

UM-040 Administrative Denial**Approved By:
Director, Health Services****Effective Date:
11/11/2025**

This Policy applies to all SECUR affiliates, associates, and subsidiaries.

Approved by Courtney Gonzales, Director of Health Services on behalf of the Utilization Management Committee.

PURPOSE

SECUR Health Plan Utilization Management Department follows all federal, state, and local guidance regarding coverage guidelines and determinations, including organizational policies and procedures. This policy provides guidance for instances where supporting clinical documentation, incomplete requests, or any other circumstance exists that may prevent a medical necessity utilization review.

DEFINITIONS

Complete Prior Authorization Request: A prior authorization request is considered complete when the information sent to the Utilization Management Department includes, but is not limited to:

- Member identifying information including full member name, date of birth, and/or member ID.
- At least one active ICD-10 code identifying the diagnosis(es) associated with the request.
- The date of item/procedure/service.
- At least one active CPT code identifying the item/procedure/service being requested.
- The full provider name.
- The provider contact phone number and/or fax number.
- The provider specialty.
- If out of network, the provider's NPI number.
- Supporting documentation from medical records that satisfies the requirements associated with the medical necessity review that must be completed by the Utilization Management Department.

POLICY

SECUR Health Plan requires complete prior authorization requests that contain all mandatory fields. Supporting documentation is to be included with all requests for prior authorization. The documentation may include, but is not limited to, clinical progress notes, laboratory results, imaging results, and physical examination findings. These documents are necessary for determining medical necessity for the item(s), procedure(s) or service(s) requested.

Incomplete Prior Authorization Requests for Standard Requests

For both inpatient and outpatient services that require prior authorization, SECUR Health Plan will do the following when an incomplete standard request is received.

1. Day 1 – Day Request is received – A member of the Utilization Management Team will contact the requesting entity by telephone **and** fax to request the information not contained in the authorization request.
2. Day 2 – A member of the Utilization Management Team will contact the requesting entity by fax to request the information not contained in the authorization request.

If the needed information is not received by Day 4, the request will be administratively denied as the necessary information has not been provided to SECUR Health Plan.

Supporting Documentation

For both inpatient and outpatient services that require prior authorization, SECUR Health Plan will do the following when supporting documentation is either not provided or is inadequate to perform a medical necessity review.

1. Day 1 – Day Request is received – A member of the Utilization Management Team will contact the requesting entity by telephone *and* fax to request the information not provided with the authorization request.
2. Day 2 – A member of the Utilization Management Team will contact the requesting entity by fax to request the information not provided with the authorization request. If information is not received by end of business on Day 2, the Intent to Deny notification will be sent to the provider and the provider will have 24 hours to request a Peer-to-Peer Discussion prior to a determination being rendered or provide the supporting documentation necessary for the medical necessity review.
3. If there is no response either with supporting documentation or a request for a Peer-to-Peer Discussion, an administrative denial will be rendered on day 3 and communicated to the provider.

For inpatient, concurrent, medical necessity reviews, the Utilization Management Team will follow the guidance outlined above for supporting documentation. If the inpatient facility fails to provide updated supporting documentation for the continued stay review, the stay will be denied from the last authorized date forward.

Expedited Requests (Not Including Part B Drug Expedited Requests)

For both expedited inpatient and outpatient services that require prior authorization, not related to Part B drug expedited requests, SECUR Health Plan has a mandated turnaround time of 72 hours. In these instances, SECUR Health Plan will do the following:

1. Day 1 – Day Request is received – A member of the Utilization Management Team will contact the requesting entity by telephone *and* fax to request the information not provided with the authorization request.
2. Day 2 – A member of the Utilization Management Team will contact the requesting entity by fax to request the information not provided with the authorization request. If information is not received by end of business on Day 2, the Intent to Deny notification will be sent to the provider and the provider will have 24 hours to request a Peer-to-Peer Discussion prior to a determination being rendered or provide the supporting documentation necessary for the medical necessity review.
3. If there is no response either with supporting documentation or a request for a Peer-to-Peer Discussion by 70 hours following the request received time, an administrative denial will be rendered on day 3 and communicated to the provider.

Expedited Part B Drug Requests

SECUR Health Plan has a mandated turnaround time of 24 hours for all expedited Part B drug requests. In these instances, SECUR Health Plan will do the following:

1. Day 1 – Day request is received – A member of the Utilization Management team will contact the requesting entity at least once by phone and once by fax to request the information not provided with the authorization request.

If the needed information is not received within 22 hours of the request, the request will be administratively denied.

For reviews that require an adverse determination due to no clinical information received, SECUR Health Plan allows the Director of Health Services to render the adverse determination in agreement and conjunction with the Chief Medical Officer and/or Utilization Management Medical Director to ensure timely rendering of the adverse determination and communication to the member and provider.

References:

None