MONTANA DPHHS Healthy People. Healthy Communities. Department of Public Health & Human Services	**BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES (BHDD) DIVISION** Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health
	Date effective: October 1, 2022 **Date revised:** October 1, 2022
Policy Number: *206a*	**Subject:** Auto-Authorization – Quality Assurance (QA)

(1) The department or the department's designee will review either 100% or a sample size, as determined below, of appropriate use of auto-authorization submitted by providers.

(2) Each provider will be scored for appropriate application of the medical necessity criteria for each of the acute services listed in Policy #206.

(3) The following scoring rubric will be utilized to determine a provider's readiness and continued use of the auto-authorization process:

Each request will be scored on a scale of 1-4 with consideration paid to timely filing, completeness of documentation, and selected medical necessity criteria being supported

- 1 = untimely, documentation not present, and medical necessity criteria is not supported; would have received request for additional information if manual review.
- 2 = timely, and/or documentation missing, and/or unclear if medical necessity criteria is supported; would have received request for additional information if manual review.
- 3 = timely, incomplete documentation, though medical necessity criteria is supported; would have received request for additional information if manual review.
- 4 = timely, and all documentation is present, and medical necessity criteria is supported; would NOT have received request for additional information if manual review.

(4) The department or the department's designee will run reports on a monthly basis for the preceding month on appropriateness of all auto-authorizations and assign the following ratings for providers:

- Green = 100% of auto-authorizations scored between a three or four.

The provider may continue auto-authorizations with no restrictions, if more than two months in a row of Green, then move to a sample size scoring rubric instead of 100% QA.

- Yellow = Less than 50% of auto-authorizations scored a one or two.

  The department or the department's designee will monitor for trends. If more than two months with a plateau or an increase in the percent of ratings with a one or a two, the provider may be moved to a red level.

- Red = More than 50% of auto-authorizations scored a one or two.

  The department or the department's designee will remove auto-authorizations for one month and the provider must return to a manual review. The provider can return to auto-authorizations after 30 consecutive days if less than 10% of manual authorizations have a need for Requests for Information.

If a provider must be moved to a manual review, the following requirements must be followed:

(1) The department or the department's designee may issue the prior authorization for as many days as deemed medically necessary up to the maximum number of days allowed as stated for each service requiring authorization. Authorization for less than the maximum days does not constitute a partial denial of services.

(2) The department or the department's designee must receive the complete prior authorization request within three (3) business days of admission.

(3) The clinical reviewer will complete the prior authorization review process within two (2) business days of receipt of complete information.

(4) The clinical reviewer will take one of the following actions:

  (a) request additional information as needed to complete the review; the provider must submit the requested information within five (5) business days of the request for additional information;

  (b) approve the prior authorization, as medically necessary up to maximum number of days allowed as stated for each service requiring authorization, that will result in a generated notification to all appropriate parties if the request meets the medical necessity criteria; or

  (c) defer the case to a board-certified physician for review and determination if the prior authorization request does not appear to meet the medical necessity criteria.

(5) The board-certified physician will complete the review and determination within three business days of receipt of the information from the clinical reviewer.