BlueCross BlueShield of Western New York

STAT Bulletin

PO Box 80 • Buffalo, New York 14240-0080

December 23, 2008
Volume 14:Issue 23

To: All Behavioral Health Providers
Contracts Affected: All Lines of Business

Clarification of Program Requirements for Behavioral Health Services

The following bulletin contains important information and clarification of program requirements for all behavioral health providers regarding Medical Necessity Determinations and Rights of Appeal and is effective 30 days from notification.

Medical Necessity Determinations and Rights of Appeal

Article 49 of the New York State Public Health Law defines the appeal process that health plans are required to use to resolve disputes regarding utilization management decisions. The Law specifically defines the requirements of the appeal process, including timeframes, for:

1. Reconsideration of an adverse determination
2. Expedited appeal of an adverse determination
2. Standard appeal of an adverse determination
3. External appeal of an adverse determination

These appeal mechanisms apply to both pre-service and post-service determinations by the Health Plan or its utilization review agents. A more complete explanation of the appeal processes can be found in the Provider Manual on our web site at www.bcbswny.com. Providers are expected to utilize these appeal processes to contest clinical decisions made by the Health Plan's Utilization Management (UM) review agents. Health Plan reimbursement will be based upon the UM review agents decision or the outcome of the mandated appeal process.

As provided by the Health Plan's Program Requirements, providers are contractually obligated to cooperate with the clinical review process by making available to the review agent the necessary clinical information to complete a review in a timely manner. The provider is contractually obligated to ensure that a process is in place for the review agent to obtain required clinical information in a timely manner even, when necessary, on weekends and holidays.

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Medical necessity denials will be issued based upon the clinical information at hand at the time of the review. Medical necessity review for emergency conditions will be performed using the "prudent layperson" standard and will be performed only on a post-service basis. If a provider is non-responsive to the review agent's requests for additional information a denial will be issued subject to full appeal rights. "Non-responsive" shall mean no follow-up by the provider following three separate requests within a reasonable time-frame for response. All notifications of denials must be sent to the provider and the member in accordance with prevailing regulation and existing contractual agreements. These notifications include notice of appeal rights.

Inpatient Review Decisions

Health Plan expects to be notified of an admission immediately and in no case later than 24 hours after the time of admission. Admission notifications, including the relevant clinical information, that occur later than 24 hours after admission should be a rare exception. In most cases of late notification of an inpatient admission the complete record of the stay will need to be submitted and reviewed for medical necessity. All days will be subject to medical necessity determination. Not withstanding the above, medical necessity reviews and notifications will be carried out within the stipulations of prevailing regulation and contract agreements.

If you have any questions regarding this bulletin, please contact the Provider Services department at 1-800-950-0051 or 1-716-884-3461.