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: May 12, 2023
Policy Number: *215*	**Subject:** Utilization Review Determinations and Notifications

Upon completion of either the prior authorization or the continued stay review, one of the following determinations below will be applied.

Authorization

An authorization determination indicates that the utilization review resulted in approval of provider requested services or services units as deemed medically necessary up to the maximum number of allowed days as stated for each service. A determination of approval does not guarantee payment. Payment is subject to Medicaid eligibility, applicable benefit provisions, and all claim processing requirements at the time the service was rendered. All services are subject to retrospective review for appropriateness by the department or the department's designee.

Request for Information

A request for information indicates the clinical reviewer or physician has requested additional information from the provider.

Denial

When a request for authorization of payment does not meet the applicable criteria to justify Medicaid payment for the service requested, the request will be denied. A denial may be issued with additional days authorized for payment to allow for discharge planning. Adverse determinations may be appealed according to the reconsideration review process and/or administrative review/fair hearing process.

Technical Denial

When an adverse determination is based on procedural issues and not on medical necessity criteria, the result will be a technical denial. Technical denials can be overturned by the department only for the following reasons:

(1) There was a clinical reason why the request for prior authorization or continued authorization could not be made at the required time and the provider submitted a subsequent authorization request within ten business days; or

(2) A timely request for prior authorization or continued stay authorization was not possible because of an equipment failure or malfunction of the department or the department's designee that prevented the transmittal of the request at the required time and the provider submitted a subsequent authorization request within ten business days.

(3) Computing the time for any request provided for in this subchapter includes weekends and holidays. If a deadline falls on a weekend or holiday, the deadline is the next business day.

(4) If the department finds exceptional circumstances that reasonably justify a provider's failure to timely request prior authorization or continued authorization, it may extend the deadline for meeting the requirement.

If a technical denial is issued for submission of information outside the allowable timeframes, a provider may submit a new prior authorization request to the department or the department's designee. Requesting a new prior authorization after a technical denial does not waive the right to request an administrative review/fair hearing of the technical denial. A new prior authorization request may not be back dated (or granted retroactive to a date in a previous prior authorization request) and must provide sufficient clinical information to support an authorization.

Notification

Following a review process, the department or the department's designee will send a letter with the determination to the member, legal representative, or authorized representative and the provider, as appropriate. The letter will contain the rationale for the determination and provide appeal information if there is a right to a fair hearing.

Formal Notification

Formal notification is sent to member/legal representative/authorized representative and the provider, as appropriate.

(1) Notification for technical denials will include:

(a) dates of service that have been denied payment due to non-compliance with procedure;

(b) references to applicable regulations governing the review process;

(c) an explanation of the right, if any, to request an administrative review/fair hearing; and

(d) address and fax number of the BHDD to request an administrative review, if applicable.

(2) Notification for clinical denial determination will include:

(a) the date or dates of service that is denied payment because the service requested did not conform with professional standards, lacked medical necessity based on the criteria, or was provided in an inappropriate setting;

(b) case specific denial rationale;

(c) date of notice of the denial determination, which is the mailing date;

(d) an explanation of the right to request a reconsideration review, and/or an administrative review/fair hearing;

(e) address and fax number of the department or the department's designee to request a reconsideration review; and

(f) address and fax number of BHDD to request an administrative review.

(3) The member and/or the provider, as appropriate, has the right to request an appeal.