Policy and Procedure

Policy Name: Utilization Review Determinations	**Policy#:** UM-102	**Version#:** 7
Author Department: Utilization Management	**Origination Date:** 7/15/2022	
Business Units Impacted: Utilization Management	**Date Last Reviewed:** 10/23/2025	
Products/LOBs: CHP+ HMO, RAE	**Date Approved by CPT:** 10/23/2025	

DEFINITIONS

Adverse Benefit Determination: Is any of the following:

- The denial or limited authorization of a requested service, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit
- The reduction, suspension or termination of a previously authorized service
- The denial, in whole or part, of payment for a service
- Failure to provide services in a timely manner as defined by the State
- The failure to act within the timeframes defined by the State for the resolution of grievances and appeals
- The denial of a member's request to dispute a member financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other)

Appeal: Is a request for review of an Adverse Benefit Determination.

Concurrent Review Utilization review (UR) process that is conducted while a treatment or services is still ongoing, such as the review of inpatient and outpatient episodes of care, to determine if services and/or treatments are medically appropriate, occur in the appropriate setting, and are being administered by appropriate providers. Concurrent Review determinations are based solely on the medical information obtained at the time of the review. The frequency of reviews is based on the severity or complexity of the patient's condition or on the necessary treatment and discharge planning activity regardless of the clinical setting.

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

- 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
- Is provided in accordance with generally accepted professional standards for health care in the United States
- Is clinically appropriate in terms of type, frequency, extent, site, and duration
- Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider
- Is delivered in the most appropriate setting(s) required by the client's condition
- Is not experimental or investigational
- Is not more costly than other equally effective treatment options

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

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- 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
- Assists the member to achieve or maintain maximum functional capacity.
- Is provided in accordance with generally accepted professional standards for health care in the United States
- Is clinically appropriate in terms of type, frequency, extent, site, and duration
- Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider
- Is delivered in the most appropriate setting(s) required by the client's condition
- Provides a safe environment or situation for the child
- Is not experimental or investigational
- Is not more costly than other equally effective treatment options

*Please reference UM104 Early and Periodic Screening, Diagnostic and Treatment

Prospective Review Utilization Review process that is conducted prior to a scheduled admission or course of treatment or service. Prospective Review is necessary for the pre- authorization of healthcare services to determine if services or treatments are Medically Necessary, planned in the appropriate setting and will be provided by participating providers, whenever possible. Prospective Review determinations are based solely on the medical information obtained at the time of the review. For the purposes of NCQA, this is referred to as a Preservice request.
Retrospective Review Utilization Review process that is after the completion of a course of treatment or service. Retrospective Review is necessary to determine if services or treatments are Medically Necessary, planned in the appropriate setting and were provided by participating providers, whenever possible. Retrospective Review determinations are based solely on the medical information obtained at the time of the review.
State Fair Hearing Is the formal adjudication process for appeals described in the CCR 2505-10, Rule §8.057.3.
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, 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 experimental or investigational in a given circumstance, and reviews of a member's medical circumstances when necessary to determine if an exclusion applies in a given situation.

SCOPE:
This policy addresses the utilization review processes conducted by Colorado Access (COA or organization) to evaluate the medical necessity of healthcare services provided to Medicaid and CHP+ members and procedures for prospective/concurrent/retrospective reviews and adverse

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benefit determinations.

PURPOSE:

To ensure timely, appropriate, and standardized medical necessity determinations of healthcare services covered by COA under the utilization review process, facilitate member access to necessary care, and establish clear procedures for notifying members and providers of adverse benefit determinations.

STATEMENT OF POLICY:

COA will maintain processes for Utilization Review determinations that assures appropriate and timely determination and notification of authorizations and denials. When conducting Utilization Review, COA:

- Accepts information from any reasonable source that will assist in the review process;
- Collects only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;
- Requires only the section(s) of the medical record necessary in that specific case to determine whether Medical Necessity or appropriateness of the admit or extension of stay, frequency or duration of service; COA does not routinely request copies of all medical records on all patients reviewed – additional medical records will only be requested when there is difficulty in making a review determination;
- Offers the opportunity for a peer review if authorization is not issued after the initial clinical review and notifies providers of the peer review procedures through publication on the website. Please reference UM105 Peer Review Process.
- Administers a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from enrollees or providers; and
- Does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition to the member.
- Ensures that the 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.

COA may place appropriate limits on services under the following conditions:

1. On the basis of medical necessity criteria applied under the applicable state plan
2. For the purposes of utilization control, provided that the services furnished can reasonably achieve their purpose.
3. Family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used.
4. COA may only apply a Non-Quantitative Treatment Limitation (NQTL) for mental health or substance use disorder benefits, in any classification, in a manner comparable to, and no more stringently than, the processes, strategies, evidentiary standards, or other factors

applied to the same NQTL in the same benefit classification of the members' medical/surgical benefits.

PROCEDURES:

1. **Authorization Administrative Review**:
   A. Requests for authorization of service may be received by phone, fax, or mail.
   B. Member eligibility is verified by UR staff prior to clinical review. If a member is found to be ineligible, this information is communicated to the requestor directly and is not considered to be an adverse benefit determination.
   C. Provider contract status is verified by an intake coordinator prior to clinical review.
   D. If COA has no participating providers or there exists a need beyond the scope of participating specialty services, UM staff will work with the primary care provider or behavioral health provider to arrange for a referral to a provider with the necessary expertise to ensure that the member has access to the covered benefit.
   E. UR staff will coordinate services with other available payer sources when appropriate.
2. **Medical Necessity Criteria:** UR staff will apply the established criteria or guideline available and consider the individual needs of the member during the review. If no written criteria or guideline is available, the request will be forwarded to a physician reviewer for determination as described in COA policy and procedure UM101 Criteria for Utilization Review.
   A. UR Staff may consult with a COA Medical Director at any point during the review process.
   B. If the UR staff determines that the request for service(s) meets established criteria or guideline, the request will be authorized accordingly.
   C. If the UR staff is unable to determine if the requested service(s) meets the established criteria or guideline, the request will be forwarded to the physician reviewer for determination.
   D. If the request requires mandatory physician review, the request will be forwarded to the physician reviewer for determination. COA physician reviewers will consult with the requesting provider when appropriate.
   E. All information used to make an Adverse Benefit Determination and associated notices will be maintained in COA's transaction system and retained in the member's record for ten
   F. (10) years (see policy and procedure CMP210 Record Retention and Destruction).
3. **Out of Network (OON) Requests:**
   A. Requests for covered services from providers not contracted with COA (i.e. OON requests) are not considered medically necessary unless:
      1. COA is unable to provide for the covered service through its contracted Provider network OR

2. The requested service is an emergency service and the member's well-being is at risk if the covered service is not delivered by the OON provider.

4. Prospective/Preservice Review Request, Determination, and Notification (Standard/Nonurgent Request) for nonbehavioral, behavioral, and pharmacy healthcare services

A. When a request for Prospective Review (standard request) fails to meet COA review request procedures, a written notice will be sent to the member and provider with the reason for the failure and the proper procedures as soon as possible and no later than five (5) calendar days following the date of the original request. Prospective Review determinations will be made within a reasonable period of time appropriate to the member's medical condition, no later than seven (7) calendar days after receipt of the request for services. A written notification to the provider and/or facility will be faxed which includes a reference number. Upon request of the patient, a written notification can also be mailed.

B. For Medicaid/CHP+ pharmaceutical nonurgent preservice requests, the organization gives electronic or written notification of the decision to members and practitioners within twenty-four (24) hours of receipt of the request.

C. If the review determination is adverse to the member, COA will send notification to the member as required by state law, rule and regulations and with the elements contained in this policy and procedure (please reference Section 7 below).

D. In the case of a determination to authorize or deny a service, UR staff will notify the provider in the case of an approval, and the member and the provider in the case of a denial of the determination within a reasonable period of time appropriate to the member's medical condition, no later than ~~ten (10)~~ seven (7) calendar days after receipt of the request for services.

E. If an Adverse Benefit Determination occurs during a member's hospital stay or course of treatment, the service will continue without liability to the member until COA notifies the member of the determination.

F. Extension of prospective review period:

1. The time period for making a determination may be extended one (1) time for up to fourteen (14) calendar days. Extensions will be utilized if the member or provider requests an extension, or COA justifies a need for additional information. The extension must be in the member's best interested in order to be granted.

2. COA will justify to the Department (upon request) a need for additional information and how the extension is in the member's interest.

3. COA will send a written Notice of Extension to the member within the first ~~ten (10)~~ seven (7) calendar days from the date the initial request was received. COA will include

in the Notice of Extension the reasons for the delay and the expected date of determination. The Notice of Extension will inform the member of the right to file a Grievance with COA if he or she disagrees with the decision to extend.

4. If an extension is necessary due to the failure of the member to submit necessary information in order to reach a determination, COA will inform the member through the Notice of Extension of the needed information and a fourteen (14) calendar day deadline for the information to be submitted.

5. Prospective/Preservice Expedited/Urgent Review Request, Determination, and Notification for nonbehavioral, behavioral, and pharmacy healthcare services

A. If the provider indicates (or COA determines) that standard prospective timeframes could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, COA will review the request within a reasonable period of time appropriate to the member's medical condition, no later than seventy-two (72) hours after receipt of the request for services.

B. Requests for residential treatment for substance use disorder treatment are considered prospective Expedited reviews and will be reviewed within seventy-two (72) hours. Request for residential substance use disorder treatment for pregnant or postpartum members will be reviewed within twenty-four (24) hours.

C. For Medicaid/CHP+ pharmaceutical urgent preservice requests, the organization gives electronic or written notification of the decision to members and practitioners within twenty-four (24) hours of receipt of the request.

D. If the review determination is adverse to the member, COA will send a notification to the member as required by state law and rules and regulations and with the elements contained in this policy and procedure (please reference Section 7 below).

E. Extension of the prospective expedited review period:

1. The time period for making a determination may be extended one (1) time for up to fourteen (14) calendar days. Extensions will be utilized if the member or provider requests an extension or COA justifies a need for additional information. The extension must be in the member's best interested in order to be granted.

2. COA will send a written Notice of Extension to the member within the first ~~ten (10)~~ seven (7) calendar days from the date the initial request was received. COA will include in the Notice of Extension the reasons for the delay and the expected date of determination. The Notice of Extension will inform the member of the right to file a Grievance with COA if he or she disagrees with the decision to extend.

3. If an extension is necessary due to the failure of the member to submit necessary information in order to reach a determination, COA will inform the member through the Notice of Extension of the needed information and a fourteen (14) calendar day deadline

for the information to be submitted.

4. COA will justify to the Department (upon request) a need for additional information and how the extension is in the member's interest.

6. Concurrent Expedited/Urgent Review Request, Determination and Notification for nonbehavioral, behavioral, and pharmacy healthcare services

A. Concurrent Review urgent care requests to extend the course of treatment beyond the initial period of time or the number of treatments must be submitted seventy-two (72) hours prior to the expiration date of the original authorization.

B. Concurrent Review urgent care determinations will be made as soon as possible taking into account the member's medical condition and no later than seventy-two (72) hours following the receipt of the request.

C. For Medicaid/CHP+ pharmaceutical urgent concurrent requests, the organization gives electronic or written notification of the decision to members and practitioners within twenty-four (24) hours of receipt of the request.

D. A written confirmation of continued certification is faxed to the facility and includes the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services.

E. If the review determination is adverse to the member, COA will send a notification to the member as required by state law and rules and regulations and with the elements contained in this policy and procedure (please reference Section 7 below).

7. Retrospective/Postservice Review Requests, Determination, and Notification for nonbehavioral, behavioral, and pharmacy healthcare services

A. Retrospective Review Determinations will occur within a reasonable period of time and no later than thirty (30) calendar days after the date of receiving the review request.

B. Retrospective Review requests must be submitted to COA within ninety (90) calendar days of the admission or start date of treatment.

C. The time period for making a Retrospective Review determination begins on the date the request is received by COA regardless if all the information necessary to make the determination accompanies the request.

D. If the determination is adverse to the member, COA will send notification to the member and the member's provider as required by state law and rules and regulation and with the elements contained in this policy and procedure (please reference Section 7 below).

E. Extension of retrospective review period

1. COA may extend the time period for making a determination and notifying the member and provider one time for up to fourteen (14) calendar days, provided the extension is

necessary due to extenuating circumstances beyond COA's control and it notifies the member prior to the expiration of the initial 30-day time period, of the circumstances requiring the extension of time and the date by which it expects to make a determination.

2. With an extension, the time period for making a determination starts on the date when COA sends the notice of extension to the member or the date when the member submits necessary information or the due date when the specified information was to be sent in, whichever is earlier.
3. COA will send a written notice of extension to the member and the provider within the first thirty (30) calendar days from the date the initial request was received. COA will include in the Notice of Extension the reasons for the delay and the expected date of determination. The notice of extension also informs the member of the right to file a Grievance with COA if they are not in agreement with the extension.
4. If an extension is necessary due to the failure of the member to submit necessary information in order to reach a determination, COA will inform the member through the Notice of Extension of the information necessary to complete the request and provide a thirty (30) calendar day deadline from the date of receipt of the notice for the information to be submitted. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline shall be extended to the next business day.

8. Adverse Benefit Determinations.

A. Written notification will be sent to the member and provider when COA makes an Adverse Benefit Determination. A Notice of Adverse Benefit Determinations will be mailed within the following timeframes:

1. For standard prospective service authorization decisions, no later than seven (7) calendar days after the receipt of the request for service.
2. For expedited service authorization decisions, no later than 72 hours after receipt of the request for service. For expedited service authorization decisions for pregnant and postpartum members seeking residential substance use disorder treatment, no later than 24 hours after receipt of the request for service.
3. For extended service authorization decisions, no later than the date the extension expires.
4. For service authorization decisions not reached within the required timeframes, no later than the date the time frame expires.
5. For denial of payment, at the time of any denial affecting the claim.

B. As standard practice, COA does not reduce, suspend, or terminate previously authorized services. On the rare occasion that this type of adverse benefit determination would occur, COA will give notice at least ~~10~~ seven (7) calendar days before the intended effective date

of the proposed adverse benefit determination unless one of the following exceptions are met:

1. Notice may be mailed no later than the date of the adverse benefit determination if:
    i. COA has factual information confirming the death of the member;
    ii. COA receives a clear written statement signed by the member stating that: he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this is the result of supplying the information;
    iii. The member has been admitted to an institution where he/she is ineligible under the plan for further services;
    iv. The member's address is determined unknown and the post office or mail carrier returns COA mail directed to the member indicating no forwarding address;
    v. COA establishes that the member has been accepted for services by another local jurisdiction, state, territory, or commonwealth;
    vi. A change in the level of medical care is prescribed by the member's physician; or
    vii. The notice involves an action made with regard to the preadmission screening requirements of 1919(e)(7) of the Social Security Act.
    viii. The transfer for discharge from a facility will occur in an expedited fashion.
2. If COA has verified probable member fraud, COA will provide notice five (5) calendar days before the effective date of the proposed adverse benefit determination.

C. Adverse Benefit Determination notifications will be written (paper or electronically) for members and in written or oral form for providers in an easily understood manner to include the following:
    1. The specific action COA has taken or intends to take;
    2. The reasons for the Adverse Benefit Determination, including an explanation of the specific medical basis for an Adverse Benefit Determination;
    3. Reference to the specific plan provision on which the determination was based;
    4. Description of any additional material or information necessary for the member to complete the benefit request, including the reason why the material or information is needed;
    5. The member's right (or member's designated representative) to request reasonable access to and copies of all documents and records relevant to the adverse benefit determination;
    6. A statement referencing the specific rule, clinical guideline, protocol, or similar criterion used to make the determination, and/or the scientific or clinical judgment for making the determination for cases where service was denied based on medical necessity, experimental or investigation

treatment or similar exclusions, along with instructions that these materials or further explanations will be provided to the member free of charge upon request and how to request them. Upon request from the member, attending physician or other ordering provider or facility rendering service for clinical criteria, the request will be forwarded to a Manager of Utilization Management.

7. For mental health, behavioral health, or substance use disorder benefits, the Notice of Adverse Benefit Determination will also include a statement explaining that members are protected under the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which providers that limitations placed on access to mental health and substance use disorder benefits may be no greater than any limitations placed on access to medical and surgical benefits. The statement also includes information about contacting the office of the ombudsman for behavioral health care if the member believes his or her rights under MHPAEA have been violated;
8. The member's right to appeal under the Child Mental Health Treatment Act (CMHTA), when applicable;
9. For substance use disorder treatment, information about how each dimension of the most recent edition of the American Society of Addiction Medicine (ASAM) criteria that was considered when determining medical necessity for any adverse determination.
10. The member's and the provider's right to file an Appeal on behalf of the member and the procedures for filing an Appeal, including the telephone number(s) of the department responsible for handling Appeals, who may be contacted for additional information;
11. The date the Appeal is due;
12. The circumstances under which expedited resolution is available and how to request it;
13. The member's right to request a State Fair Hearing and the procedures for exercising the right to a State Fair Hearing, and the availability of assistance in the filing process;
14. Written assurance that the filing of an Appeal will not result in a loss of Medicaid or Child Health Plan Plus coverage and will not subject the member to retaliation;
15. For Medicaid members, the member's right to have benefits continue, when certain criteria are met, if the member files an Appeal or a request for State Fair Hearing within the timeframes specified for filing and pending resolution of the Appeal, and how to request that benefits be continued;
16. The name, date, signature, and credentials of the physician issuing an Adverse Benefit Determination.

D. The Notice of Adverse Benefit Determinations will be written in language easy to understand, available in State-established prevalent non-English languages in the region (English and Spanish), and available for translation in non-prevalent languages by request. Alternative formats (e.g., large print, Braille, audio recording) are also available upon request.

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E. Appealing Adverse Benefit Determinations. COA has established a process for providers and/or members to appeal Adverse Benefit Determinations. See UM106 Member Appeal Process.

F. Monitoring Compliance. A random sample of Adverse Benefit Determinations will be audited periodically for compliance and potential improvement opportunities.

G. Patient Safety. To improve patient safety and reduce medical errors, UM staff are also responsible for identifying potential or known patient safety issues. If a potential safety concern is identified during Utilization Review, the UM staff will complete the referral form for a Quality of Care concern according to the Quality of Care Concern Policy.

REFERENCES:
ADM203 Member Grievance Process
UM101 Criteria for Utilization Review
UM103 Emergency and Post-Stabilization Care
UM104 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
UM106 Member Appeal Process
QM201 Quality of Care Concern Investigations

ATTACHMENTS:
None

POLICY HISTORY:

SUMMARY OF REVIEW/REVISION/APPROVAL DATES:
Version 1:09/15/21 Version 2:11/15/21 Version 3:11/01/22 Version 4:11/17/23 Version 5:01/24/24 Version 6: 11/21/2024, Version 7: 10/23/2025 Annual Review, NCQA updates.

APPROVAL BODY: COA Core Policy Team **APPROVAL DATE:** 10/23/2025