Centennial Care Reporting Instructions
Prior Authorization – Report #42

Report Objective

To capture information on services requiring prior authorization and examine changes and trends in authorizations and denials of services over time.

General Instructions

The managed care organization (MCO) is required to submit the Prior Authorization report on a quarterly basis. This report is due on April 30, July 30, October 30 and January 30 of each year. Please adhere to the following reporting periods and due dates:

Quarter	Reporting Period	Report Due Date
1	January 1 – March 31	April 30th
2	April 1 – June 30	July 30th
3	July 1 – September 30	October 30th
4	October 1 – December 31	January 30th

An Excel workbook is provided as a separate attachment for submission. Quantitative data and any qualitative data must be entered in the Excel workbook. With the exception of the grey, calculated fields, the MCO must ensure that data is entered in all fields. The report will be considered incomplete if any required field is left blank. Enter "0" if there is no data available to report. An electronic version of the report in Excel must be submitted to the New Mexico (HSD) by the report due date listed above. The report shall be submitted via the State's secure DMZ FTP site. The date of receipt of the electronic version will serve as the date of receipt for the report.

If any new data/information becomes available in subsequent quarters for previously reported data for the current year, the MCO must update data for prior quarters within the current quarter report submission.

This report is formatted to capture prior authorization data on a monthly/quarterly basis. **Data for each prior authorization request must be reported within the monthly/quarterly column that corresponds to the month/quarter in which the MCO received the authorization request.**

The MCO shall submit the electronic version of the report using the following file labeling format: MCO.HSD42.Q#CY##.v#. The "MCO" part of the labeling should be the MCO's acronym for their business name. With each report submission, change the quarter reference (Q# - e.g., Q1), the calendar year (CY## - e.g., CY19), and the version number (v# - e.g., v1), as appropriate. The version number should be "1" unless the MCO is required to resubmit a report for a specified quarter. In those instances, the MCO will use "2" and so on for each resubmission.

The Reporting Period, MCO Name, and Report Run Date must be entered in the fields provided at the very top left corner of the first worksheet in the Report. Using the format illustrated below, enter the start and end dates for the Reporting Period. The MCO Name should be the MCO's full business name. Using the format illustrated below, enter the Report Run Date. The Report Run Date refers to the date that the

data was retrieved from the MCO's system. All dates and the MCO name entered on the first worksheet will automatically populate the top of all other worksheets in the report.

Reporting Period	MM/DD/YYYY	through	MM/DD/YYYY
MCO Name	MCO's Full Name		
Report Run Date	MM/DD/YYYY		

Attestation and Penalties

The MCO shall ensure that all data is accurate and appropriately formatted in each of the tabs prior to submitting the Report. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit accurate reports and/or failure to submit properly formatted reports may result in monetary penalties of $5,000 per report, per occurrence.

The MCO shall include a signed Centennial Care Report Attestation Form with each Report submitted. Failure to submit a signed attestation form by the Report due date will result in the entire Report being late. Per Sections 4.21 and 7.3 of the Centennial Care contract, failure to submit timely reports may result in monetary penalties of $1,000 per report, per calendar day. The $1,000 per calendar day damage amounts will double every ten calendar days.

Related Contract Requirements

1. Section 4.21 – Reporting Requirements
2. Section 7.3 – Failure to Meet Agreement Requirements

Definitions

Administrative (Admin) Denial	A denial of authorization requests due to the requested procedure, service or item not being covered by Medicaid or due to provider non-compliance with administrative policies and procedures established by either the MCO or the Medical Assistance Division. Administrative denials may be done on initial as well as concurrent reviews.
Approval	Approvals are either initial or concurrent review decisions, which yield utilization authorizations based on the member meeting the clinical criteria for the requested service(s) and/or level of care.
Clinical Denial	A denial for a Medicaid service based on the member not meeting medical necessity for the requested service. If utilization management (UM) recommends an alternative service based on the client's need for a lower level of service and the requesting provider accepts this alternative service, it is considered a new request for the alternative service and a clinical denial of the original service request.

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Continued Authorization Request	A request for prior authorization for the continuation of a service that a member is currently receiving.
Initial Authorization Request	A new request for prior authorization for a service that the member is not currently receiving.
Requests Partially Denied	For an initial authorization request, an authorization of the type of service requested by the provider but in lesser amounts or units of service than were requested. The authorization is based on the member's medical necessity.
Requests Pended or In Progress	A prior authorization request is considered "pended" when the decision is delayed due to lack of documentation and a request for information is made from the MCO to the provider. A decision by the MCO to "pend" approval does not extend or modify required utilization management decision timelines. Failure of the provider to provide requested information may result in an administrative denial. A prior authorization request is considered "in progress" when the authorization request has been received, but a decision has not yet been made at the time the report is compiled. Does not include requests pended.
Reduction of Service	For a continued authorization request, an authorization of the type of service requested by the provider but in lesser amounts or units of service than were requested. The authorization is based on the member's medical necessity.
Termination of Service	The decision made during a review which yields a denial based on the current service no longer meeting medical necessity.

Section I: Summary

The "Summary" tab captures key metrics from the Detail Summary tabs regarding behavioral health services, physical health services, and dental services. Data is reported for the current and three previous quarters.

Enter the reporting period, MCO name, and report run date on the top portion of the worksheet (Columns A through F, Rows 1 through 3). Note that this information will auto-populate within all other tabs for Sections II through V.

Note that the report through date entered in cell E1 is also used to populate month, quarter, and calendar year-to-date (CYTD) labels column/section headings within this workbook. As such, it is important that the correct date format of **mm/dd/yyyy** be used when entering the applicable report through date.

Data entry for all other areas of this worksheet is not required because it is auto-populated based on data captured in Sections III and IV of this report.

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Section II: BH, PH and Dental Analysis

This report contains section-specific analysis tabs for BH, PH and Dental. Before entering data in the workbook, ensure that the appropriate section-specific "Analysis" tab is selected. This section of the report collects quantitative and qualitative analysis regarding prior authorizations. Please respond to the following questions taking into consideration the data reported for the reporting period. Address the following within the BH Analysis, PH Analysis, and Dental Analysis sections:

Summary

1. In reviewing the refreshed data provided in the (BH, PH, Dental) Services Summary for previous quarters, how do the values compare from quarter to quarter (i.e., are there any significant increases or decreases or any significant outliers that raise concerns)? Although the current quarter's data is less complete when compared to previous quarters, does the MCO have any concerns about the current data reported? Are there any concerns that need to be addressed by the MCO?
2. Are there any significant increases or decreases in the approval and denial percentages reported in the (BH, PH, Dental) Services Summary when comparing refreshed data for previous quarters? Although the current quarter's data is less complete when compared to previous quarters, are there any concerns about the current data reported? Are there any concerns that need to be addressed by the MCO?

Analysis

1. List any services that require prior authorization for which the approval rate is ≤ 75% (clinical denials ≥ 25%) for the current quarter; how do they compare to the three previous quarters? Expand list and provide refreshed data, as necessary.
2. List the reasons for administrative denials for the current quarter; how do they compare to the last three previous quarters? Expand list and provide refreshed data, as necessary.
3. List the reasons for pended requests for the current quarter; how do they compare to the last three previous quarters? Expand list and provide refreshed data, as necessary.

Behavioral Health, Physical Health, Dental Health Sorted

1. Based on the refreshed data provided in the (BH, PH, Dental) Sorted tab, did the MCO identify any trends or have any concerns for any services listed? Identify service(s) and document trends/concerns. Expand list, as necessary.

Section III: Detail Summary

This tab captures key metrics from the report regarding behavioral health services, physical health services and dental services. Data entry is not required on this worksheet because it is auto-populated based on data captures in Sections IV and V of this report.

Section IV: Behavioral Health Services, Physical Health Services, and Dental Services

Before entering data in the workbook, ensure that the appropriate tab is selected. This section of the report instructions applies to Section IV tabs of the report and captures information regarding prior authorization requests for behavioral health services, physical health services, and dental services.

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Predetermined BH, PH and Dental service categories are listed in Column A of the respective tabs and cannot be changed or added to. The MCO must enter prior authorization data applicable to each category and update, as needed, in subsequent reporting periods.

Section IV is formatted to capture prior authorization data on a monthly basis. **Data for each prior authorization request must be reported within the monthly column that corresponds to the month in which the MCO received the authorization request.** For example, if the MCO received an authorization request on January 31, and the approval was communicated on February 1, the approval should be reported in the January column.

The last block of data (Total) is a summary of information for all services included in the Behavioral Health Services, Physical Health Services, and Dental Services worksheets. **The figures calculated in these totals sections are used to populate the Detail Summary and Summary sections of the report.**

Behavioral Health Services that require prior authorization are:

1. ARTC for Adults with Substance Use Disorders – Prior authorization is not required for up to five days for eligible recipients meeting ASAM level three criteria to facilitate immediate admission and treatment to the appropriate level of care. Within that five day period, prior authorization for continued care must be obtained from MAD or its designee.
2. ARTC for Youth
3. Applied Behavior Analysis (ABA) – Stage three specialty care services require prior authorization to continue services and must be secured every six months
4. Behavioral Health Respite Care (after 30 days or 720 hours/year)
5. Inpatient Psychiatric Care in Freestanding Psychiatric Hospital or Psychiatric Unit of Acute Care Hospital – for an eligible recipient under 21 years of age
6. Institution for Mental Diseases (IMD)
7. Non-Accredited Residential Treatment Center (RTC)
8. Group Home
9. Partial Hospitalization Services in Acute Care or Freestanding Psychiatric Hospital (after 45 days)
10. Treatment Foster Care I
11. Treatment Foster Care II

Physical Health Categories and/or Services that require prior authorization are:

1. Inpatient Services
2. Physician Surgical/Diagnostic Procedures – Excluding Transplants (Total number for all procedures listed below, identified by CPT code, that requires prior authorization by the MCO)
    - Integumentary (10021 - 19499)
    - Musculoskeletal (20005 – 29999)
    - Respiratory (30000 – 32999)
    - Cardio/Hemic/Lymphatic (33010 – 39599)
    - Digestive (40490 – 49999)
    - Urinary/Genital/Endocrine (50010 – 60699)
    - Nervous (61000 – 64999)
    - Eye, Ocular Adnexa, Ear (65091 – 69990)
    - Radiology (70010 – 79999)
    - Pathology/Laboratory (80047 – 89398, 0001U – 0023U)
    - Medicine (90281 – 96999 excluding Speech Therapy, 97597 - 99607)
3. Transplant Services (In and Out-of-State)

4. Other Out-of-State Services (excluding those reported in #s 2 and 3 above)
5. Physical Therapy (97161 – 97546) – do not include therapy provided through Long-Term Care
6. Occupational Therapy (97161 – 97546) – do not include therapy provided through Long-Term Care
7. Speech Therapy (92507 – 92508) – do not include therapy provided through Long-Term Care
8. Vision Services (V2020 – V2799)
9. Hearing Services (V5008 – V5364)
10. Enteral/Parenteral Therapy (B4034 – B4160)
11. Durable Medical Equipment (E0100 – E1063, K0001 – K0552)
12. Orthotics/Prosthetics (L0112 – L9900)
13. Transportation Services
14. Value-Added Services
15. Other (i.e. Transportation Services, OPPS, Medical Supplies)

Dental Services that require prior authorization are:

1. Diagnostic (D0100 – D0999)
2. Preventive (D1000 – D1999)
3. Restorative (D2000 – D2999)
4. Endodontics (D3000 – D3999)
5. Periodontics (D4000 – D4999)
6. Removable Prosthodontics (D5000 – D5899)
7. Maxillofacial Prosthetics (D5900 – D5999)
8. Oral/Maxillofacial Surgery (D7000 – D7999)
9. Orthodontics (D8000 – D8999)
10. Adjunctive General Services (D9000 – D9999)

Prior Authorization Data by Service/Category

In conjunction with the definitions above, the following table provides a description for each row of data required for each service and/or service category within the BH Services, PH Services, and Dental Services tabs. Although row headers, numbers, and descriptions are defined for the first service block, this set of information applies uniformly to all other service blocks within the tabs.

Quarterly data within Columns F, J, N, R, and Year-to-Date data within Column S are all auto-calculated and do not require data entry. Note that quarterly and YTD unique member counts require data entry and are not auto-calculated.

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Row Header	Row Number	Description
Unique Members	7	The number of unique members enrolled in the MCO during each month, quarter, and calendar year-to-date. Counts are to be entered in the BH Services tab. The PH Services and Dental Services tabs are auto-populated with counts from the BH Services tab; for those tabs, data entry is not required in this field.
Total Requests for Service	8	The total number of prior authorization requests received during the month for the service listed in Column A. It is the sum of the number of initial authorization requests (Row 9) and the number of continued authorization requests (Row 15) for the service. Data entry is not required in this field.
Number of Initial Authorization Requests	9	The number of initial authorization requests received during the month for the service listed in Column A. For the initial authorization requests received during the month, this row auto-calculates the sum of corresponding approvals, clinical denials, administrative denials, partial denials, and requests pending. Data entry is not required in this field.
Approvals	10	The number of approvals of initial authorization requests for the service listed in Column A.
Clinical Denials	11	The number of clinical denials for initial authorization requests for the service listed in Column A.
Administrative Denials	12	The number of administrative denials for initial authorization requests for the service listed in Column A.
Partial Denials	13	The number of service determinations for initial authorization requests that are partially denied for the service listed in Column A.
Requests Pending or In Progess	14	The number of initial authorization requests received during the month that are pending or in progress as of the last day of the reporting period for the service listed in Column A. Example: CY Q1 Report Submission: An initial authorization request is received during March and as of Quarter-ending March 31, is in pending status. For this report submission, the count should be reported in this row in the column for March. This count will also be included in the auto-calculated Q1 and CYTD counts. CY Q2 Report Submission: The initial authorization request that was pending at Q1-end was approved in April. For this report submission, the count should be reported in the approval row in the column for March (when the request was made). This count will also be included in the auto-calculated Q1 and CYTD counts.

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Row Header	Row Number	Description
Number of Continued Authorization Requests	15	The number of continued authorization requests received during the month for the service listed in Column A. For the continued authorization requests received during the month, this row auto-calculates the sum of corresponding approvals, termination of service, administrative denials, reductions of service, and requests pending. Data entry is not required in this field.
Approvals	16	The number of approvals for continued authorization requests for the service listed in Column A.
Termination of Service	17	The number of terminations of service for the service listed in Column A. Note: this row is for continued requests only.
Administrative Denials	18	The number of administrative denials for continued authorization requests for the service listed in Column A.
Reductions of Service	19	The number of reduction of service determinations for continued authorization requests for the service listed in Column A.
Requests Pending or In Progress	20	The number of continued authorization requests received during the month that are pending or in progress as of the last day of the reporting period for the service listed in Column A. See Row 14 description for reporting example.
Total Approvals	21	Total number of approved requests (initial and continued) for the service listed in Column A.
Total Clinical Denials	22	The total number of clinical denials for the service listed in Column A. Note: this row is for initial requests only.
Total Administrative Denials	23	Total number of requests (initial and continued) for the service listed in Column A that were denied for administrative reasons.
Total Partial Denials	24	Total number of initial service requests for the service listed in Column A for which partial denial of service determination was made. Note: this row is for initial requests only.
Total Reductions of Service	25	Total number of continued authorization requests for the service listed in Column A for which a reduction of service determination was made. Note: this row is for continued requests only.
Total Terminations of Service	26	The total number of terminations of service for the service listed in Column A. Note: this row is for continued requests only.
Total Pending or In Progress Requests	27	Total number of requests (initial and continued) for the service listed in Column A that are pending or in progress as of the last day of the reporting period.
Requests per 1,000 Members	28	Total requests (Row 8) multiplied by 1,000 then divided by MCO enrollment (Row 7). Data entry is not required in this field.

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Row Header	Row Number	Description
Approvals/Requests	29	Total approvals (Row 21) divided by total requests for service (Row 8). Data entry is not required in this field.
Approvals per 1,000 Members	30	Total approvals (Row 21) multiplied by 1,000 then divided by MCO enrollment (Row 7). Data entry is not required in this field.
Denials/Requests	31	Total denials (clinical denial, administrative denial, partial denial, reduction of service, and termination of service) (sum of Rows 22 through 26) divided by total requests for service (Row 8). Data entry is not required in this field.
Denials per 1,000 Members	32	Total denials (clinical denial, administrative denial, partial denial, reduction of service, and termination of service) (sum of Rows 22 through 26) multiplied by 1,000 then divided by MCO enrollment (Row 7). Data entry is not required in this field.

Sections V: BH Sorted, PH Sorted, and Dental Sorted

Before entering data in the workbook, ensure that the appropriate tab for each section is selected. This section of the report instructions applies to Section V tabs of the report and captures information regarding prior authorization requests for behavioral health services, physical health services, and dental services, and is divided into Services Requested, Services Approved and Services Denied. The number of authorization requests per 1,000 members, number of approvals per 1,000 members, and the number of denials per 1,000 members for each category in each section is reported. The data for these sections should be transferred from the respective quarterly data (not year to date) in Sections III and V of the report. Data for previous quarters must be refreshed and provided in Columns C, D and E from previous quarters (i.e. current quarter is Q3 in Column B, previous quarter is Q2 in Column C, next quarter reported is Q1 in Column D, last quarter reported is Q4 of previous calendar year in Column E).

Section V is formatted to capture prior authorization data on a quarterlly basis. **Data for each prior authorization request must be reported within the quarterly column that corresponds to the quarter in which the MCO received the authorization request.** For example, if the MCO received an authorization request on March 31, the request should be reported in the Q1 column.