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| MedStar Family Choice | | |
| **ADMINISTRATIVE POLICY AND PROCEDURE** | | |
| **Policy #:** | **110 B** | |
| **Subject:** | **UM Process** | |
| **Section:** | **Care Management** | |
| **Effective Date:** | **10/01/2007** | |
| **Revision Date(s):** | **09/08, 01/09, 04/09, 11/09, 03/10, 09/10, 07/11, 09/11, 03/13, 10/13, 06/14, 08/14, 10/14, 10/15, 07/16, 10/16** | |
| **Review Date(s):** | | |
| **Responsible Parties:** | **Theresa Bittle, Sharon Henry** | |
| **Responsible Department(s):** | **Case Management** | |
| **Regulatory References:** | **NCQA 2016: UM 4A, G; UM 5A, B; UM 6A, C; MED 1B<br>District of Columbia Contract: Sections C.14.2, C.10.2.5.1.3, C.10.2, C.14.2.2, C.14.6.4.2, C.14.8.6<br>DC Delmarva: GS 6, QA 9, QA 10, QA 11<br>42 CFR Sections 438.404, 42 CFR 438.210(d)** | |
| **Approved:** | | |
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**Purpose:** **This policy describes the oversight mechanisms and processes designed to promote consistency in the Utilization Management (UM) process with the goal of ensuring that members receive appropriate, quality health services in a timely manner.**

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

**Policy:** **MedStar Family Choice has a formal UM system designed to process pre-service, post-service and concurrent requests for authorization of services.**

**Definitions:**

**Notification of Admission:** Message from any hospital entity indicating that the member is admitted but does not include clinical review. An example of Notification of Admission would be a 'Face Sheet' or a telephone call.

**Request for Authorization:** Notice of admission, including date of admission, facility, attending physician, diagnoses accompanied by clinical review.

**Clinical Review:** Clinical information pertaining to the current inpatient days which is beyond the 'Diagnoses' documented on the face sheet. An example would be review prepared by the Utilization Review nurse.

**Redetermination:** Review of additional material, at the discretion of MFC when a concurrent denial is issued for insufficient or missing clinical information with option to reverse the decision to deny. This is a review of additional material and not a request for the denial to be reviewed.

**Peer to Peer Review:** A communication between a practitioner and the MFC Physician Advisor to provide additional information, clinical insight or other information for pended or denied authorizations for inpatient services.

**Appeal:** A formal request to an organization by a practitioner or member for reconsideration of a decision with the goal of finding a mutually acceptable solution.

**Standards & Applicability:**

A. For all determinations, MedStar Family Choice (MFC)
    1. Bases UM determinations only on the appropriateness of care and services, individual member needs, the availability of community resources and benefit coverage.
    2. Does not reward clinicians or other individuals for issuing adverse determinations of coverage or service.
    3. Does not provide financial incentives for UM decision-makers that encourage decisions that result in underutilization.

B. MedStar Family Choice is compliant with the standards and regulations set forth by DHCF, NCQA, and HIPAA.
    1. UM decisions are made within the defined timeframe requirements.
    2. Appropriately qualified health care professionals are involved in decision-making.
    3. Relevant clinical information is consistently gathered. Clinical information includes, but is not limited to, office and hospital records, a history of the presenting problem, a clinical exam, diagnostic testing results, treatment plans and progress notes, patient psychosocial history, and information on consultations with the treating practitioner. Only the minimum information necessary will be requested.
    4. Member confidentiality is maintained.
    5. The Medical Director, Director of Case Management, and Supervisor of UM (RN) are responsible for supervising all medical necessity decisions rendered by clinical staff.

C. For any previously authorized service, written notice to the enrollee must be provided at least 10 days prior to reducing, suspending or terminating a covered service. (42CFR 438.404(c)1)

D. For standard or expedited authorization decisions not reached within the timeframes specified in their respective sections below, written notice must be mailed on the date that the timeframes expire.

E. If the time for issuing a decision is extended MFC will give the member written notice of the reason for such an extension and inform the member of the right to file a grievance if he or she disagrees with the decision to extend the time allowed for issuing the authorization decision.

F. If extending the timeframe for making a determination, MFC will make determination as expeditiously as the member's health requires and no later than the date the extension expires.

**Procedure:**

A. Inpatient Review (Urgent Concurrent) Procedures
    1. All inpatient reviews will be conducted by an RN Utilization Review Case Manager.
    2. Each UR CM will identify patients for telephonic or electronic review via their task list or Request for Authorization from the facility's Case Management/Utilization Department. All concurrent review is performed telephonically or electronically.
    3. When performing a clinical review, the UR CM will identify himself/herself as a MFC employee and provide his/her name and title when receiving, initiating or returning telephone calls to members, authorized representatives, clinicians or facilities.
    4. The UR CM will concurrently gather information necessary to make a clinical determination from the hospital CM/UM department. Facilities are permitted to fax or telephone clinical information to the CM confidential line.
    5. Upon gathering the clinical information, the UR CM applies InterQual criteria. If the case involves a delivery of a newborn, the UR CM will automatically approve two days for vaginal delivery and four days for C-section delivery for both the mother and baby per Federal mandate.
    6. Authorization determinations are to be based solely on the clinical information obtained at the time of the review determination. Throughout the initial and concurrent review process, the UR CM has access to a Physician Advisor.
    7. If the clinical information provided to MFC meets InterQual Criteria, the admission will be approved. The hospital will be notified via the Daily Communication Log of the approval of the admission, level of care, and the next review date. The nurse reviewer may consult with a Physician Advisor for advice on the next review date.
    8. If the clinical information provided to MFC fails to meet the InterQual criteria or MFC policies/protocols, the case is to be pended to a Physician Advisor. The Physician Advisor may utilize a board-certified consultant to assist in making a medical necessity determination. The PA may request additional information. MFC will communicate a decision to authorize or deny within 24 hours of the receipt of the Request for Authorization. MFC may elect to grant an extension for an additional 48 hours for additional information to be submitted.
    9. All Requests for Authorization of inpatient days must be accompanied by clinical review. Notification of an admission without clinical review is not considered a Request for Authorization. Clinical review is defined as clinical information pertaining to the current inpatient stay which is beyond the diagnosis documented on the face sheet. A face sheet, without clinical review, will be considered 'Notification of an Admission' and will not constitute a Request for Authorization.

10. Notification of Admissions will be recorded on the Daily Communication Log. MFC will note member name and date of admission on the Daily Communication Log until clinical review is received or the patient is discharged. Once the member is discharged, the UR CM will document that the review is in 'retrospective' status.
11. Post initial review, MFC will document the next scheduled review date on the Daily Communication Log. If the member is discharged from the facility before the next scheduled review date, the nurse reviewer will enter the discharge date into the Clinical Software System tem, update approved days and close the admission event. Upon receipt of the clinical information, MFC will make a determination within one calendar day of the scheduled review date. Clinical review not received on the scheduled review date may be subject to denial. MFC may elect to grant an extension for an additional 48 hours. MFC will send a Daily Communication Log to hospitals with reported inpatient days. Communication logs will note, at minimum, the member name, admission date, approved and/or denied dates of service, next scheduled review date, and the reference #, once a Request for Authorization has been submitted.

12. If the facility does not follow the proper procedure for authorization, MFC personnel are to inform the facility representative of the specific UM requirements and procedures.
13. MFC adheres to the following decision timeframe requirements in making urgent concurrent review determinations:

Table 1: Authorization Determinations - Urgent Concurrent

| **REVIEW TYPE** | **TIMELINE FOR UM DECISION MAKING** | **NOTIFICATION METHOD** | **WHO MUST BE NOTIFIED** |
|---|---|---|---|
| Concurrent - urgent | Within 24 hours of the receipt of the Request for Authorization<br>*See text above for possible extension | Electronic or written | **Electronic:** Facility<br>**Written:**<br>- Facility<br>- Treating physician or clinician (denials only*)<br>- PCP (denials only*)<br>- Member (denials only*) |

**Also includes authorization of a service in an amount, duration, or scope that is less than requested*

14. Documentation of all the aforementioned activities is made in the Clinical Software System, concurrently.
15. Any cases meeting criteria for disease/case management or quality improvement will be referred via the Clinical Software System.
16. Redetermination: A redetermination is not considered an appeal. If an Urgent Concurrent denial is issued for insufficient or missing clinical information, and the facility or practitioner submits the clinical review or the missing information while the member remains an inpatient or up to 3 business days after discharge, MFC reserves the right to review the additional material and reverse the decision to deny. MFC staff will use the additional information submitted and apply the appropriate InterQual criteria. If the additional information meets the InterQual criteria, the nurse reviewer may approve the day. If the additional information does not meet the InterQual Criteria, the nurse reviewer will pend the case to a Physician Advisor. The same reviewer or PA may review and reverse the decision to deny. If the same

reviewer or PA would not overturn the denial, MFC will issue a final denial letter to the facility or practitioner with the total days denied and referred to the content of the denial letter for guidance on the appeal process.

17. Peer to Peer: A Peer to Peer is not considered an appeal. If a facility day(s) is pended or an Urgent Concurrent denial is issued, the facility or practitioner may request a Peer to Peer Review while the member remains an inpatient or up to 3 business days after discharge. A Peer to Peer Review is a communication between a practitioner at the hospital and the MFC Physician Advisor. During a Peer to Peer, the facility based practitioner may provide additional information, clinical insight or other information to explain why the hospital day(s) should be approved. MFC reserves the right to request documentation to support information supplied verbally and will incorporate this information into the Clinical Software System record. The same Physician Advisor involved in the case will participate in the Peer to Peer, when possible. This PA may reverse the decision to deny and approve the day if the information provided during the Peer to Peer warrants approval based on the PAs clinical opinion. If the PA would not overturn the denial, the facility based practitioner will be informed that the denial stands and referred to the content of the denial letter for guidance on the appeal process.

B. Elective Admissions and Outpatient Authorizations (Urgent & Non-urgent)
    1. All outpatient reviews, pharmacy reviews, and elective pre-certifications for admissions will be conducted by a LPN, RN, or MD. A social work case manager may data enter an approved authorization.
    2. Outpatient pre-authorization is required for the following:
        a. Services with a facility fee
        b. Research / investigative procedures
        c. OON procedures
        d. Cosmetic procedures
    3. Outpatient authorizations/elective admission requests are accepted electronically via Referral form or telephone.
    4. When performing a clinical review, the CM will identify himself/herself as a MFC employee and provide his/her name and title when receiving, initiating or returning telephone calls to members, authorized representatives, clinicians or facilities.
    5. The CM will gather minimally necessary information to make a clinical determination from individuals involved in treating the member such as the PCP, specialist, or treating clinician.
    6. Upon gathering the clinical information and the Request for Authorization, the CM applies InterQual criteria or MFC protocols. MFC protocols supersede InterQual criteria. The availability of network providers is also considered.
    7. Authorization determinations are to be based solely on the clinical information obtained at the time of the request for coverage. Throughout the review process, the CM has access to a physician advisor.
    8. If the clinical information provided to MedStar Family Choice fails to meet the InterQual criteria or MFC policies/protocols, the service is not a covered benefit, or the request is for an OON provider/facility, the case is referred to a physician advisor. The requesting provider will be consulted with, when appropriate.

9. Standard Pre-Service Authorization decisions must be made as expeditiously as the Enrollee's health condition requires and the member must be notified in writing within 48 hours of the decision and within fourteen (14) days of the receipt of the request for service, with a possible extension of up to fourteen (14) days if:
    1) The Enrollee or the Provider requests an extension; or
    2) Contractor justifies to DHCF upon request, a need for additional information and how the extension is in the Enrollee's interest. In the event that the practitioner/facility fails to provide sufficient information to make an authorization, the CM will make at least one attempt to obtain clinical information. An administrative denial occurs after failure to supply clinical information.
10. Expedited Pre-Service Authorization (Urgent) decisions, in which a Provider indicates or Contractor determines that applying the standard Pre-Service Authorization time frame could seriously jeopardize the Enrollee's life or health or ability to attain, maintain or regain maximum function, must be made as expeditiously as the Enrollee's health condition requires and the member or member representative must be notified in writing within 48 hours of the decision and within 72 hours of receipt of the request for service. If clinical information is received after the administrative denial is rendered, the medical record will be reviewed as an appeal since a formal administrative adverse decision letter was sent to the provider, facility, PCP and member.
11. If the facility does not follow the proper procedure for authorization, MFC personnel are to inform the facility representative of the specific UM requirements and procedures.
12. Elective Admissions and Outpatient Authorization Determinations
    a. MFC adheres to the following decision timeframe requirements in making elective admission and outpatient authorization determinations

Table 2: Authorization Determinations - Elective Admissions & Outpatient

| REVIEW TYPE | TIMELINE FOR UM DECISION MAKING | TIMELINE FOR NOTIFICATION | NOTIFICATION METHOD | WHO MUST BE NOTIFIED |
|---|---|---|---|---|
| Pre-service (urgent) (Expedited) | Within 72 hours of receipt of the Request for Authorization. | Within 48 hours of the decision and 72 hours of the receipt of the request. | Verbal (optional) Electronic or written (required for denials) | - Requesting practitioner / provider (approval and denial*)<br>- PCP (only written notification required-denial only*)<br>- Member or authorized representative (denial only*) |
| Pre-service (non-urgent) (Standard) | Within fourteen (14) days of the receipt of the Request for Authorization, with a possible extension of up to fourteen (14) days if: The Enrollee or the Provider requests an extension; | Within 48 hours of the decision and within 14 days of the receipt of the request. | Verbal (optional) Electronic or written (required for denials) | - Requesting practitioner / provider (approval and denial*)<br>- PCP (only written notification required-denial only*)<br>- Member or authorized representative(denial only*) |

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| | or Contractor justifies to DHCF upon request, a need for additional information and how the extension is in the Enrollee's interest. | | | |

**Also includes authorization of a service in an amount, duration, or scope that is less than requested*

13. Documentation of all the aforementioned activities is made in the Clinical Software System, concurrently.
14. Any cases meeting criteria for disease/case management or quality improvement will be referred via the Clinical Software System.
15. Denial letters will be generated by the CM. The CM will proof read the letter and sign the physician advisor's name followed by their initials.

C. Post Service (Retrospective) Review Determinations

Post-service reviews occur when services have already been delivered or prior authorization did not occur. Participating treating physicians/clinicians and members have up to 180 calendar days after the last date of service to request a post-service review (this is not an appeal since there was never an initial review).

1. Inpatient post-service
   a. The UR CM may retrospectively review authorization requests that are received within 30 days from the date of discharge or last date of service. The appeals staff will prepare the post-service review for the Physician Advisor regarding requests for retrospective review ≥ 30 calendar days, but ≤ 180 calendar days from the date of discharge or the last date of service.
   b. For retrospective reviews < 30 days, the UR CM will gather information necessary to make a clinical determination from the hospital CM/Appeal department. Facilities are permitted to fax or mail the clinical records.
      i. The appeals staff will prepare the post-service review for the Physician Advisor for inpatient post-service reviews ≥ 30 calendar days, but ≤ 180 calendar days from the date of discharge or the last date of service. However, this review is not considered an appeal and the physician advisor makes the decision regarding approval or denial.
   c. Upon gathering clinical information, the UR CM or physician advisor applies InterQual criteria or MFC policies/protocols.
   d. Authorization determinations are to be based solely on the clinical information obtained at the time of the review determination.
   e. If the clinical information provided to MFC fails to meet the InterQual criteria or MFC policies/protocols, the case is to be referred to a physician advisor. The physician advisor may utilize a board-certified consultant to assist in making a medical necessity determination. The requesting provider will be consulted with, when appropriate.
   f. In the event that the facility fails to provide clinical information to make an authorization determination based upon medical necessity and it has been < 30 days, the UR CM will make at least one request for clinical information. If the

clinical information is not received within 30 days from the date of service, an administrative denial will occur.

g. If the facility fails to provide clinical information to make an authorization determination based upon medical necessity and it has been > 30 days, the practitioner/facility will be notified of the need to initiate a formal appeal process since a formal administrative adverse decision letter was sent.
h. If the facility does not follow the proper procedure for authorization, MFC personnel will inform the facility representative of the specific UM requirements and procedures.

2. Outpatient post-service
   a. The appeals staff will prepare the post-service review for the Physician Advisor directing any requests for retrospective review within 180 calendar days from the last date of service.
   b. The appeals staff will gather information necessary to make a clinical determination from individuals involved in treating the member such as the PCP, specialist, treating clinician.
   c. Upon gathering the clinical information, the Physician Advisor applies InterQual criteria or MFC policies/protocols. MFC protocols supersede InterQual criteria. Authorization determinations are to be based solely on the clinical information obtained at the time of the review determination.
   d. In the event that the facility fails to provide sufficient information to make an authorization determination, the appeals staff will make at least one request for clinical information. If the clinical information is not received within 30 days of the last date of service, an administrative denial will occur. If clinical information is received after the administrative denial is rendered, the facility will be notified of the need to initiate a formal appeal process since a since a formal administrative adverse decision letter was sent.
   e. If the facility does not follow the proper procedure for authorization, MFC personnel will inform the facility representative of the specific UM requirements and procedures.

3. Post-service Review Determinations
   a. MFC adheres to the following decision timeframe requirements in making post-service review determinations.

Table 3: Post-service Review Determinations

| **REVIEW TYPE** | **TIMELINE FOR UM DECISION MAKING** | **TIMELINE FOR NOTIFICATION** | **NOTIFICATION METHOD** | **WHO MUST BE NOTIFIED** |
|---|---|---|---|---|
| Post-service (inpatient) | Within 30 calendar days of the receipt of the Request for Authorization. | Two (2) business days after the determination, but within 30 calendar days of the initial request for authorization. | - Electronic or written | -Treating physician or clinician (denial only*)<br>- PCP (denial only*)<br>- Facility<br>- Member (denial only* and if financial risk) |
| Post-service (outpatient) | Within 30 calendar days of the receipt | Two (2) business days after the determination, | - Electronic or written | - Treating physician or clinician |

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| | of the Request for Authorization. | but within 30 calendar days of the initial request for authorization. | | - PCP (denial only*)<br>- Facility (denial only*)<br>- Member (denial only* and if financial risk) |

**Also includes authorization of a service in an amount, duration, or scope that is less than requested*

b. Documentation of all the aforementioned activities is made in the Clinical Software System.
c. Any cases meeting criteria for disease/case management or quality improvement will be referred via the Clinical Software System.
Denial letters for inpatient Post-Service inpatient will be generated and completed in the Clinical Software System by the UR CM.

D. Authorization of Service after Reversal Decision
1. If contractor is notified of the District Office of Administrative Hearings decision to reverse a decision, the service shall be authorized or provided **no later than two (2) business days after reversal or notification of reversal** from the District.
2. In cases involving an expedited Appeal, services shall begin **within twenty-four (24) hours of the reversal.**

E. OON Facilities
1. Inpatient cases involving emergent/urgent admission will be reviewed based on medical necessity.
2. Inpatient requests for elective procedures will be redirected to an in-network facility unless the in-network facilities do not have the specialty to treat the case presented. If the request is a post-service review of an elective procedure, MFC will deny for services not authorized unless the clinical supports emergent or urgent care.

F. OON Providers
1. These requests will be redirected to a network provider unless there is no clinical expertise available within the network for the presenting case or the case involves continuity of care.
2. If the request is a post-service review for services provided by a non-participating provider, MFC will deny for services not authorized unless the clinical supports emergent or urgent care.

G. Second Opinions
1. Upon request, MFC will provide for a second opinion from a qualified health professional. If the qualified health professional is not available within our network, MFC will make arrangements for the member to obtain a second opinion from an out-of-network provider at no cost to the member.

H. Member Protected Health Information (PHI)
1. Member PHI is to be kept confidential in accordance with applicable laws.
2. The use and disclosure of PHI is to be limited to the minimum amount necessary to accomplish the purpose of the intended disclosure.
3. PHI is to be used solely for the purpose of UM, including case management and discharge planning, quality management, and disease management.

4. PHI is to be shared only with entities and/or individuals who have authority to receive the information and who need access to the information in order to conduct UM and other related processes.
5. MFC is to make reasonable efforts to limit the use and disclosure of PHI to the minimum amount necessary to accomplish the purpose of the use or disclosure.

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| **Summary of Changes:** | **10/16:**<br>• Updated UM denial letter are generated and documented in the clinical software system by the CM without the use of paper trackers.<br>• Replaced CCMS with clinical software system<br>• Added pharmacy to section B, number 1<br>• Revised the Post-service (retrospective) review determinations process<br>• Deleted Denial/Appeal Response Form from document<br>**07/16:**<br>• Updated revision date and regulatory references<br>**10/15:**<br>• Added 'Redetermination' and 'Peer to Peer' processes.<br>• Added definition of 'Appeal' to document distinction between this and 'Redetermination' and 'Peer to Peer' processes. |