



UNIFORM MANAGED CARE MANUAL 3.21.1 Independent Review Organization Process

DOCUMENT HISTORY

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¹ Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions

² Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

³ Brief description of the changes to the document made in the revision.



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I. Applicability

This chapter applies to managed care organizations (MCOs) participating in the STAR, STAR+PLUS, STAR Kids, and STAR Health Programs, and Dental Contractors providing children’s Medicaid Services to Members through dental maintenance organizations (DMOs). References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR, STAR+PLUS, STAR Kids and STAR Health Programs, and the Medicaid Dental Contractors.

For the purposes of this chapter, the term “MCO” includes health maintenance organizations (HMOs), insurers, Dental Contractors, and any other entities licensed or approved by the Texas Department of Insurance.

Information in this chapter applies only to MCO service denials and reductions.

II. Purpose and Background

This chapter provides operational guidance and process information for MCOs and DMOs about the External Medical Review (EMR) that is completed by designated Independent Review Organizations (IROs).

Senate Bill 1207, 86th Legislature, Regular Session, established EMR processes for:

- MCO service denials and reductions; and
- Eligibility denials for certain programs based on medical or functional necessity.

All capitalized terms in this chapter are defined in (1) the Uniform Managed Care Contract (UMCC), Attachment A, Terms and Conditions or (2) the Dental Services Contract, Attachment B, Terms and Conditions. The term, “emergency appeal,” as used in UMCM Chapter 3.21, has the



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same meaning as the term, “Expedited MCO Internal Appeal,” as used in this UMCM chapter. Similarly, the term, “emergency external medical review,” as used in UMCM Chapter 3.21, has the same meaning as “expedited EMR request,” as used in this UMCM chapter.

III. EMR Process – Service Reductions and Denials

A. Member Requests

After exhausting the Expedited MCO Internal Appeal or MCO Internal Appeal process provided by the MCO, the Member, the Member’s authorized representative, or the Member’s Legally Authorized Representative (LAR) must contact the MCO to request an EMR and State Fair Hearing. The Member, the Member’s authorized representative, or the LAR must request the EMR and State Fair Hearing at the same time. However, the Member, the Member’s authorized representative, or the LAR may request an EMR if the State Fair Hearing has not occurred, and the State Fair Hearing will be rescheduled. A Member’s representative includes any person or entity acting on behalf of the Member in compliance with state law and 42 C.F.R. § 438.402. According to the UMCC, the Member’s LAR means the Member’s representative as defined by state or federal law, including Tex. Occ. Code § 151.002(6), Tex. Health & Safety Code § 166.164, and Tex. Estates Code Ch. 752.

A Member, a Member’s authorized representative, or a Member’s LAR cannot request only an EMR. The Member, Member’s authorized representative, or Member’s LAR must request either (1) a State Fair Hearing or (2) both an EMR and a State Fair Hearing. The Member, the Member’s authorized representative, or the Member’s LAR has 120 Days to request either (1) a State Fair Hearing or (2) both an EMR and a State Fair Hearing. The 120-Day timeframe starts from the date that the MCO mails its Expedited MCO Internal Appeal or MCO Internal Appeal decision letter to the Member.

Under 42 CFR § 438.402 and § 438.406, Medicaid appeals, such as a Member’s EMR request, can be conveyed to the MCO orally or in writing. A Member does not need to follow-up on an oral EMR request by making an identical request in writing.

As noted above, there are two types of EMR requests, a standard EMR request and an expedited EMR request. A standard EMR request is appropriate when the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function is not jeopardized. The expedited EMR request is allowable when the Member, Member’s authorized representative, or Member’s LAR believes and can demonstrate that taking the time for a standard EMR request could jeopardize the Member’s life, physical or mental health, or ability to attain, maintain, or regain maximum function.

B. MCO Record Submission and Timeframes

The MCO must send all documentation the MCO utilized to make its service reduction or denial decision, including information submitted by the Member, the Member’s authorized representative, the Member’s LAR, or the provider during the MCO appeal process, to



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the HHSC EMR Intake Team, an HHSC team that assigns EMR requests to IROs and monitors the EMRs for timely completion. The MCO must submit only those records to the HHSC EMR Intake Team that it reviewed to make the service denial or reduction determination that is being appealed. The records that the MCO must submit include but are not limited to the following:

- service request (including prior authorizations);
- supporting clinical documents;
- letters requesting additional information from the provider(s) or the Member, the Member's authorized representative, or the Member's LAR regarding the service request;
- documentation of any phone calls with the requesting provider or any other information provided by the requesting provider;
- MCO staff name(s) of those who conferred in the service denial or reduction decision; and
- any names of peers or providers that were consulted regarding the Member's Expedited MCO Internal Appeal or MCO Internal Appeal.

The MCO must send the previously identified service reduction or denial information to the HHSC EMR Intake Team within the following timeframes:

- Expedited EMR Request – Within one Day of receiving the EMR request from the Member, the Member's authorized representative, or the Member's LAR, unless received after 3:00 p.m. CST on a Friday, or any Day HHSC is closed for business. If the EMR Request is received after 3:00 p.m. CST on Friday, or on a day HHSC is closed for business, the Expedited EMR Request is due no later than noon the following Business Day; or
- Standard EMR Request – No later than three Days after receiving the EMR request from the Member, the Member's authorized representative, or the Member's LAR.

C. IRO Assignment

The MCO must enter the EMR request in the Texas Integrated Eligibility Redesign System (TIERS). Upon completion of the MCO's EMR request, the HHSC EMR Intake Team will receive an automatically generated alert regarding the EMR request via TIERS.

The HHSC EMR Intake Team will review the EMR request and check for possible conflicts of interest between the IRO, the MCO, the Member, and the provider(s) associated with the MCO Adverse Benefit Determination that is the basis of the Member's EMR request. The HHSC EMR Intake Team will then assign the Member's EMR request to an IRO using a rotational format. For standard EMR Requests, the HHSC EMR Intake Team will send an email to the IRO notifying it of the EMR assignment no later than the next Day after the EMR request and associated MCO



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documentation is received from the MCO. For Expedited EMR Requests, the HHSC EMR Intake Team will send an email to the IRO notifying it of the EMR assignment no later than the same Day the EMR request and associated MCO documentation is received from the MCO. Any IROs with a conflict of interest related to the EMR request will not be assigned the request. If any conflicts of interest are identified following the IROs assignment to the EMR request, the assigned IRO must return all records associated with the EMR request to the HHSC EMR Intake Team no later than the next Business Day after the IRO is notified of the conflict. If the originally assigned IRO is disqualified due to a conflict of interest, the HHSC EMR Intake Team will reassign the EMR request to a replacement IRO, using the rotational format.

The HHSC EMR Intake Team assignment email will provide the following information to the IRO:

- Date EMR was requested by the Member, the Member's authorized representative, or the Member's LAR;
- Due date for MCO documentation to be uploaded to TIERS;
- Due date for the IRO's EMR decision;
- Member information, including predominant or preferred language;
- Member's authorized representative or Member's LAR information, if applicable;
- MCO documentation used to make Adverse Benefit Determination; and
- MCO information that IROs must use for the notice of MCO action (see **UMCM Chapter 3.21, Medicaid MCO's Notices of Actions Required Critical Elements**), including
 - MCO name,
 - MCO address,
 - MCO phone number, and
 - Reason for MCO service denial or reduction determination.

D. Member EMR Request Withdrawal

If the Member, the Member's authorized representative, or the Member's LAR decides to withdraw the EMR request, the Member, the Member's authorized representative, or the Member's LAR must initiate an EMR request withdrawal communication to the MCO. The Member, the Member's authorized representative, or the Member's LAR must submit the request to withdraw the EMR to the MCO using one of the following methods: (1) in writing, via United States mail, email, or fax; or (2) orally, by phone or in person. The MCO must convey the EMR withdrawal request to the HHSC EMR Intake Team no later than the next Business Day that the EMR withdrawal request is received from the Member, the Member's authorized representative, or the Member's LAR.



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E. IRO Processing

The IRO must complete the EMR using the following timeframes:

- Expedited EMR Request– No later than the next Business Day following receipt of the MCOs records related to the service denial or reduction determination (see also, **Section 3(B), MCO Record Submissions and Timeframes**) from the HHSC EMR Intake Team; or
- Standard EMR Request– No later than ten Days following receipt of the MCO records related to the service denial or reduction determination (see also, **Section 3(B), MCO Record Submissions and Timeframes**) from the HHSC EMR Intake Team.

The IRO must ensure that its reviewers are Texas licensed, board-certified clinical reviewers (in the case of providers), or where appropriate, fully credentialed, licensed, non-provider clinical reviewers of the same specialty or area of practice that would generally provide the type of treatment that is the subject of the EMR. An IRO non-physician may not overturn an MCO physician's decision.

The IRO must accurately complete reviews of Adverse Benefit Determination made by the MCO based on medical and functional necessity. MCOs should submit any issues/concerns regarding EMRs to HHSC at EMR_Intake_Team@hhsc.state.tx.us

F. IRO Decision Determinations

Upon completion of the EMR, the IRO will make one of the following determinations:

- Upheld - meaning the IRO agrees with the MCO's determination in its entirety (see also, **Section 3(G)(1), Post Decision Activities**);
- Partially overturned - meaning the IRO allowed a portion of the service request that the MCO denied or reduced (see also, **Section 3(G)(2), Post Decision Activities**);
- Overturned - meaning the IRO disagreed with the MCO determination in its entirety and approved all services that the MCO had denied or reduced (see also, **Section 3(G)(3), Post Decision Activities**).

At its discretion, HHSC will overrule the IRO if it determines that the IRO decision is clearly in conflict with federal law, state law, or HHSC policy.

G. IRO EMR Decision Notifications

The IRO must send written notification of its EMR decision, no later than the due date established in the HHSC EMR Intake Team assignment email (see also, **Section 3(C), IRO Assignment**), to the following parties: the Member; the Member's authorized representative or Member's LAR, if applicable; the MCO; and the HHSC EMR Intake Team.



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If a provider claiming to be associated with the denied services that are the basis of the EMR request makes a written request for the IRO's EMR decision, the IRO must make a determination as to whether the provider is associated with the denied services underlying the EMR request. If the IRO determines that the provider is associated with the denied services that are the basis of the EMR request, the IRO must provide written notice of the EMR decision to that provider within three Days of determining the provider's association with the underlying EMR request. If the IRO determines that the provider is not associated with the denied services that are the basis of the EMR request, then the IRO must send a written notice denying the provider's request for the EMR decision within three Days of determining that the provider is not associated with the underlying EMR request.

The Member, Member's authorized representative, or Member's LAR must be notified by the IRO of its EMR decision in a letter (for the purposes of this chapter, referred to as "IRO Decision Notice") sent via encrypted email, if an email address is provided by the Member, Member's authorized representative, or LAR or United States mail using the approved template provided by HHSC. The MCO must be provided a copy of the IRO Decision Notice that the IRO sends to the Member, Member's authorized representative, or Member's LAR, also sent via encrypted email, if an email address is provided by the MCO or United States mail.

For expedited EMR requests, the Member, Member's authorized representative, or Member's LAR will be notified by the IRO of its EMR decision via secure email, if the Member's, Member's authorized representative, or Member's LAR email address was provided to the IRO in the HHSC EMR Intake Team's assignment email. If the IRO was not provided the Member's, Member's authorized representative, or Member's LAR email address, the IRO must send the expedited EMR decision, including the IRO Decision Notice, to the Member, Member's authorized representative, or Member's LAR via United States mail. The IRO must notify the MCO and HHSC EMR Intake Team of its expedited EMR determination via secure email by attaching a copy of the IRO Decision Notice that was sent to the Member, Member's authorized representative, or Member's LAR.

H. Post Decision Activities

1. Decision Upheld

After the IRO sends notification of an upheld decision, the HHSC EMR Intake Team will enter the EMR decision in TIERS, which will generate an automated update to the MCO and the Fair and Fraud Hearings section of the HHSC Appeals Division. The HHSC EMR Intake Team will also upload a copy of the IRO's Decision Notice to TIERS.

2. Decision Partially Overturned

After the IRO sends notification of the partially overturned decision, the HHSC EMR Intake Team will enter the decision information in TIERS, which will generate an



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automated update to the MCO and the Fair and Fraud Hearings section of the HHSC Appeals Division. The HHSC EMR Intake Team will also upload a copy of the IRO Decision Notice in TIERS.

If the Member's benefits were not continued following receipt of the EMR request and the State Fair Hearing request, the MCO is required to reinstate the Member's benefits within 72 hours of the MCO receiving the EMR decision. The MCO must enter the date that the Member's services are resumed in TIERS.

3. Decision Overturned

After the IRO sends notification of the overturned decision, the HHSC EMR Intake Team will enter the decision information in TIERS, which will generate an automated update to the MCO and the Fair and Fraud Hearings section of the HHSC Appeals Division. The HHSC EMR Intake Team will also upload a copy of the IRO Decision Notice in TIERS.

If the Member's benefits were not continued following receipt of the EMR request and the State Fair Hearing request, the MCO is required to reinstate the Member's benefits within 72 hours of the MCO receiving the EMR decision.

4. Withdrawing State Fair Hearing Request

It is the responsibility of the Member, Member's authorized representative, or Member's LAR to withdraw a State Fair Hearing request. If the Member, Member's authorized representative, or Member's LAR does not withdraw the State Fair Hearing request, regardless of the EMR decision, the Member, the Member's authorized representative, or the Member's LAR is required to attend the State Fair Hearing.

IV. MCO Reimbursement of EMR

HHSC will initially make payment to the IRO for costs related to conducting an EMR. HHSC will then send a reimbursement request to the MCO requiring reimbursement for the amount paid to the IRO for conducting the EMR. The MCO must reimburse HHSC within ten Business Days following receipt of HHSC's reimbursement request.