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| Utilization Management Program: Disclaimers | |  |
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**Evidence Based Clinical Criteria/Guidelines**

*Adverse Determination:* In cases where the clinical criteria and/or guidelines used in a review leads to an adverse determination, criteria and/or guidelines used and principal reason for the determination will be disclosed to the provider and patient upon request.

*Provider Access:* Providers are made aware of the evidence based clinical criteria/guidelines utilized in making certification determinations, which are readily available upon request to the provider.

*Patient Access:* Clinical criteria and/or guidelines are applied to patients on a case-by-case basis considering special circumstances of each case that may require deviation from the norm. Additionally, the Payer Compass Medical Director and professional staff applies clinical criteria and/or guidelines based on the capacity of its practitioners and the provider delivery system including its ability to provide care in alternative settings when needed.

**Non-Certifications Appeal**

*Appeals Processing:* It is the policy of Payer Compass to provide a methodology for processing appeals (both expedited and standard) to maintain compliance in accordance with the U.S. Department of Labor (DOL) claims regulations 29 CFR 2560.503-1 claims procedure and 29CFR2590.715-2719 internal claims and appeals and external review processes, URAC’s Utilization Management Standards, and applicable state laws.

**Pre-certification Requirements**

*Health Plan Language:* Pre-certification requirements are not within the discretion of Payer Compass as they are determined by the health plan and/or Third-Party Administrator. Payer Compass does not modify or amend existing preauthorization requirements or restrictions. Payer Compass does not create or implement new pre-certification requirements or restrictions. Payer Compass applies the pre-certification requirements and restrictions of the health plan for which it performs the utilization review services. However, providers are made aware of current—new, as modified or amended—pre-certification requirements or restrictions at the time of the pre-certification request or upon written request.

**State Requirements**

*Service Hours:* If state regulations require communications outside of the normal service hours, the state regulation will supersede the Access to Services Policy (see State specific policies for further details).

*General State Requirements:* Specific state requirements are followed when they are more restrictive or otherwise different than the U.S. DOL and URAC requirements.

*Regulatory Requirements:* Written screening criteria and review procedures shall be made available for review and inspection by representatives of the state insurance department or other regulators of a state in which Payer Compass does business, for copying, and as necessary for such regulators to carry out their lawful duties under state law.  Such documentation will be provided to any licensed health care provider at a nominal cost that is sufficient to cover copying and mailing expenses. Any such information delivered to a state will be treated as confidential to the extent allowed under such state’s laws.