External Medical Review

The review process conducted by an independent, external medical review (EMR) entity that is initiated by a health care provider who disagrees the decision to deny, limit, reduce, suspend or terminate a covered service for lack of medical necessity. Permedion is contracted by Ohio Department of Medicaid (ODM) to perform EMRs.

Requesting an EMR

To request an EMR, you must first appeal the decision to deny, limit, reduce, suspend or terminate a covered service for lack of medical necessity using our internal care provider appeal or claim dispute resolution process. Failure to exhaust the internal appeals or claim dispute resolution process results in your inability to request an EMR. EMR is only available to health care providers for services delivered to members enrolled in Medicaid managed care and/or OhioRISE.

An EMR can be requested as a result of:

- A service authorization denial, limitation, reduction, suspension or termination (includes pre-service, concurrent or retrospective authorization requests) based on medical necessity
- A claim payment denial, limitation, reduction, suspension or termination based on medical necessity

Denials, limitations, reductions, suspensions or terminations based on lack of medical necessity include, but are not limited to, decisions made by UnitedHealthcare Community Plan where:

- Clinical documentation or medical record review is required in making the decision to deny (includes preservice, concurrent and retrospective reviews)
- Clinical judgement or medical decision making (i.e. referred to a licensed practitioner for review) is involved
- A clinical standard or medical necessity requirement (e.g. InterQual®, MCG®, ASAM or OAC 5160-1-01, including EPSDT criteria, and/or the MCO's clinical coverage or utilization management policy or policies) is not met

We inform you of your option to request an EMR as part of any denial notification.

Submitting an EMR

The request for an EMR must be submitted to Permedion within 30 calendar days of the written notification that the internal appeals or health care provider claim dispute process has been exhausted.

Complete the Ohio Medicaid MCE External Review Request form located at gainwelltechnologies.com/permedion > Ohio Medicaid and submit to Permedion together with the required supporting documentation including:

- Copies of all adverse decision letters (initial and appeal)
- All medical records, statements (or letters) from treating health care providers, or other information that you want considered in reviewing case

Upload the request form and all supporting documentation to Permedion's provider portal located at ecenter.hmsy.com. If you are a new user, send your documentation through secured email at imr@gainwelltechnologies.com to establish portal access. Note: When requesting an EMR, you may submit new or other relevant documentation as part of the EMR request.

If Permedion determines that your EMR request is not eligible for an EMR and you disagree, ODM or its designee will determine if an EMR is appropriate.

The EMR process does not interfere with your right to request a peer-to-peer review, a member's right to request an appeal or state hearing or the timeliness of appeal and/or state hearing resolutions.

Once you have submitted the EMR request, you do not need to take further action.

EMR results

- After the EMR request has been submitted, Permedion shares the documentation with UnitedHealthcare Community Plan
- Following the review of the information, we may reverse the denial, in part or in whole
  - If reversed, you will receive a written decision within 1 business day for expedited prior authorization requests and 5 business days for standard prior authorization requests and notify Permedion
  - If we decide to reverse the decision in part, the remaining will continue as an EMR
- Permedion has 30 calendar days for a standard request and 3 business days for an expedited request to perform its review and issue a decision
- If the decision reverses the coverage decision in part or in whole, that decision is final and binding
- If the decision agrees with UnitedHealthcare Community Plan's decision to deny, limit, reduce, suspend or terminate a service, that decision is final
- For reversed service authorization decisions, we authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when we receive the EMR decision
- For reversed decisions associated solely with health care provider payment (i.e. the service was already provided to the member), we pay for the disputed services within the time frames established for claims payment in Exhibit C, Ohio Regulatory Requirements Addendum, of the Dental Benefit Providers, Inc. Dental Provider Agreement

Call Permedion at **1-800-473-0802 (option 2)** for more information about the EMR.

Dental Benefit Providers®

External Medical Review

Frequently Asked Questions

General

Question	Answer
What is External Medical Review (EMR)?	EMR is the review process conducted by an independent, external medical review entity that is initiated by a provider who disagrees with a managed care organization (MCO)'s and/or the OhioRISE (Resilience through Integrated Systems and Excellence) plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity.
Who oversees and conducts the EMR process?	The EMR will be conducted and overseen by Permedion. This vendor has a contract with Ohio Department of Medicaid (ODM) to conduct EMRs.
All EMR requests are reviewed by licensed physicians. Are the reviewing physicians licensed in the state of Ohio?	The EMR entity has a medical director licensed in the state of Ohio who approves all completed reviews. Reviewing physicians are independent contractors.
What types of services qualify for EMR?	Only services denied, limited, reduced, suspended, or terminated for lack of medical necessity by a Medicaid MCO and/or the OhioRISE plan are eligible for EMR. This includes claims submitted to the MCO and/or OhioRISE plan which have been denied for lack of medical necessity. EMR is not currently available for MyCare Ohio, Single Pharmacy Benefit Manager (SPBM), or fee-for-service (FFS) Medicaid programs.
What situations qualify for EMR?	An EMR can be requested by a provider as a result of either of the following: • An MCO and/or the OhioRISE plan's service authorization denial, limitation, reduction, suspension, or termination (includes pre-service, concurrent, or retrospective authorization requests) based on medical necessity. • An MCO and/or the OhioRISE plan's claim payment denial, limitation, reduction, suspension, or termination based on medical necessity. Denials, limitations, reductions, suspensions, or terminations for lack of medical necessity include, but are not limited to, those which:

Question	Answer
	1. Required clinical documentation or medical record review in making the decision to deny (includes pre-service, concurrent, and retrospective reviews). 2. Involved clinical judgement or medical decision-making (i.e., request was referred to a licensed practitioner for review). 3. Were based on not meeting a clinical standard or medical necessity requirement (e.g., InterQual®, MCG®, American Society of Addiction Medicine (ASAM), or Ohio Administrative Code (OAC) rule 5160-1-01, including Early Periodic Screening, Diagnostic, and Treatment (EPSDT) criteria)).
Are there specific criteria and/or a hierarchy to determine "medical necessity"?	OAC rule 5160-1-01 defines medical necessity. Any services where the MCO or OhioRISE plan's decision was to deny, limit, reduce, suspend, or terminate a covered service due to lack of medical necessity is eligible for EMR. ODM follows the OAC and industry standards to determine criteria for medical necessity. The MCO and the OhioRISE plan must use ODM-developed medical necessity criteria to determine medical necessity. In the absence of ODM-developed medical necessity criteria, the MCO and the OhioRISE plan must use clinically accepted, evidence-informed medical necessity criteria (e.g., InterQual®, MCG®, and ASAM) as approved by ODM. In the absence of ODM-developed medical necessity criteria or ODM-approved, clinically-accepted, evidence-informed medical necessity criteria, the MCO and the OhioRISE plan's adaptation or development of medical necessity criteria must be based upon current strongest evidence such as results of United States scientific studies that are published in peer reviewed medical literature or otherwise.
How do providers and the EMR entity communicate?	Communication between the provider and the EMR entity will occur primarily via the EMR entity's portal, through which providers will submit EMR requests and provide documentation. The EMR entity will also send providers letters through the portal when an EMR request is accepted, rejected, and when a determination is made.

Question	Answer
What actions must providers take before requesting EMR?	Prior to requesting an EMR, providers must first appeal or dispute the decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity using the MCO and/or the OhioRISE plan's internal provider appeal or claim dispute resolution process.
How does the EMR entity confirm that the provider has completed either the first level of internal prior authorization appeals or first level of provider claim dispute process with the MCO and/or OhioRISE plan.?	Part of the documentation that initiates the EMR is a form that the provider completes and sends with their documentation through the EMR entity's portal. There are fields in the form to indicate the provider has completed the internal process. The EMR entity also sends this form to the MCO and/or OhioRISE plan to confirm the required internal prior authorization appeals or claims dispute resolution processes have been completed.
What if providers still have questions about EMR?	For more information about the External Medical Review, contact Permedion at 1-800-473-0802, and select Option 2.

Requesting an EMR

Question	Answer
How can providers request an EMR?	Providers must complete the "Ohio Medicaid MCE External Review Request" form located at www.hmspermedion.com (select Contract Information and Ohio Medicaid) and submit to the EMR entity together with the required supporting documentation. Providers must upload the request form and all supporting documentation to the EMR entity's provider portal located at https://ecenter.hmsy.com/ (new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish portal access).
What documentation should providers submit with an EMR request?	When requesting an EMR, providers may submit new or other relevant documentation as part of the EMR request, including: • Copies of all adverse decision letters from the MCO and/or the OhioRISE plan (initial and appeal). • All medical records, statements (or letters) from treating health care providers, or other information the provider wants considered in the review that has not been previously submitted to the MCO or OhioRISE plan.

Question	Answer
Is there a deadline for when providers can request EMR?	The request for an EMR must be submitted to the EMR entity within 30 calendar days of the written notification from the MCO and/or the OhioRISE plan that either the first level of internal prior authorization appeals or first level of provider claim dispute process has been completed.
Does the provider need to inform the MCO and/or the OhioRISE plan of the EMR request?	No. Providers must submit their EMR requests directly to the EMR entity. Once the request is approved, the EMR entity will contact the MCO and/or the OhioRISE plan and request the relevant information to the EMR request.
Appendix A of the Next Generation Medicaid Managed Care provider agreement says the MCO and/or the OhioRISE plan must allow a provider to request an external medical review if the MCO and/or the OhioRISE plan does not issue its response within 30 business days for provider claim disputes. Does this mean that the provider can submit an EMR before a final determination is made in the provider claim dispute resolution process?	Yes. The standard for the MCO and/or the OhioRISE plan's review of a claim's dispute is 30 business days. Providers may not request EMR before the 30 business days is completed. The provider is not required to request EMR at the 30-day mark if the issue isn't resolved. Providers may choose to delay requesting an EMR when there is active communication with the MCO regarding a claims dispute resolution.
Can providers request peer-to-peer review in addition to EMR?	Yes. The provider may, but is not required to, request a peer-to-peer review in addition to requesting an EMR. The EMR process does not interfere with the provider's right to request a peer-to-peer review.
What actions do providers need to take after submitting an EMR request?	Once the provider has submitted the EMR request, they do not need to take further action.

Decisions and Outcomes

Question	Answer
How long is the EMR review process?	The EMR entity has 30 calendar days for a standard request and three business days for an expedited request to perform its review and issue a decision.
What are the potential outcomes of the EMR?	Upon conclusion of the EMR request, the EMR entity will issue one of two decisions: • If the decision reverses the MCO or the OhioRISE plan's coverage decision in part or in whole, that decision is final and binding on the MCO or the OhioRISE plan. • If the decision agrees with the MCO or the OhioRISE plan's decision to deny, limit, reduce, suspend, or terminate a service, that decision is final.

Question	Answer
How are providers notified of the EMR entity's determination?	After the EMR process, the EMR entity will issue the decision in a written letter to the provider.
If a provider's request is determined by the EMR entity to not be eligible for EMR and the provider disagrees, what should the provider do?	If the EMR entity determines the provider's EMR request is not eligible for an EMR, and the provider disagrees, ODM or its designee will determine if an EMR is appropriate. Provider questions or requests for clarifications should be submitted via the portal. The provider does not need to take any further action.
What happens after an MCO or the OhioRISE plan reverses its decision based on an EMR decision that has been issued?	For reversed service authorization decisions, the MCO and/or the OhioRISE plan must authorize the services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from when the MCO and/or the OhioRISE plan receives the EMR decision. For reversed service authorization decisions, providers should contact the MCO and/or OhioRISE plan to coordinate the service(s). For reversed decisions associated solely with provider payment (i.e., the service was already provided to the member), the MCO and/or the OhioRISE plan must pay for the disputed services within the timeframes established for claims payment in Appendix L of the Provider Agreement and/or the OhioRISE Provider Agreement.
Can an MCO and/or the OhioRISE plan reverse its denial of a prior authorization or claim prior to the EMR decision being issued?	Yes. After the EMR request has been submitted, the EMR entity will share any documentation shared by the provider with the MCO and/or the OhioRISE plan. Following review of this information, the MCO and/or the OhioRISE plan may reverse its' denial, in part or in whole prior to the EMR decision being issued. If the MCO or the OhioRISE plan reverses any part of its decision, the provider will receive a written decision from the MCO or OhioRISE within: • One business day for expedited prior authorization requests • Five business days for standard prior authorization requests. The MCO or OhioRISE will also notify the EMR entity. If the MCO and/or the OhioRISE plan decides to reverse its decision in part, the remaining part will continue as an EMR. If the MCO or the OhioRISE plan reverses its' decision in whole, the EMR review is cancelled by the EMR entity.
Who is responsible for paying EMR fees?	Pursuant to Appendix A of the Medicaid Managed Care provider agreement and the OhioRISE provider

Question	Answer
	agreement, the MCO and/or the OhioRISE plan is financially responsible for the fee.
If the MCO and/or the OhioRISE plan's decision is not overturned, is the MCO and/or the OhioRISE plan able to pass the fee along to the provider?	No, in accordance with Appendix A of the Medicaid Managed Care provider agreement, the MCO and/or the OhioRISE plan is financially responsible for the fee.