**MCO PREAUTHORIZATION/PRE-SERVICE DENIAL**

**QUARTERLY REPORT INSTRUCTIONS**

**REPORTING FORMS**

The MCO Preauthorization/Pre-Service Denial Quarterly Report and the Quarterly Pre-Service Denial Listing Report can be found by accessing the link below or by following the path from the Qlarant portal to the **MCO Resource Site** in the Pre-Service Denial/Appeal/Grievance Analysis Task.

Path:

Qlarant Portal Path: Maryland MCO Resource Site > Pre-Service Denial/Appeal/Grievance Analysis > Quarterly Reporting Forms and Samples

Link: [MCO Preauthorization/Pre-Service Denial Report and Instructions Folder](https://portal.qlarant.com/sites/PAV/eqr/md/res/PreService%20DenialAppealGrievance%20Analysis/Forms/AllItems.aspx?RootFolder=%2Fsites%2FPAV%2Feqr%2Fmd%2Fres%2FPreService%20DenialAppealGrievance%20Analysis%2FQuarterly%20Reporting%20Forms%20and%20Samples&FolderCTID=0x012000E1006A94B4928341BD9D18747584FA0C&View=%7bDE0F9023-7933-4489-8ECE-1D3738D4158C%7d)

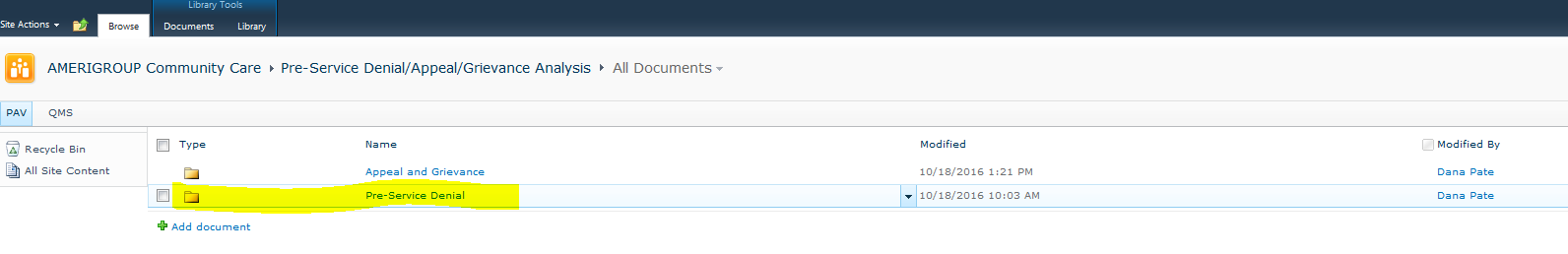
**Submit one consolidated quarterly report inclusive of MCO and delegates’ preservice denials.**

**Note: Please include reporting for delegates handling authorizations for covered benefits. Delegates for optional benefits (i.e. dental) should not be included here.**

Additionally,please attach a completed Quarterly Pre-Service Denial Listing Report as supporting documentation that includes a listing of each pre-service denial for the MCO and each delegated vendor.

**REPORTING TIMELINES**

Within 30 days of the end of each quarter, upload a completed MCO Preauthorization/Pre-Service Denial Quarterly Report and the Quarterly Pre-Service Denial Listing Reports to the MCO portal under the Pre-Service Denial/Appeal/Grievance Analysis Task Tab.



**REPORT NAMING**

(MCO)(1st/2nd/3rd/4th)QTR(Year)PreserviceDenialReport

(MCO or Delegated Vendor)(1st/2nd/3rd/4th)QTR(Year)PreserviceDenialListing

**QLARANT CONTACTS**

Email Aimee Dietsch at [dietscha@qlarant.com](mailto:dietscha@qlarant.com) when the reports have been uploaded to the portal and copy Sara Dixon at [dixons@qlarant.com](mailto:dixons@qlarant.com).

**MCO PREAUTHORIZATION (PA)/PRE-SERVICE DENIAL QUARTERLY REPORT INSTRUCTIONS**

1. Complete the general information at the top of the form:
   * Name of MCO
   * Reporting Quarter (1st, 2nd, 3rd, or 4th)
   * Year of Quarterly Report
2. **Total PA Requests during the Reporting Quarter (#):** Report the total number of PA requests received or processed during the reporting quarter. (This number will be your denominator for #3, #4, #5 and #6).
3. **Total PA Requests Received with Complete Information (# and %):** Report the number of PA requests that were received with complete information. Calculate the % received complete using the overall total PA requests as the denominator and the number of PA requests received with complete information as the numerator.
4. **Total PA Requests Received Requiring Additional Information (# and %):** Report the number of PA requests that were received requiring additional information. Calculate the % requiring additional information using the overall total PA requests as the denominator and the number of PA requests received requiring additional information as the numerator.
5. **Total PA Requests Approved (# and %):** Report the number of PA requests that were approved. Calculate the % approved using the overall total PA requests as the denominator and the number of PA requests approved as the numerator.
6. **Total PA Requests Denied (# and %):** Report the number of PA requests that were denied. Calculate the % denied using the overall total PA requests as the denominator and the number of PA requests denied as the numerator.
7. **Total PA Requests Unresolved in Quarter (#):** Report the number of PA requests that were unresolved from the previous and current reporting period.
8. **Total PA Requests Resolved in Quarter (#):** Report the number of PA requests that were resolved during this reporting period.
9. **Total Pre-Service Denials in the Quarter (#):** Report the total number of pre-service denials in the reporting quarter. (This number will be your denominator for #10-14).
10. **Pre-Service Denials for Members < 21 Yrs of Age (# and %):** Report the number of pre-service denials in the quarter that were for members under 21 years of age. Calculate the % using the overall total of pre-service denials as the denominator and the number of pre-service denials for members under 21 years of age as the numerator.
11. **Standard Pre-Service Medical Denials (# and %):** Report the number of standard pre-service medical denials. Calculate the % using the overall total of pre-service denials as the denominator and the number of standard pre-service medical denials as the numerator.
12. **Expedited Pre-Service Medical Denials (# and %):** Report the number of expedited pre-service medical denials. Calculate the % using the overall total of pre-service denials as the denominator and the number of expedited pre-service medical denials as the numerator.
13. **Pre-Service Outpatient Pharmacy Denials (# and %):** Report the number of pre-service outpatient pharmacy denials in the quarter. Calculate the % using the overall total of pre-service denials as the denominator and the number of pre-service outpatient pharmacy denials as the numerator.
14. **Pre-Service Denials/1000 Members (#):** Report the number of pre-service denials per 1000 members. Use the member population at the end of the quarter to calculate this number.
15. **Top 5 Service Categories**

* Report the top five service categories (highest to lowest) using the codes identified in the MCO Pre-Service Denial Categories attached.
* Report the number of pre-service denials associated with identified code.
* Calculate the % using the overall total of pre-service denials as the denominator and the number of pre-service denials associated with the identified code as the numerator.

1. **Top 5 Denial Reasons**

* Report the top five denial reasons (highest to lowest) using the codes identified in the MCO Pre-Service Denial Reasons attached.
* Report the number of pre-service denials associated with identified code
* Calculate the % using the overall total of pre-service denials as the denominator and the number of pre-service denials associated with the identified code as the numerator.

1. **Compliance with TAT Requirements**

Report for both Pre-Service Denials Meeting Determination TATs and Pre-Service Denials Meeting Notification TATs:

* **Total Standard Pre-Service Medical Denials (#)**
* **Standard Pre-Service Medical Denials Meeting TAT (# and %)**
* **Total Expedited Pre-Service Medical Denials(#)**
* **Expedited Pre-Service Medical Denials Meeting TAT (# and %)**
* **Total Pre-Service Outpatient Pharmacy Denials (#)**
* **Pre-Service Outpatient Pharmacy Denials Meeting TAT (# and %)**

1. **Compliance with Prescriber Notification TAT Requirement**

* **Total Outpatient Pharmacy PA Requests Resolved in Quarter (#)**
* **Prescriber Notification of Outcome Within 24 Hours of PA Request (# and %)**

1. **Explanation of Any Major Variances From Prior Quarter:** Report relevant explanations of outliers or any major variances from the prior quarter that are relevant to the reviewer when reviewing the quarterly report.

**QUARTERLY PRE-SERVICE DENIAL LISTING REPORT INSTRUCTIONS**

1. Complete the general information at the top of the form:

* Name of MCO or Delegated Vendor
* Quarter (1st, 2nd, 3rd, or 4th)
* Year of quarterly report

1. **Member Name (Last, First):** Enter the member’s name. Use a comma to separate.
2. **Medicaid #:** Enter the member’s 8-digit Medicaid number. No spaces or dashes.
3. **Authorization #:** If your organization has an authorization number, enter it here. If not applicable, write N/A.
4. **Under 21 (Y/N):** If the member is under 21, enter Y; if not, enter N.
5. **Expedited Pre-Service Medical Request (Y/N):** If the services requested are expedited, enter Y; if not, enter N. Expedited services require a decision and notification within 72 hours of receipt; see COMAR 10.67.09.04A(2).
6. **Denial Date:** Use mm/dd/yy format to indicate the date the service was denied.
7. **Service Category Code:** Use the chart attached to these instructions to enter the appropriate code for the type of service denied. Descriptions are provided for guidance.
8. **Reason for Denial:** Use the chart attached to these instructions to enter the appropriate code for the reason the service/benefit was denied.
9. **Service/Benefit being Denied:** Note what service/benefit is being denied.
10. **MCO Explanation:** In 50 words or less, state what was denied (specifically), and justification for denial, reduction, or termination of services/benefits.
11. **Date Letter Sent:** Use mm/dd/yy format to indicate the date the denial letter was sent to the member.

**MCO PRE-SERVICE DENIAL CATEGORIES**

**Effective FY 2020 Reports**

|  |  |
| --- | --- |
| **Code** | **Services Description** |
| **1A** | Diagnostic/Lab: those medically necessary services provided to diagnose or rule out certain health conditions, illnesses or injuries. (excluding Radiology) |
| **1B** | Diagnostic/Lab: Radiology |
| **2** | Durable Medical Equipment (DME)/Disposable Medical Supplies (DMS): DME is equipment which satisfies the following   * + It can withstand repeated use   + It is used to serve a medically necessary purpose   + It has no practical use in the absence of illness, injury, disability or health condition. Examples are wheelchairs, canes   DMS is a consumable or disposable item with minimal or no potential for reuse which is used to serve a medically necessary purpose and, with the exception of disposable gloves and incontinence supplies, have no practical use in the absence of illness, injury, disability or health condition. (COMAR 10.09.12.01) ( MCO Transmittal #14 – June 9, 1999) |
| **3** | Inpatient/Admission Hospital Services: Hospital as defined in 10.67.01.01.B(84) and in accordance with 10.67.06.07 |
| **4A** | Medical/Surgical: those services which are medical or surgical in nature, including, but not limited to: specialty provider visits, home health services and visits, outpatient services, surgical interventions, etc. (excludes services related to Pain Management, Private Duty Nursing, Therapies – see 4B, 4C, and 4D) |
| **4B** | Medical/Surgical: related to Private Duty Nursing [Private Duty Nursing: as defined in COMAR 10.67.01.01.B(144) |
| **4C** | Medical/Surgical: related to Therapies including OT, PT, Speech/Language |
| **4D** | Medical/Surgical: Non-pharmacy pain management |
| **5A** | Pharmacy services\*: drugs, insulin, contraceptives, hypodermic needles and syringes, enteral nutritional and supplemental vitamins and mineral products and other medications as specified in:  HealthChoice: COMAR 10.67.06.04 or Pharmacy Transmittal # 189 – 6/3/09. |
| **5B** | Pharmacy services: Chronic Pain Management |
| 6 | Substance Abuse: No longer in use as COMAR 10.09.65.11 repealed effective 2/16/2015 (recodified 10.67.06.10 effective 11/1/2019). |
| **7** | Transportation per COMAR 10.67.06.27.A(5) |
| **8** | Vision: services specified in COMAR 10.67.06.14 |
| **9** | Other : not otherwise specified |

**MCO DENIAL CATEGORIES**

**Please select the primary reason for denial**

|  |  |  |
| --- | --- | --- |
| **Code** | **Category** | **Examples** |
| **NMN-1\*** | Not Medically Necessary – Full Denial | Investigational; experimental; not standard of care; taking opioids/tramadol but request suboxone; no evidence of conservative treatment; does not meet care guidelines (e.g., MCG or Interqual); poor pt. compliance (i.e. CPAP use); termination of services |
| **NMN-2\*** | Not Medically Necessary – Partial Authorization | Partial authorization: Non-formulary; authorize less quantity than requested; # of services does not meet plan guidelines; purchase denied/rental approved; step therapy; quantity limits (i.e., PT visits, # of pills); no failure of formulary alternative; x-ray ok but not CT scan; service authorized but at an alternate location |
| **NMN-3\*** | Not Medically Necessary – Lack of or inadequate/  incomplete documentation from the requesting provider to support request | Use when this is the only reason given  Lack of documentation of failure/intolerance/ineffectiveness of alternate treatment (i.e. oral vs. injectable); lack of documentation of adherence to plan (i.e. home exercise plan); lack of documentation of effectiveness/ compliance (i.e. CPAP); lack of documentation of medical necessity (i.e. disposable blue pads) |
| **ADM-1** | Administrative – Denied pending request of primary payor | Denied pending request of primary payor; other carrier/payor responsibility; Alternative insurance |
| **ADM-2** | Administrative – Recipient ineligible on date of service |  |
| **ADM-3** | Administrative – Did not meet time guidelines for authorization |  |
| **ADM-4** | Administrative - Out of network provider | Service available in-network |
| **ADM-5\*\*** | Administrative - Not a covered service/benefit |  |
| **ADM-6\*** | Administrative – Location | Service available at alternate site (i.e. outpatient not inpatient; freestanding clinic not hospital) but no authorization issued; Local vs. Mail Order vs. Specialty Pharmacy |
| **OTH** | Other | Not otherwise listed |

\*Med. – Medical necessity as defined in COMAR 10.67.01.01.B(112)

\*\*Typically “not a covered service” should not be used as the basis for denial of services to children/EPSDT services