

**PUERTO RICO HEALTH INSURANCE ADMINISTRATION
GOVERNMENT HEALTH PLAN
COMPLIANCE AND CLINICAL AFFAIRS OFFICE**

**POLICIES AND PROCEDURES FOR HOSPITALS STAYS
REVIEW DETERMINATION AND APPEALS**

DECEMBER 2016

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SECTION I - TITLE

The following process will be known as: POLICIES AND PROCEDURES FOR REVIEW AND DETERMINATION OF HOSPITALS STAYS

SECTION II - LEGAL BASIS

The following Policies and Procedures have been adopted by the authority conferred to the Puerto Rico Health Insurance Administration ("PRHIA") by Act No. 72 of September 7th, 1993 as amended; and by Act No. 170 of August 12th, 1988 as amended, better known as the Commonwealth of Puerto Rico Uniform Administrative Procedures Act.

SECTION III - PURPOSE

These policies and procedures have been prepared for establishing a uniform, standardized, and objective Review and Determination process for inpatient stays among the Managed Care Organizations (MCO's) contracted by the PRHIA, any other Independent Utilization Review Organizations (IURO) subcontracted for such purposes, and the Hospital Providers contracted by the MCO's.

SECTION IV - INTRODUCTION

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Recognizing the impact and complexity of the inpatient stays review, determinations and appeals policies and processes on the hospitals and MCOs, ASES evaluated current procedures on each MCO and contracted provider's hospitals. Because of this assessment, ASES recognized the need to develop a uniform process allowing MCOs and hospitals to face a single approach.

The following sections includes the essential elements of this policy which are:

- **Section VI "Definitions"** - establishes the meaning of the key terms identified and used in the policies and procedures.


- **Section VII “General Rules”** - establishes the rules, policies and procedures that are required to be followed by the MCOs, the Hospital Providers, and the IURO throughout the procedures detailed in Section VIII.
- **Section VIII “Detailed Procedures”** – establishes the steps to be taken by each party involved in the process. The procedures begin with a flowchart that illustrates the steps to be taken by each key procedure.


SECTION V – EFFECTIVE DATE

This policy and procedures is effective for services rendered on or after January 1st 2017.

SECTION VI - DEFINITIONS

For these policies and procedures, the terms listed below shall have the following meaning:

1. **Adverse Determination:** When an organization, MCO or an Independent Utilization Review Organization, denies, reduces or terminates a benefit service, or does not pay a benefit service, partially or totally, based upon medical necessity.
2. **Affirmed Determination:** A decision made at a subsequent level of review upholding the previous decision on a case. 
3. **Appeal:** Provider's request to reconsider a decision in a case that the provider does not agree with the adverse determination
4. **ASES:** Administración de Seguros de Salud de Puerto Rico (Puerto Rico Health Insurance Administration, or “PRHIA”, by its English acronym), the entity in the Commonwealth responsible for the oversight and administration of the Government Health Plan Program, or its Agent.
5. **Attending physician:** physician responsible for the medical care of a patient, while he/she remains hospitalized.
6. **Concurrent Review:** is the clinical evaluation to assure medical necessity and treatment intensity while the patient is hospitalized prior to the discharge.
7. **Clinical Reviewer:** the clinician responsible to perform concurrent or retrospective reviews of an admission.

8. **Determination Notice:** official notification provided by the MCO, or its delegated entity, to the Hospital Provider with the decision on a case reviewed either approving or denying services or inpatient days.
9. **Medical Review File:** medical record, either paper or electronic, compiled to assess or validate the utilization review process and Medical Necessity determinations.
10. **Findings Notice:** written notification provided by the MCO clinical reviewers to the Hospital Provider's during the concurrent process, for which a final determination has not been made and may have an impact on final determinations.
11. **Grievance:** An expression of dissatisfaction about any matter other than an Action.
12. **Government Health Plan (GHP or PSG for its Spanish acronym):** The government healthcare services program (formerly referred to as "La Reforma" or "MI Salud") offered by the Commonwealth of Puerto Rico, and administered by ASES, which serves a mixed population of Medicaid Eligible, CHIP Eligible, and Other Eligible Persons, and emphasizes integrated delivery of physical and Behavioral Health Services.
13. **Independent Utilization Review Organization (IURO):** An external independent organization, not owned partially or totally by the MCO (including its owners and any of its subsidiaries), which can perform a decision related to medical necessity on a concurrent or retrospective review or during an appeal process. 
14. **Managed Care Organization or "MCO":** An entity that is organized for providing health care, licensed by the Puerto Rico Insurance Commissioner of ("PRICO"), which contracts with ASES for the provision of Covered Services and Benefits in designated Service Regions based on PMPM Payments, under the GHP program.
15. **MCO Medical Advisors:** MCO licensed physician available to be consulted by the Clinical Reviewer about any case concerning the clinical determinations that may be performed.
16. **Medical Guidelines (also called clinical guidelines, clinical protocol or clinical practice guideline):** refers to systematically developed recommendations for patient care, which are based on scientific research, data or evidence, and are used to guide health care decisions for a defined clinical condition or under specific circumstances. Reference standards of medical care

and criteria used to make decisions of medical necessity may be InterQual (McKesson), Milliman, Medicare National Coverage Determinations and other clinical guideline accepted by the general medical community.

17. Medical Necessity: medical need based on generally accepted medical practices specific to the medical or behavioral health condition of the Enrollee at the time of treatment, Medically Necessary Services are those that relate to (i) the prevention, diagnosis, and treatment of health impairments; (ii) the ability to achieve age-appropriate growth and development; or (iii) the ability to attain, maintain, or regain functional capacity (iv) appropriate level of care as per clinical condition. Additionally, Medically Necessary services must be:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible Enrollee's medical condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the Enrollee or the convenience of the provider or hospital; and
- Not primarily custodial care (for example, foster care).
- The services must fulfill the necessary intensity of treatment at the place where the medical service is provided
- For a service to be Medically Necessary, there must be no other effective and more conservative or substantially less costly treatment, service, or setting available.

18. Medical Policy: refers to an internal organization medical guideline developed based on general accepted medical practice, mandatory regulations or law and benefits coverage.

19. Revoked Determination: A decision made at a subsequent level of review reversing (totally or partially) a previous determination on a case.

20. Provider: Any hospital, licensed or otherwise authorized to provide physical or behavioral health services in the jurisdiction in which they are furnished.

21. **Utilization Management Coordinator (UM Coordinator)** (or Utilization Review Coordinator): The person appointed by the Hospital to conduct medical record review and coordinate related Utilization Management or Utilization Review activities.
22. **Utilization Management (or Utilization Review) Medical Director, or Hospital UM Medical Director:** The physician appointed by the Hospital as the chairman or director of the Utilization Management Program or Utilization Review Committee.
23. **Retrospective Review:** a process that involves evaluation and analysis for Medical Necessity and the appropriateness and timeliness of the delivery of medical care during the patient's stay in the hospital that takes place after the patient has been discharged.

SECTION VII - GENERAL RULES

This section establishes the rules and policies that are required to be followed by the MCOs, Providers, and IUROs throughout the procedures detailed in Section VIII. These rules have been divided based upon their applicability to each of the procedures to be executed.

Section 18 of Article VI of Act 72-1993, as amended, provides that any health care organization contracted by PRHIA (or its delegated entities) shall not deny proper authorization for hospitalization of a patient, including length of stay, payments for rendered treatment services, drugs and adequate provision of health services to such patient, when there is medical recommendation based on Medical Necessity for those purposes. The aforementioned statute will apply, if the provided services are included in the covered benefits by the GHP, the services are provided while the health policy is in full effect, and the patient is eligible for the GHP.

A. Medical Criteria Rules

Rules related to medical criteria are indicated below:

- a- Medical Criteria to be applied as reference for the evaluation should be accepted. It should consider the best practices for the established diagnosis. The reference standard needs to be included as part of the final determination.
- b- In all cases when other clinical circumstances exist, that may change the course of action, those circumstances need to be addressed and established. Medical necessity must respond to the acceptable medical criteria, considering

variances related to comorbidities, possible therapeutics restrictions or contraindications.

- c- The final responsibility for the patient treatment lies in the attending physician, who establishes the diagnosis, treatment and provides medical advice to the patient and family.
- d- The level of care needs to be consistent with the appropriate intensity of treatment required for the patient's condition at the lower cost possible.
- e- MCO's medical policies used shall be applied within the framework of GHP covered benefits.

B. Key Requirements

The following requirements are applicable to all the parties involved in the performance of Concurrent, Retrospective, and Appeal Utilization Review Determination procedures. Proper evidence of compliance must be retained by the MCOs and submitted to ASES when requested.

1. MCOs must educate its utilization review personnel and Hospital Facilities on clinical review criteria and due utilization review determination process. Evidence of this education must be kept in file and will be available for auditing by ASES.
2. The MCOs will have either a section within their Providers Manual or a separate Hospital Review Manual including the following information:
 - a. A detailed process documentation of the Concurrent, Retrospective and Appeal process, as approved by ASES. Including, but not limited to, process flowcharts, time frames, medical guidelines and medical criteria used for clinical determinations.
 - b. The mailing address or secured electronic mailing address where the Provider must send all its appeal requests.
 - c. The Provider's right to request and receive a copy of the criteria used in the evaluation of the request for appeal with all the relevant documents used for the determination.
 - d. The contact information: mailing address, telephone number, fax number, and email address of the MCO designated personnel for soliciting the first appeal and the IURO if a second appeal.

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- e. The specific means of communication (notification via e-mail, surface mail, the MCO's website, or a remittance advice) to duly notify any of the following findings or determinations made by the MCOs or IURO to the providers.
3. The MCOs must include in its policy that their hospital reviewers shall not receive any kind of incentive, bonus, or any additional benefit from the MCO or any other party based on the amount of denied or approved utilization determinations made during his or her job performance.
4. The MCOs must provide a quarterly report to ASES on all hospital days audited, total days approved for payment, total days denied, and the monetary amount that denied days represents.

C. Concurrent and Retrospective Review Policies and Rules:

1. The concurrent and retrospective review process may be performed by the MCO directly or thru a subcontracted Independent Utilization Review Organization (IURO), different from the ASES contracted IURO for Level 2 appeals. In those cases, in which the concurrent, retrospective review or a level 1 appeal process is performed by an IURO, the word *MCO* must be substituted by the word *IURO*.
2. The concurrent, retrospective, and appeal determination will be directed to the Hospital **Utilization Management (or Utilization Review) Medical Director** or its designated clinician representing the facility. TR2
3. MCO's review personnel must have a direct access to the MCO Medical Advisors or Coordinators to be consulted during any of the steps of the review process.
4. The MCO must establish reporting alerts on a quarterly basis and submit an explanation or applicable action to be implemented if utilization determination statistics change drastically (50%+- from the average baseline of the previous year) or continue to show increase in that average denial rate for two consecutive quarters. The reporting alerts and explanation or applicable action to be implemented must be submitted to ASES in the quarterly report.
5. The denial determination notification (Final Determination) must include:

- a. Beneficiary name
- b. Service date
- c. Admission diagnosis
- d. Final diagnosis
- e. Identification of attending physician,
- f. Specific reasons for denial. For example:
 - i The member has no eligibility under the GHP.
 - ii The service is not covered under the GHP benefits.
 - iii There is lack of evidence or information to support the medical necessity.
 - iv The services did not comply with the established clinical criteria for intensity of care at the assigned level of care.
 - v The services are not supported by the medical record documentation requirements such as a daily attending physician evaluation and assessment, and nurses required documentation, as per MCO's and Hospital Providers agreement.
 - vi Failure to submit timely requested information
 - vii Other (specify)
- g. The reasoning for the adverse determination, the medical criteria and the reference to the guidelines or protocol used as the determination basis.
- h. Provider appeal rights notification and procedures.

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SECTION VIII - DETAILED PROCEDURES

The following summarizes the minimum steps to be taken by the appropriate personnel designated by the MCO and IURO under contract. No changes, modifications, additions or deletions of the following procedures shall be made by either the MCO, the IURO or the Provider personnel. In those cases, in which the concurrent, retrospective review or a level 1 appeal process is performed by an IURO, the word *MCO* must be substituted by the word *IURO*

A. Concurrent Utilization Determination Procedures

The concurrent utilization determination process takes place when the beneficiary is being treated and has not been discharged by the Provider.

1. Concurrent Review Policies and Rules

- a At least 90 percent of the admissions identified by the hospital must be reviewed during the concurrent process, and remaining within five (5) days of the discharge. If not, the hospital will be allowed to bill for those services and the medical plan adjust according to the section B. (Retrospective Review Determination Policies and Rules).
- b Concurrent records must be made available to the MCOs Clinical Reviewer by the Hospital.
- c The MCOs shall report to ASES on a quarterly basis their concurrent review rate, approved and denied days and cost impact of denied days.
- d The Hospital is required to make the necessary arrangements to have the medical records (electronic or not electronic records) available for the review and case discussion.
- e The Findings Notice must detail the specific reasons for the potential denials of days, including the clinical criteria that were not met to support the approval of the recommended length of stay. 
- f The Hospital will have five (5) business days to present supporting evidence per the Findings Notice and coordinate the discussion of the denied services between the MCO and the Hospital **Utilization Management (or Utilization Review) Medical Director** or its designated person. After five (5) business days, if the hospital does not present the supporting evidence, the MCO's personnel will consider the Finding Notice as final and will terminate the review process for the evaluated period.
- g MCO shall perform a Final Determination within five (5) business days after receiving the supporting evidence or the case discussion whichever occurred latest.

2. Procedure

1. Notification of Inpatient Admissions:

- a. MCO's personnel must receive from the Hospital a daily patient admission census report.
- b. MCO's personnel must register the admissions in its system in less than twenty-four (24) hours from the date of admission.

2. Review Process:

- a. MCO's personnel shall validate the admission census received with the hospital admission census.
- b. MCO's personnel shall coordinate the availability of concurrent records with the UM Hospital Coordinator.
- c. The case will be reviewed periodically as necessary depending on the specific and individual circumstances. If the patient is discharged before the next scheduled review, the MCO reviewer will have up to five days after discharged notification to complete the final review notification. The Hospital will have additional five days for the case discussion and submission of supporting evidence.

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3. Findings Notice:

- a. MCO's personnel will proceed with the records evaluation and if any finding is identified, the MCO's personnel shall deliver a Findings Notice to the Hospital **Utilization Management (or Utilization Review) Medical Director** or Hospital **Utilization Management Coordinator** (or Utilization Review Coordinator, the same business day the record was reviewed.
- b. MCO's reviewers shall document on their system or file, the findings and notification details.
- c. Upon receipt of the Findings Notice, the UM Hospital Coordinator will review the record and provide the supporting evidence in response to the Findings Notice.

- d. A verbal discussion between MCO Medical Advisor and the Hospital Utilization Director on any adverse issue on the Findings Notice will be scheduled and held prior to pronounce a final determination by the MCO.

4. Adverse Determination Notice:

- a. After the verbal discussion between the MCO and the Hospital Utilization Directors is held, if the adverse determination is sustained, the MCO's personnel shall deliver the final Determination Notice to the Hospital Utilization Director on the same date the determination was made.
- b. Upon delivery of the Determination Notice, the MCO's personnel shall get the Hospital Utilization Director acknowledgment of receipt, and document the date of notice in the system or file.

5. Approval Determination Notice:

- a. For all approvals, the MCO's personnel shall deliver the approved determination notice to the UM Hospital Coordinator on the same determination date.
- b. Upon delivery of the Approval Determination Notice, the MCO's personnel must get the UM Hospital Coordinator acknowledgement of receipt, and document the date of notice in the system or file.

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B. Retrospective Review Determination Procedure

The retrospective process takes place when the utilization review begin after the beneficiary has been discharge from hospital.

1. Retrospective Review Policies and Rules

- a. No later than thirty (30) days from the discharged date, the Hospital shall notify the MCO's personnel of all the inpatient discharges to begin the retrospective review process. If the cases are not presented within the 30-day period, the MCO's personnel should close the admission with a total denial.

- b. No later than twenty (20) calendar days from the discharge notification to the MCO by the hospital, the MCO must provide the hospital a written determination.
- c. In case of an adverse determination, the MCO's reviewer must coordinate a verbal discussion with the Hospital Utilization Director (or his/her designated) within five (5) business days.
- d. The Hospital **Utilization Management Coordinator** (or Utilization Review Coordinator) will have another five (5) business days to present any supporting evidence per the Findings Notice. After five (5) business days, if hospital do not present the evidence requested, the MCO's personnel will consider the Findings Notice as final and will terminate the review process.
- e. MCO shall perform a Final Determination within five (5) business days after receiving the supporting evidence or the case discussion whichever occurred latest.

2. Procedure

a. Notification of Discharges:

- i The MCO's personnel receives the discharge report from hospital and registers its receipt date and information in its system or file.

b. Review Process:

- i The MCO personnel will identify from the discharge report, any case for which a concurrent review was not performed and will notify the hospital utilization coordinator the needs of a retrospective review.
- ii MCO's personnel coordinates the availability of the retrospective records with Hospital **Utilization Management Coordinator** (or Utilization Review Coordinator no later than 20 calendar days after hospital notification of the discharge date.

- iii MCO's personnel will assess the case to make the proper utilization determination in accordance with Medical Necessity criteria within 5 calendar days from the date the record is available.

c. Findings Notice:

- i After completing the record review the MCO reviewer will notify the Hospital Provider the findings identified. A Findings Notice will be completed the same business date the record review was ended. The MCO reviewer will document the date and persons notified on their system or file.
- ii A verbal discussion between MCO Medical Advisor and the Hospital Utilization Director on any adverse issue on the Findings Notice will be scheduled and held prior to pronounce a final determination by the MCO.

d. Adverse Determination Notice:

- i After the verbal discussion between the MCO and the Hospital Utilization Directors is held, if the adverse determination is sustained, the MCO's personnel shall deliver the final Determination Notice to the Hospital Utilization Director on the same date the determination was made. 12
- ii The MCO's personnel must get the acknowledgement of receipt of the Determination Notice from the Hospital Utilization Director, and document the date of notice in the system or file.

e. Approval Determination Notice:

- i For all approved utilization determinations, the MCO's personnel shall deliver the approved Determination Notice to the UM Hospital Coordinator on the same determination date.
- ii MCO's personnel shall get the approved Determination Notice acknowledgement of receipt from the Hospital **Utilization Management Coordinator** (or Utilization Review Coordinator), and document the date of notice in the system or file.


C. Appeal Process

A provider dissatisfied with an adverse concurrent or retrospective final determination may request an appeal of such determination. The Appeal Process requires an independent and objective approach in each of the two levels of the process, meaning that the case appealed must be evaluated by a licensed physician who was not involved in the initial evaluation of the concurrent or retrospective utilization adverse determination, nor has participated in any other prior level of the appeal process.

There are two levels of appeals. The first level is to be performed by the MCO. The second level will be performed by an IURO.


1. First Level Appeal

A. Policies and Rules

1. The Appeal Process must be requested by the Hospital Provider within forty-five (45) calendar days, following the date in which the Provider received the concurrent or retrospective final adverse determination. 
2. The request for an appeal of an Adverse Determination must include the patient's name, the contract number, date of service, place of service, complete copy of medical records and a written justification with any other relevant information that on provider's judgment may contribute to revert the adverse determination.
3. The MCO will assign a licensed physician to conduct a full evaluation of the submitted medical records and related information. He/she will evaluate the case using its medical criteria and the best practice guidelines or protocols.
4. A determination will be done and sent in written to the provider with a detailed explanation of the appeal determination. In case of an affirmed Adverse Determination (sustained adverse determination), the letter needs to include their right to initiate a second level appeal within an external utilization review organization (IURO's), within the next 30 days.
5. A decision to affirm an adverse determination may be based upon:
 - a Eligibility

- b Service not covered under the GHP benefits
- c Lack of evidence or information to support the medical necessity or the level of care.
- d The services did not comply with the established clinical criteria for intensity of care at the assign level of care.
- e The services are not supported by the medical record documentation requirements such as a daily attending physician evaluation and assessment, and nurses required documentation, as per MCO's and Hospital Providers agreement.
- f Failure to submit timely requested information
- g Other (specify)

B. Procedure

1. The Provider shall submit the Appeal Request Form electronically to the contracted MCO with an explanatory statement establishing the reasons to object the determination and any additional evidence related to the case.
2. The MCO's personnel inserts a receipt note in the Appeal Log System or File and the name of the Provider, brief description of the appealed determination, date of notification, date of receipt, and any other information provided and deemed necessary. 
3. The MCO's personnel will gather all in-house documents related to the determination under review and prepare an appeal file for the request. This file will be sent to the reviewer physician assigned.
4. The MCO shall assign the appeal to a licensed physician, who has not intervened in the previous review process and determination.
 - a. The physician should review and evaluate the case file and all the documents and evidence.
 - b. Any additional evidence deemed necessary must be requested to the provider allowing five (5) business days for its submission.
 - i. If the information is not received, the reviewer will reach a determination with the evidence at hand.
 - ii. An initial determination may be upheld based on "failure to submit information".
 - c. Prior to proceed with a determination, the reviewer physician should discuss the case by means of a telephone conference


- or a face to face meeting. After such discussion, a determination must be done within five calendar days.
- d. A Determination Letter will be sent by certified mail to the Hospital Provider.

5. In case of a sustained adverse determination, the notification must establish the hospital provider's right to request a second level appeal.
6. The Appeal Log System or File shall be updated based on the determination made. All related information must be kept in file.

2. Second Level Appeal – Independent Utilization Review Organization (IURO)

If the provider still doesn't agree with the first level appeal determination, they may submit a second appeal directed to the attention of the Independent Utilization Review Organization, as determined and contracted by ASES.


A. Policies and Rules

1. The provider must submit the appeal request within 30 days from the date of the first appeal determination. 
2. The MCO will provide to the IURO the complete appeal file from the first appeal level as well as all the available documented information existing in the MCO.
3. The IURO may ask for any other information to the MCO or the provider. Those supporting documents needs to be provided within ten (10) calendar days, following the date on which they were solicited.
4. The IURO personnel shall evaluate any new information presented by the Provider and MCO to decide on the case and shall document the rationale used as well as guidelines, policies, protocols or any other relevant information to justify the final determination.
5. The IURO's determination will be notified to the Provider and MCO by certified mail within thirty (30) calendar days from the moment the

appeal or any additional related requested information is received, whichever is later.

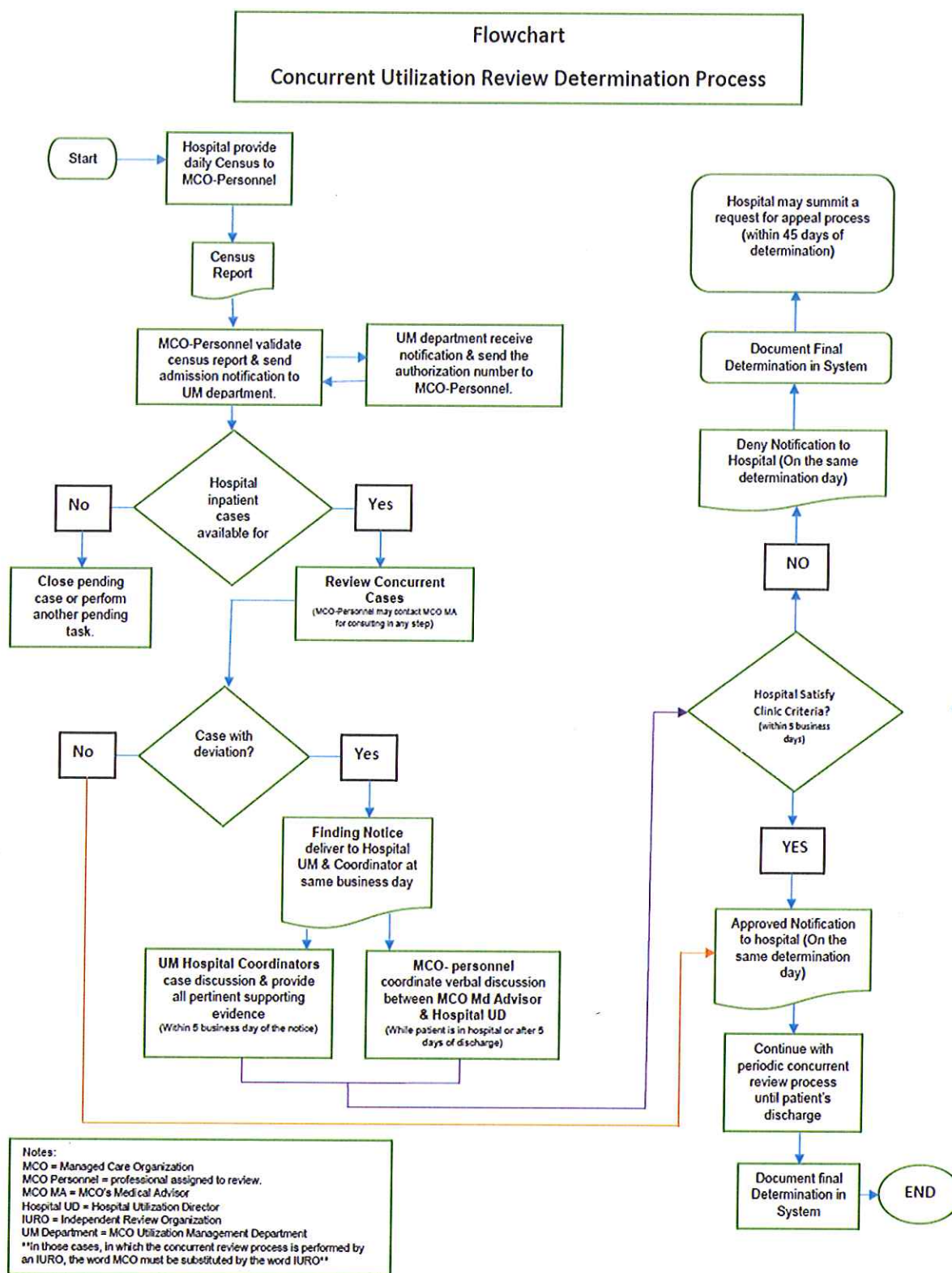
6. It will be discretionary to the IURO to use a Peer to Peer Review to resolve the discrepancy.

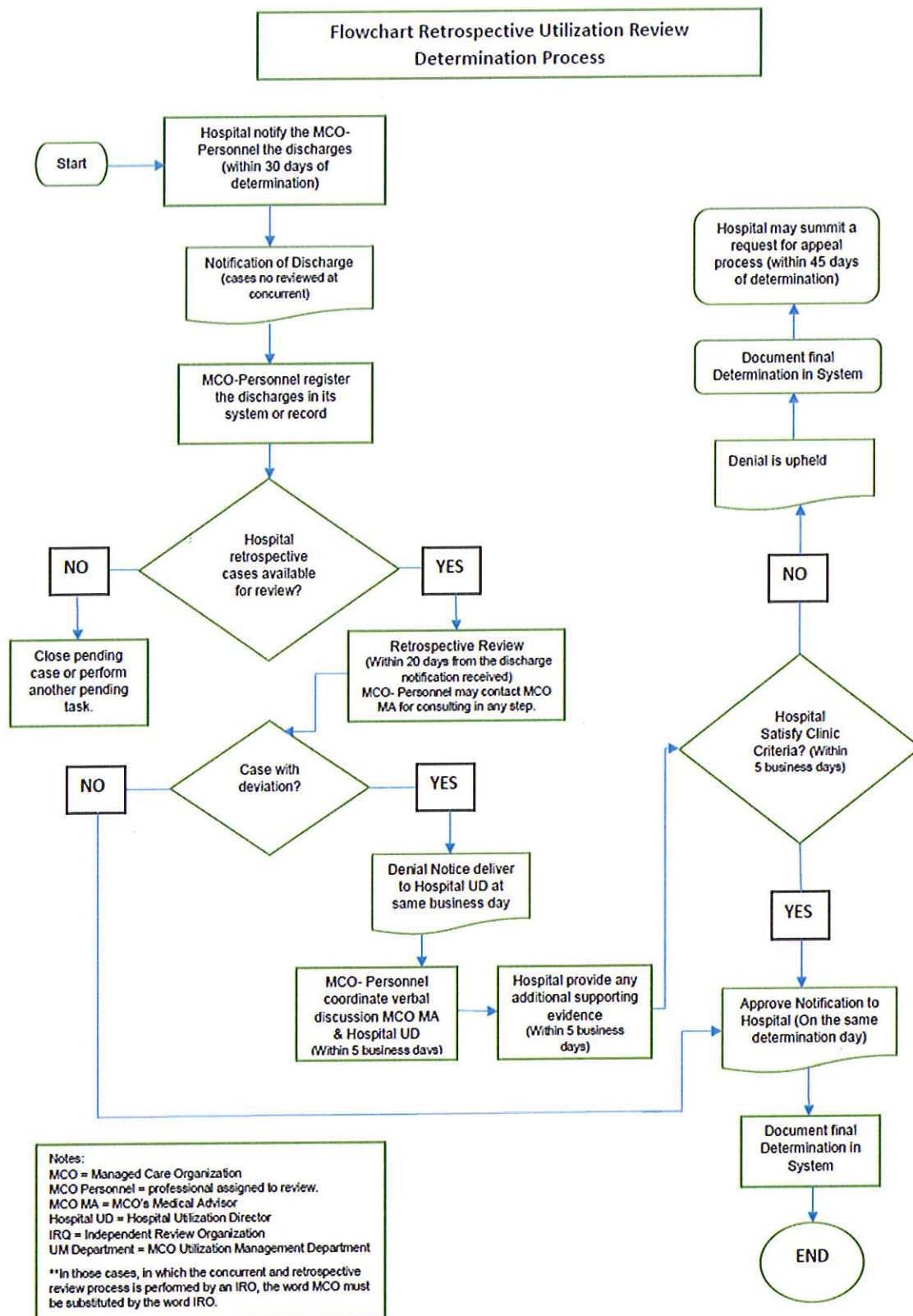
B. Procedure

1. If the Provider is not satisfied with the determination made on the first Level Appeal, he may request a review to the IURO by presenting the appropriate documentation and any other additional information to support the request. Copy of the request must be sent to the MCO.
2. Once received, the IURO personnel will insert a note in system or file including the date of the request for the Second Level Appeal, the name of the Provider, brief description of the determination to be appealed, date of notification, and any other information provided and deemed necessary. 
3. The IURO will request copy of the First Level Appeal file to the MCO allowing five (5) calendar days for its submission.
4. The IURO's designated personnel will refer the case to the assigned independent Reviewer Physician
 - a The physician should analyze the case file and all the documents and evidence and reach a determination within 30 days from the receipt date.
 - b Any additional evidence deemed necessary must be requested to the provider or MCO, as appropriate, allowing 5 days for its submission.
 - i If the information is not received, the reviewer will reach a determination with the evidence at hand.
 - ii An initial determination may be upheld based on "failure to submit information".
5. A Determination Letter will be sent by certified mail to the Hospital Provider and the MCO. The notification must include the rationale used as well as the clinical guidelines and references used for such determination. This notification will be available in the MCO appeal log.
6. In case of a reversed determination, the MCO must proceed with the proper adjudication of the services.

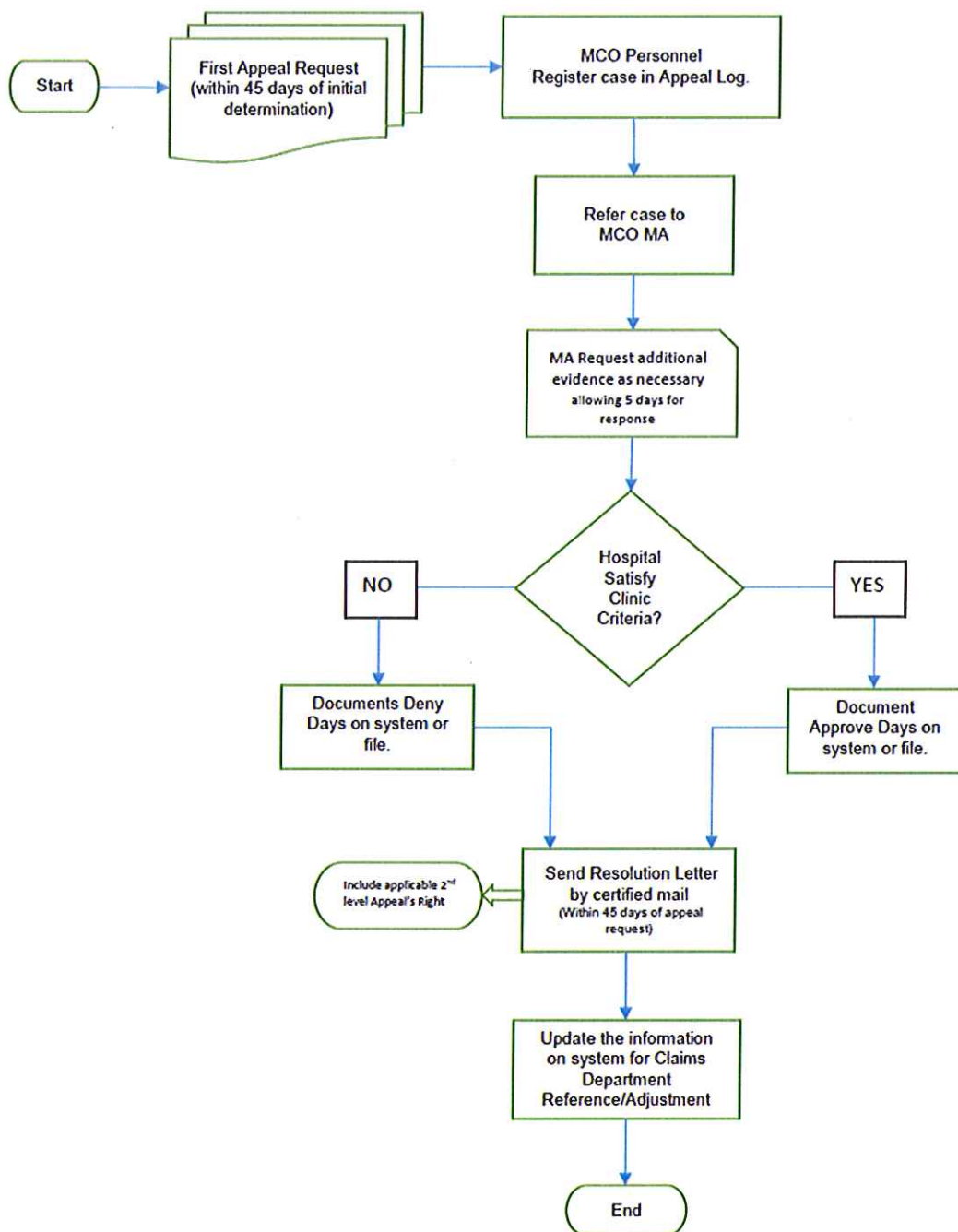
7. The Appeal Log System or File shall be updated based on the determination made. All related information must be kept in file.

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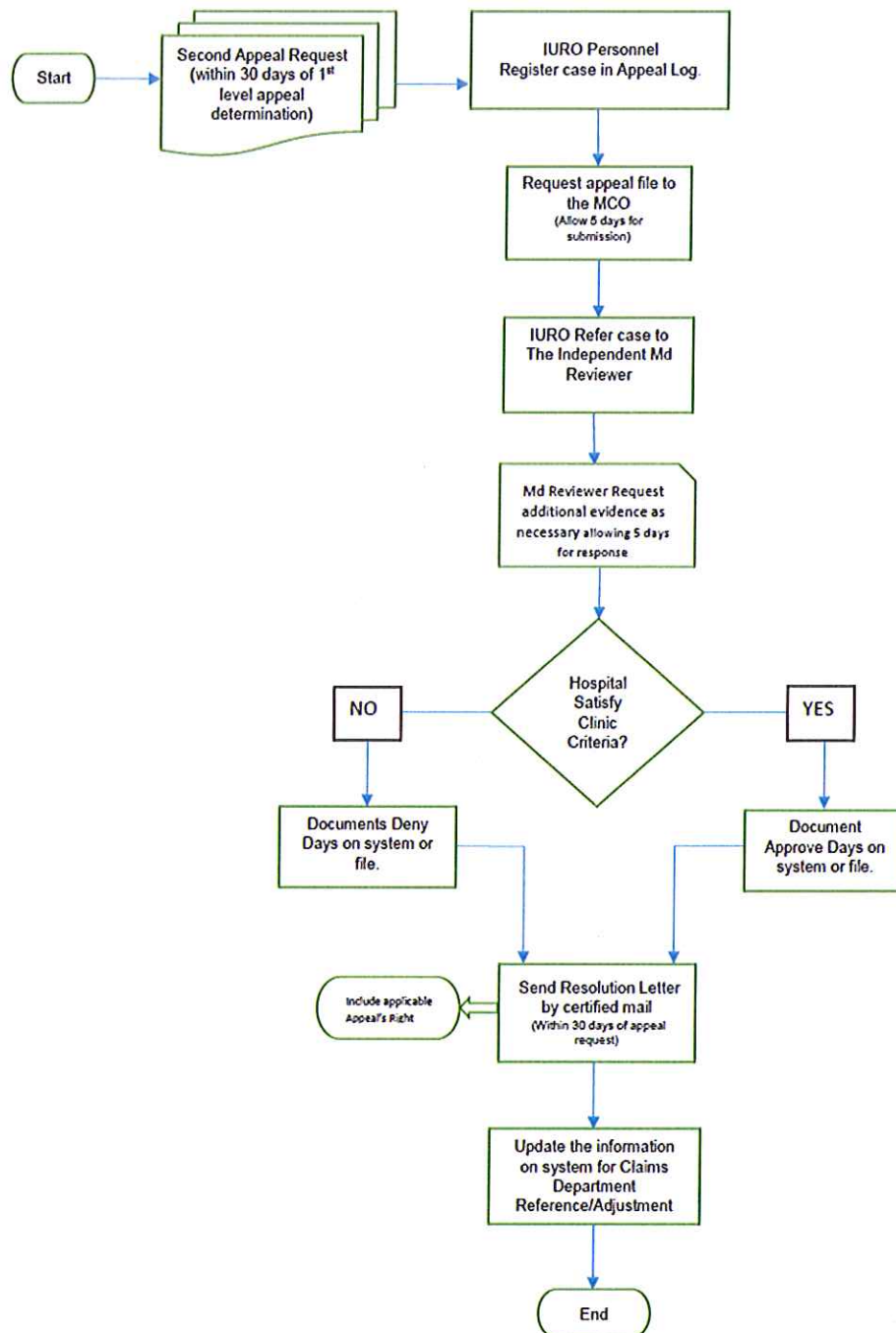


Flowchart Appeal Process 1st Level



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Flowchart Appeal Process 2nd Level IURO



REVIEWED BY: _____

DATE: _____

APPROVED BY: _____

DATE: 12/23/2016