Policy and Procedure

Policy Name: Criteria for Utilization Review	**Policy#:** UM-101	**Version#:**
Author Department: Utilization Management	**Origination Date:** 9/15/2021	
Business Units Impacted: All lines of business for which COA performs Utilization Review.	**Date Last Reviewed:** 11/17/2023	
Products/LOBs: AMS	**Date Approved by CPT:** 1/24/2024	

DEFINITIONS:

Medically Necessary (RAE/Medicaid and CHP+) Those covered mental health or substance use disorder services which are determined under the applicable Utilization Management (UM) Program to be:

1. Will or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all
2. Is provided in accordance with generally accepted professional standards for health care in the United States
3. Is clinically appropriate in terms of type, frequency, extent, site, and duration
4. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider
5. Is delivered in the most appropriate setting(s) required by the client's condition
6. Is not experimental or investigational
7. Is not more costly than other equally effective treatment options

Medically Necessary (for EPSDT under Medicaid): A program, good, or service that:

1. Will or is reasonably expected to assist the client to achieve or maintain maximum functional capacity in performing one or more Activities of Daily Living
2. Is provided in accordance with generally accepted professional standards for health care in the United States
3. Is clinically appropriate in terms of type, frequency, extent, site, and duration
4. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider
5. Is delivered in the most appropriate setting(s) required by the client's condition
6. Provides a safe environment or situation for the child
7. Is not experimental or investigational
8. Is not more costly than other equally effective treatment options
   Please reference UM104 Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

Utilization Review (UR): A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, referrals, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. For the purposes of this policy and procedure, utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered

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experimental or investigational in a given circumstance, and reviews of a covered person's medical circumstances, when necessary, to determine if exclusion applies in a given situation. Please reference UM102 Utilization Review Determinations for more information about the utilization review process.

SCOPE:

PURPOSE:

STATEMENT OF POLICY: Colorado Access (COA) uses criteria for utilization review that is no more restrictive than that used in the regulatory, statutory, or contractual requirements relative to the product line under which utilization review is being completed. COA is responsible for covering services that address:

- The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability
- The ability for a member to achieve age-appropriate growth and development
- The ability for a member to attain, maintain, or regain functional capacity
- The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of their choice.

COA makes Utilization Review determinations based on professionally recognized written criteria or established guidelines and specifies the procedures to apply those criteria in an appropriate and consistent manner. COA utilizes nationally recognized clinical criteria and relevant community standards of care for utilization review:

1. COA first purchased InterQual criteria in 1998. COA has maintained annual licensure for InterQual criteria and uses these criteria for Utilization Review determinations for all lines of business. The InterQual criteria are reviewed annually by senior medical staff and when new updates are released between the annual reviews; staff are providing training as needed based on InterQual updates.
2. COA began using the American Society of Addiction Medicine (ASAM) criteria in January 2021 for all levels of care related to the treatment of substance use disorders (SUD).
3. If InterQual or ASAM does not have criteria for a service or level of care, Colorado Access applies the criteria listed in the definition above (see Procedure 3 below for more information). COA assures that all clinical decision-making criteria are consistent with the Clinical Practice and Preventative Health Guidelines reviewed and approved by the COA Clinical Oversight and Alignment Committee. Decision making criteria for the drug utilization review program are reviewed and approved by the COA Pharmacy and Therapeutics Committee in conjunction with the Pharmacy Benefit Manager (currently Navitus Health Solutions).COA ensures that any

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utilization management criteria or service limitations for mental health disorders and substance use disorders are no more restrictive than the predominant UM criteria or service limitations under the medical/surgical benefits for the same treatment classification. COA covers all medically necessary covered treatments for covered behavioral health (BH) diagnoses, regardless of any co-occurring conditions. COA ensures that a diagnosis of an intellectual or developmental disability, a neurological or neurocognitive disorder, or a traumatic brain injury does not preclude an individual from receiving a covered behavioral health service.

PROCEDURES:

1. Application of Criteria
   A. All clinical staff with decision-making authority are trained (at hire and ongoing) on InterQual and ASAM criteria (see UM100 Qualifications for Staff Engaged in UM Activities for more information about staff with decision making authority).
   B. Utilization review staff considers the individual needs of the member as well as the capacity and resources of the local delivery system when applying utilization review criteria.
   C. After available information is submitted to COA, Utilization Review staff conducts Utilization Review using adopted written criteria.
   D. If the information provided does not meet medical necessity criteria for the services being requested, the Utilization Review staff forwards the request to a physician for review. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested will be made by a physician who has appropriate clinical expertise in treating the member's condition or disease.
   E. COA assures that staff and physicians performing determinations of medical necessity are consistent in the application of criteria for decision making through annual (and ad hoc, if needed) inter-rater reliability assessments. Each staff member must pass the inter-rater reliability assessment with a score of 90% or higher.
2. Dissemination of the Criteria
   A. All Utilization Review criteria are available to members, potential members, and relevant providers upon request.
   B. New or revised criteria are published and disseminated in the applicable provider manuals and on the COA website.
   C. All adverse benefit determination notifications sent to members and providers include instructions on how to obtain a copy of the criteria used in the review.
3. Criteria Applied by Service Type: Colorado Access uses InterQual and ASAM criteria for each

service type/level of care available (relevant to the services that require prior authorization). If no InterQual or ASAM criteria are available, Colorado Access applies the general medical necessity definition established by this policy in the definitions above. The following table lists the services that currently require prior authorization and the criteria that are applied to each type of review. If a service does not have InterQual or ASAM listed, then no InterQual or ASAM criteria are available for use.

Behavioral Health Service Types			
Level of Care	**InterQual Criteria**	**Statutory definitions of medical necessity**	**ASAM Criteria**
Inpatient Hospitalization		X	
Acute Treatment Unit (non-hospital)		X	
Day Treatment		X	
Partial Hospitalization		X	
Long-term Residential Services		X	
Short-term Residential Services		X	
Mental Health Intensive Outpatient Services		X	
Psychological Testing	X	X	
SUD Inpatient – Withdrawal Management (ASAM 3.7WM)		X	X
SUD Inpatient treatment (ASAM 3.7)		X	X
SUD Residential treatment (ASAM 3.5)		X	X
SUD Residential treatment (ASAM 3.3)		X	X
SUD Residential treatment (ASAM 3.1)		X	X
SUD Intensive Outpatient treatment (ASAM 2.1)		X	X

Physical Health Service Types			
Level of Care	**InterQual Criteria**	**Statutory definitions of medical necessity**	**ASAM Criteria**
Inpatient Hospitalization	X	X	
NICU	X	X	
Inpatient Rehabilitation	X	X	
Inpatient Transplant	X	X	
Outpatient Facility Procedures	X	X	
Durable Medical Equipment		X	

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Physical Health Service Types			
Level of Care	**InterQual Criteria**	**Statutory definitions of medical necessity**	**ASAM Criteria**
Early intervention Rehabilitation		X	
Home Health – Nursing		X	
Home Health – Occupational Therapy		X	
Home Health – Physical Therapy		X	
Home Health – Speech Therapy		X	
Outpatient Rehabilitation		X	
Outpatient infusions/injections		X	

REFERENCES:
UM100 Qualifications for Staff Engaged in Utilization Management Activities UM102 Utilization Review Determinations

ATTACHMENTS:
N/A

POLICY HISTORY:

SUMMARY OF REVIEW/REVISION/APPROVAL DATES:
(Dates in parentheses include review but no revisions)

APPROVAL BODY: COA Core Policy Team **APPROVAL DATE:** 1/24/2024