does not have that authority. The CM may not explain this distinction to the provider, and thus may also not explain next steps that may generate a treatment authorization.

If a provider, in conversation with a CM, is told that his/her treatment request is not authorized, the provider should immediately request the specific reason(s) and then
address the reason(s) with further pertinent clinical data. **If the added information does not result in a treatment authorization, the provider should next immediately request a Peer-to-Peer Review with an MCO Medical Director and make his/her case again.** A Peer-to-Peer Review must be scheduled by the MCO within 24-hours of the request, and also occur within that time period, unless the provider requests a delay. If not, an authorization for up to a few days until the Peer-to-Peer Review can occur must be granted.²

In Peer-to-Peer Reviews, as well as in Utilization Reviews with CMs, a respectful and collegial tone is recommended. Becoming adversarial may lead to a denial simply because the MCO MD may not be provided with the patient-specific clinical information that satisfies medical necessity guidelines. An assertive approach—rather than an aggressive approach or a submissive/defeatist “hat in hand” approach—is preferable. Both of the latter tones, again, may result in a denial that need not have occurred.

**MCOs are highly regulated by each state. It may be surprising to learn that denial rates are between 2% - 4%. MCO Medical Directors attempt to avoid denials.**

**Providers should not weaken or reduce their treatment plans during a Utilization Review or Peer-to-Peer Review.** Bargaining and accepting less of a treatment authorization, such as a lower level of care and/or for fewer sessions, or a different medication than requested, may cause loss of the provider’s clinical credibility in the eyes of the MCO reviewer, and this can make future reviews suspect and more difficult.

There is an exception to this premise, however. A provider may decide a compromise is acceptable (e.g., 10 authorized sessions of IOP out of 18 requested). In this case, the provider may suggest to the patient that s/he self-pay for the sessions not authorized. The provider should verify beforehand with the MCO that there is no prohibition against the practice of a patient switching to self-pay for further treatment after an insurance denial. Most MCOs allow this practice, and patients are often grateful that a portion of their treatment cost is covered by insurance.

**Providers are discouraged from accepting a ‘pended’ treatment authorization request.** These occur when a CM or MCO MD neither authorizes nor denies (remember: only MCO MDs, but not CMs, can deny) but instead ‘pends’ a treatment request. The provider is invited to send in patient chart clinical information during or after the completion of treatment, at which time the treatment is authorized or denied. This is tempting to agree to, as it quickly ends what can be a challenging telephone call and is not an actual denial, at least not then. However, with the “heat off,” the likelihood of a denial may significantly increase. Also, negotiating with a patient to self-pay after the treatment has been provided and then denied for payment could be considered unethical, and should be discouraged. The patient may feel that the provider did not pursue his/her insurance authorization properly, and the therapeutic relationship with the patient may be jeopardized.

² Most states require that an MCO make available a Peer-to-Peer Review within 24 hours after a request by a provider. State regulations vary in this regard.
Appeals

*If the treatment request is denied by the MCO MD, the provider should undertake an appeal as quickly as possible.* It is important for a provider to understand and follow appeal options regarding his/her patient's specific insurance benefit and state regulations. The appeal steps are best explained to the provider by a CM or an MCO MD (after a Peer-to-Peer Review resulted in a denial). MCOs are typically obligated to offer one to three levels of appeal. To be blunt: if the MCO MD issues a denial, it is a common perception that the UR “request for authorization” process is over and the matter is ended—but this is not the case.

*Appeal letters and supporting patient chart documentation should justify the original treatment request and should speak to the MCO’s specific level of care medical necessity guideline.* When the requesting provider is convinced that the severity of illness (SI) justifies the proposed intensity of service (IS), the provider should firmly continue to make the case for the denial to be overturned and for the original treatment request to be authorized. Successful appeal letters tend to be focused, detailed, and lengthy. The letter format may be a series of paragraphs, each one beginning with the assertion that a different required medical necessity criterion is met (the specific medical necessity criterion is often quoted *verbatim* from published MCO level of care guidelines for the level of care requested). The remainder of the paragraph verifies the provider’s assertion(s) by noting specific patient symptoms, reinforced by specific patient quotes (e.g., “Patient continues to meet medical necessity guidelines for opioid detox level of care July 15-17 due to moderate to severe withdrawal symptoms, verified by COWS scores of 38 on July 15th, 28 on July 16th, and 16 on July 17th. He was observed exhibiting goose-flesh skin, a heart rate of 110, muscle twitching, and multiple episodes of nausea and vomiting, and stated ‘I feel like I’m going to die. My cravings are really bad’ on July 17th.”).

As a final appeal and after exhausting all other appeals, many but not all states in the U.S. provide for an Independent Medical Review (IMR) separate and external from the MCO for non-ERISA³ benefit plans. The provider should inquire with the MCO to see if an external IMR is a possibility in the case he/she is pursuing. With an external IMR, the state Commissioner of Insurance Office or the Department of Insurance or Department

---

³ ERISA, the Employee Retirement Investment Security Act of 1974, pertains to an employer’s self-insured retirement and healthcare insurance employee benefit plans. As a Federal Act, ERISA regulation overrides individual state insurance regulation. Such self-insured plans, which have heretofore been exempt from state insurance laws, are called “ERISA-exempt health plans.” In this case, a patient who has an ERISA-exempt healthcare insurance plan, also termed an ASO (Administrative Services Only) healthcare plan, administered by an MCO, is not eligible for an external IMR, otherwise required by some states’ Departments of Insurance or Managed Care. As a final level of appeal, the ERISA insurance benefit patient is instead eligible for an internal IMR, conducted by an MCO MD who is different from and does not report to the original MCO MD who denied the treatment authorization request. If the authorization request is denied at this level, a patient may approach his/her employer directly and ask that the treatment be covered. Since it is the employer who is self-funding the healthcare benefit, the employer’s decision on this and all such matters is final.
of Managed Health Care contracts with physicians who specialize in mental health and/or addiction and are not affiliated with a managed care company to review the appeal. The cost of IMRs is borne by the insurance company.

Note that national statistics are that approximately 50% of denials are reversed on appeal. However, providers who use appeal letters to attack the MCO or ventilate frustration tend to detract from the merits of the treatment request; such an adversarial tone diminishes the chance for success.

**UR Time Compensation**

Regarding monetary compensation for the time providers spend in Utilization Review discussions with MCOs, in most cases, the treatment provider may notify a patient up-front that s/he will be charged for the time it takes to accomplish this task, just as a provider may charge for the time it takes to write a letter or complete a specific medical report the patient requests. However, it is important to first check with the patient’s MCO to verify if this is permissible. Some MCOs permit this patient charge, and some prohibit it; but in any event, charging the patient for this service without prior notification of your charging policies could be viewed as unethical. It is rare for an MCO itself to pay the provider for the time expended in Utilization Review telephone calls or writing appeal letters. In any case, it is not acceptable, and is considered by most observers to be insurance fraud, for a provider to charge for a longer treatment visit than is actually conducted and then use part of the visit for insurance authorization purposes.

Adopted by the ASAM Board of Directors March 2009.

© Copyright 2009, American Society of Addiction Medicine, Inc. All rights reserved. Permission to make digital or hard copies of this work for personal or classroom use is granted without fee provided that copies are not made or distributed for commercial, advertising or promotional purposes, and that copies bear this notice and the full citation on the first page. Republication, systematic reproduction, posting in electronic form on servers, redistribution to lists, or other uses of this material, require prior specific written permission or license from the Society. ASAM Public Policy Statements normally may be referenced in their entirety only, without editing or paraphrasing, and with proper attribution to the Society. Excerpting any statement for any purpose requires specific written permission from the Society. Public Policy statements of ASAM are revised on a regular basis; therefore, those wishing to utilize this document must ensure that it is the most current position of ASAM on the topic addressed.