Document Title: *Policy and Procedure # MBH 5: Notification of Determination for Medicare Members (*Was *Policy and Procedure #MBH 4: Notification of Determination)*
Department: Clinical Services

Policy:

Establishing a mechanism ensuring notification is communicated to the provider, facility and member once a request for service is determined.

Responsibility:

Clinical Services Department (Clinical Services) Team

Procedure:

1. All requests for service are reviewed by the appropriate Clinical Services team member for determination.

2. The following people or entities can assist in meeting certification requirements:

   - A licensed facility rendering services;
   - A physician or other licensed provider;
   - The patient; or
   - An authorized patient representative.

3. If the request for service is approved, notification is communicated verbally to the provider, facility and/or member, within applicable regulatory timeframes. (See *Policy and Procedure # MBH 911: Turnaround Timeframes*.)

4. Information included in the verbal notification includes:

   - An authorization or reference number;
   - The name of the approved provider;
   - The number of days, visits or units approved;
   - The service(s) approved;
   - The date of admission or onset of services;
   - The approved timeframe for rendering services;
   - Any updated total number of days, visits or units approved; and
   - The next anticipated review date, if applicable.

5. If the request is approved, written notification is sent upon request.

6. If the request for service is not certified, notification is communicated verbally and in writing to the provider, facility and/or member, within applicable regulatory timeframes. (See *Policy and Procedure # MBH 911: Turnaround Timeframes*.)

Written Notification of Non-certification Decisions In Which The Member Is Held Harmless From Paying Charges

1. Written notification of non-certification is sent to the attending provider, the facility providing services. A courtesy copy is sent to the member when appropriate.

2. Written notification includes the following:

    - The specific date and time coverage by American Behavioral ends;
    - A clause verifying that the patient is held harmless from paying charges after coverage by American Behavioral ends;
    - The principal reasons for the determination not to certify, or, in the case of an appeal, the determination to uphold a non-certification;
    - The clinical rationale used in making the non-certification decision or the decision to uphold the non-certification in the case of an appeal;
    - Instructions for initiating an appeal of the non-certification (except when all avenues of appeal have been exhausted); and
    - A statement of the availability of appeals-related policies and procedures and the specific clinical criteria upon which the decision is based.

3. Upon request from the attending physician, or other ordering provider or facility rendering service, the organization provides specific clinical review criteria upon which the non-certification was based.

4. A request-for-service determination is not reversed unless information provided to the Clinical Services team member is materially different from the information reasonably available at the time of the original determination.

Written Notification of Non-certification Decisions In Which The Member May be Held Responsible for Paying Charges

1. Examples of when a member may be held responsible for paying charges include the patient staying at a facility after being discharged and circumstances in which there is a non-covered benefit. There could be other circumstances in which a member may be held responsible for paying charges, so, if in doubt, **ask**.

2. Written notification of non-certification is sent to the attending provider, the facility providing services. (See attached.)

3. The notification must be sent to the member on the Center for Medicare and Medicaid Services (CMS)-approved *Denial of Medical Services* letter template. (See attached.)

4. A copy of the CMS-approved member appeal rights sheet must always be included with the member letter. (See attached.) This does not have to be included with the provider/facility notification.

1. Written notification includes the following:

    - The specific date and time coverage by American Behavioral ends;
    - The principal reasons for the determination not to certify, or, in the case of an appeal, the determination to uphold a non-certification;
    - The clinical rationale used in making the non-certification decision or the decision to uphold the non-certification in the case of an appeal;
    - Instructions for initiating an appeal of the non-certification (except when all avenues of appeal have been exhausted); and
    - A statement of the availability of appeals-related policies and procedures and the specific clinical criteria upon which the decision is based.

2. Upon request from the attending physician, or other ordering provider or facility rendering service, the organization provides the specific clinical review criteria upon which the non-certification was based.

3. A request-for-service determination is not reversed unless information provided to the Clinical Services team member is materially different from the information reasonably available at the time of the original determination.

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