ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**115 B**	
Subject:	**UM Criteria Policy**	
Section:	**Care Management**	
Effective Date:	**11/01/2012**	
Revision Date(s):	**06/13, 05/14, 10/14, 07/16, 10/16**	
Review Date(s):		
Responsible Parties:	**Theresa Bittle, Sharon Henry**	
Responsible Department(s):	**Case Management**	
Regulatory References:	**District of Columbia Contract: Section C.8.2.5.4 42 CFR 438.114(a) NCQA 2016: UM 4 F DC Municipal Regulations and DC Register, Chapter 29, Medicaid Reimbursement for Personal Care Services**	
Approved:		
	Carol Attia, RN AVP, Care Management	**Patryce A. Toye, MD Senior Medical Director**

Purpose: **This policy describes criteria utilized in order to facilitate consistency in UM decision making.**

Scope: **MedStar Family Choice, District of Columbia Healthy Families and Alliance**

Policy: **MedStar Family Choice follows documented UM criteria to facilitate consistency in UM decision making.**

Procedure:

The following criteria, as documented on MFC web site, are utilized for UM decision making:

1. Pre-Authorization/Retrospective Review

A. MedStar Family Choice follows a basic pre-authorization process: The member's health care provider forwards clinical information and requests for services to MedStar Family Choice by phone, fax or infrequently by mail. Telephones are manned on business days from 8:00am-5:30pm at 855-210-6203 or 202-243-5400. Our fax number is 202-243-5496 and faxes are received 24 hours/day, 7 days/week. Faxes and voice messages

received after hours will be addressed the next business day. The after-hours voice mail message includes name and telephone number to contact for after hours needs. The message also contains telephone number for MFC representative to be contacted for urgent pharmacy issues.

B. All appropriate ICD-10/CPT/HCPCS codes along with supporting clinical information must be included in requests for pre-authorization. Requests for authorization can be included on the Universal DC Medicaid Referral Form with clinical information attached. Our experienced clinical staff reviews all requests. MedStar Family Choice pre-authorization decisions are based on the following criteria and documents:
   - MedStar Family Choice Protocols
   - MFC Pharmacy Policies and Procedures
   - McKesson InterQual Criteria
   - Medicare and Medicaid Guidelines
   - District of Columbia Department of Health Care Finance contract and transmittals
   - MFC MCO benefit coverage
   - MFC Provider Manual
   - MFC Member Handbook
   - FDA Approval
   - District of Columbia Medicaid Fee Schedule Codes
   - Availability of services within the MFC network
   - MFC Transition of Care Policy
   - Pain Management Contracts
   - District of Columbia Code of Regulations

C. MFC reserves the right to direct services to participating practitioners and facilities. Services outside the network are available only when they are not available within the network or for continuity reasons.

D. MedStar Family Choice's utilization management decision making is based on the medical necessity of the service and the existence of MCO enrollment and coverage.

E. MedStar Family Choice has up to fourteen (14) calendar days following the receipt of the request to process a complete authorization request. Requests are considered complete when all necessary clinical information is received from the provider. An additional 14 calendar days can be given to make a decision if it is requested by the member or the provider, or if MFC believes it is in the best interest of the member. If the service requested is denied the provider may contact our Care Management Department to discuss the decision with the appropriate Physician Advisor.

F. A limited number of services require authorization from MedStar Family Choice Care Management before the patient receives care. The list is included in the MFC Provider Manual.

G. Retrospective requests are reviewed against the above specified criteria and are not guaranteed for approval. Retrospective services that could have been provided within the network are not likely to be retrospectively approved unless upon review the care needed was urgent or emergent; a DC DHCF defined self referral service, or a continuity of care issue.

H. Health care services which are not included in the Medicaid and/or Alliance benefit package, as stated in the DC Managed Medicaid Contract Section C.8 are subject to administrative denial since they are not the liability of the MCO.

I. Request for payment of services where the claim does not match the clinical provided will be subject to denial.

2. Pharmacy

A. MFC pays for a wide variety of medications, as outlined in the formulary. If a practitioner feels it medically necessary to prescribe a medication that is not on the formulary, the prescriber may submit this request to MFC. Such a request must include clinical documentation that supports the medical need for that specific medication and any prior use of available formulary medications, when applicable. All non-formulary requests are reviewed by a Physician Advisor. The Physician advisor will make a determination based on pharmacy policies and procedures and current regulations. Prescribers may call MedStar Family Choice at 855-210-6203, or fax requests to 202-243-5496.

B. Requests for Synagis (palivizumab) require a completed Statement of Medical Necessity form and authorization is based on criteria set forth by the American Academy of Pediatrics Policy Statement and published in the Red Book.

C. Medications included in the DC Department of Health Care Finance (DCHF) formulary are covered by the DC Department of Health Care Finance for Alliance members. These medication requests are subject to administrative denial since they are not the liability of the MCO except for an emergency 3 day supply.

D. Alliance members follow the MFC Health Families formulary and can use any pharmacy within the MFC pharmacy network.

3. Concurrent Review

A. MFC utilizes the following criteria to make concurrent review decisions:
- InterQual
- Medicare and Medicaid Guidelines
- DC Department of Health Care Finance
- MFC benefit coverage
- Availability of services within the MFC network

B. MFC reviews clinical documentation for timeliness of care and appropriate level of care. Clinical denial determinations may be issued by a Physician Advisor when a delay in care or delay in discharge planning creates an inpatient day that could have been avoided if service had been provided timely.

C. While MFC care managers are available to assist with discharge planning, it is the responsibility of the inpatient facility to provide timely and appropriate discharge planning. Inpatient days that do not meet medical necessity as outlined in above criteria are the responsibility of the inpatient facility.

4. Emergency Care

A. In accordance with the Emergency Medical Treatment & Labor Act (EMTALA), ~~MSFC~~MFC will pay for all medical screening examinations (MSE) when the request is made for examination or treatment for an Emergency Medical Condition (EMC), including active labor. MFC does not consider a nurse exam or triage information as evidence of a medical screening exam.

B. In accordance with the Balanced Budget Act of 1997, ~~MSFC~~MFC pays for emergency services using a prudent layperson standard. An "emergency medical condition" is defined as:

a. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

C. In accordance with 42 CFR 438.114 (b) MFC may not refuse to cover emergency services based on the emergency room provider, hospital or fiscal agent not notifying the Enrollee's primary care provider, MCO, PIHP, PAHP or applicable State entity of the Enrollee's screening and treatment within 10 calendar days of presentation for emergency services.

D. MFC will pay for treatment obtained when a member had an Emergency Medical Condition, as specified in 42 CFR 438.114 (a) of the definition of Emergency Medical Condition. ~~MSFC~~MFC will not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, as defined herein, was in fact non-emergency in nature. ~~MSFC~~MFC does not require prior authorization for emergency services.

E. MFC requires and fully reviews emergency department clinical documentation for evidence of a medical screening exam and prudent layperson guidelines per 42 CFR 438.114(a). Services that are included in the member's benefit package, such out of area

care for Alliance members, are subject to administrative denial since they are not the liability of the MCO.

F. As detailed in DHCF Transmittal No. 12-27, Medicaid reimbursable emergency medical services provided to Alliance members are not the responsibility of the MCO. Hospitals should submit claims for these services directly to DHCF for reimbursement under Medicaid.

G. MFC does not specifically reward practitioners or other individuals for issuing denials of coverage of care. In addition, there are no financial incentives for UM decision makers that would encourage decisions that result in underutilization.

H. Providers may request the UM criteria utilized for a specific case by calling the MFC Care Management Department at 855-610-6203 or 202-243-5400. We are available Monday-Friday 8:00am to 5:30 pm.

5. Personal Care Services (PCS)

A. MFC uses the following criteria to make authorization decisions regarding Personal Care Services:
PCA Services Policy #1414 B to make authorization decisions regarding Personal Care Services [Embedded below]

B. Personal Care Services are defined as services that are provided by a Personal Care Aide (PCA) with the goals of:
   i. Providing necessary hands-on assistance with activities of daily living to members who are unable to perform one or more activities of daily living, and
   ii. To encourage home-based care as a preferred and cost-effective alternative to institutional care

C. Personal Care Services shall include:
   i. Performance of routine activities of daily living (such as, bathing, transferring, toileting, dressing, feeding, and maintaining bowel and bladder control);
   ii. Assisting with incontinence, including bed pan use, changing urinary drainage bags, changing protective underwear, and monitoring urine input and output;
   iii. Assisting beneficiaries with transfer, ambulation and range of motion exercises;
   iv. Assisting beneficiaries with self-administered medications;
   v. Measuring and recording temperature, pulse, blood pressure and respiration;
   vi. Observing, documenting and reporting the beneficiary's physical condition, behavior, and appearance and reporting all services provided on a daily basis;
   vii. Preparing meals in accordance with dietary guidelines and assistance with eating;
   viii. Performing tasks related to keeping areas occupied by the beneficiary in a condition that promotes the beneficiary's safety;
   ix. Accompanying the beneficiary to medical or dental appointments or place of employment and recreational activities if approved in the beneficiary’s plan of care; and

x. Recording and reporting to the supervisory health professional, changes in the beneficiary's physical condition, behavior or appearance.

D. PCA services shall not include:
   i. Services that require the skills of a licensed professional as defined by the District of Columbia Health Occupations Revision Act of 1985, as amended, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code §§ 3-1201.01 *et seq.*);
   ii. Tasks usually performed by chore workers or homemakers, such as cleaning of areas not occupied by the beneficiary and shopping for items not used by the beneficiary; and
   iii. Money management.

E. Upon receipt of an authorization request for Personal Care Services, the MFC Utilization Review Nurse will evaluate the request against the Medicare guidelines for Personal Care Services as well as the DC Regulations for Medicaid reimbursable Personal Care Services. If the criteria are met, the Utilization Review Nurse will approve the services requested. If the criteria are not met, the Utilization Review Nurse will pend the request to the Physician Advisor for further review and approval or denial.

F. If the provider requesting the Personal Care Services is not contracted with MFC, a Single Case Agreement (SCA) will be drafted. Once agreed upon and signed, final authorization for the services will be given.

1414 B Personal Care Assistant (PCA)

Summary of Changes:	**10/16:** • Added fax number for Pre-Authorization/Retrospective Review **07/16:** • Updated regulatory references • Added update indicating that Alliance members follow MFC Health Families formulary and can use any pharmacy within the MFC pharmacy network. • Clarified that MFC uses MFC PCA Services • Added update re: Policy # 1414 B to make authorization decisions regarding Personal Care Services. • Embedded PCA Services policy #1414B in document **10/15:** • References to ICD-9 changed to ICD-10 • Minor clarifications to criteria in section B of Procedures