

Prior Auth Reporting Meeting with Health Plans and Dept. of Insurance - 1/31/18

**Questions:**

**Q:** The pre-authorization template asks for pre-auth approvals and denials, including the number turned over on appeals. The summary spreadsheet asks for the number and percentage of denials and approvals that were subsequently appealed, and of those that were appealed, the number and corresponding percentage of overturns. However, since it is implausible that a provider would appeal an approval, may we ignore the question regarding appeals of approvals and respond merely to the questions regarding appeals of denials?

**A:** **Yes, appeals of denials**

**Q**: Where do we submit the file once it is prepared?

**A: Health plans should submit/email data to info@dhin.org.**

**Q:** Regarding the denial reason categories, we assume the State only wants us to report a denial in one category, not in multiple categories. Is that right? On the call, you indicated “yes” but we would like to confirm.

**A:** **Yes, the primary reason for the denial**

**Q:** The definition of “pre-authorization” could be interpreted narrowly to mean only those decisions made prospectively (before treatment starts). We don’t think that’s the State’s intent but want to confirm. For example, if we’re not notified of an admission until after a member is admitted and we end up denying one or more days, we think the state wants us to report that denial even though it was not a prospective denial. Is that right?

**A: Yes, broad interpretation, not narrow**

**Q:** There’s a problem with categories that may overlap. For example, if we approved three days of a stay, but denied the last day because the member met criteria to go home or to a lower level of care, we could count that as either “doesn’t meet medical necessity” or “care could be provided in alternate setting.” Can we choose one category (i.e. alternate setting) in these instances since this would result in reporting in multiple categories?

* This could also potentially fall into the “modified (mixed approve/deny)” category but our business partners don’t think it should. Since we are reporting denials in one category, we don’t foresee any data in the “modified” category. Will that be OK?

**A: Yes, whatever the primary reason is, but a good issue to revisit in terms of overlap in future.**

**Q:** If a member was planning to have a procedure (such as gastric bypass) and we denied the stay because the member didn’t meet criteria for the procedure, would we put that denial in the “medical necessity” category, not in the “alternate setting” category? On the call you indicated that your initial instinct was “yes,” but we would like to confirm.

**A: Yes**

**Q:** If our denial is because the member isn’t eligible for coverage under the plan (e.g., coverage terminated), will that need its own “member not covered under the plan” category? The response on the call was “yes,” but we would like to confirm.

**A: Yes**

**Q:** We understand from the call that the first report should EXCLUDE behavioral health. Can you please confirm this? Will BH data be included in the next reporting period, please confirm.

**A: Yes, excluded in the first report, but we will want to include BH in the next wave of reporting.**

**Q:** We also heard some dialogue about excluding Medicaid and Medicare data, but would like you to confirm.

**A: Title 18 doesn’t extend to Medicare and Medicaid. Ideally, it would be reported voluntarily, but the State can’t require it in Title 18. Medicaid could put it as a contracting condition in the future, but that’s not for DHIN to determine.**

**Q:** On the call we asked which date to use on the Provider Appeals tab. You indicated that the date we should use would be the initial appeal date.

**A: Correct, initial appeal date**

**Q:** Please explain what is meant by “indication offered”?

**A: The indication offered should be the indication submitted by the practitioner. The ICD, for instance, in combination, the CPT and the ICD.**

**Q:** Should partial denials be included?

**A: Yes, as partial is still a denial.**

**Q:** Should the data be pulled by Delaware sites and Delaware resident? (Meaning only Delaware residents with plans written in Delaware).

**A: DOI will determine the scope of what they can require; absent that, whatever the limits of Title 18 jurisdiction are.**