MedStar Family Choice		
ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**115A**	
Subject:	**Utilization Management (UM) Criteria**	
Section:	**Care Management**	
Initial Effective Date:	**10/01/2007**	
Revision Effective Date(s):	**07/18**	
Historical Revision Date(s):	**09/08, 11/09, 09/10, 09/11, 10/12, 10/13, 11/13, 7/14, 10/14, 01/15, 10/15, 10/16, 07/17, 01/18**	
Review Effective Date(s):		
Historical Review Date(s):		
Responsible Parties:	**Theresa Bittle, Priscilla Thomas, Blaine Willis**	
Responsible Department(s):	**Case Management**	
Regulatory References:	**NCQA 2018: UM 4G, UM 7A, UM 11E** **MDH Memorandum Dated 12-7-2017 RE: Hepatitis C Medications Approval Timelines (Also includes drugs other than Hepatitis C)**	
Approved:		
	Theresa Bittle, RN **AVP, Clinical Operations**	**Patryce A. Toye, MD** **Chief Medical Officer**

Purpose: **This policy describes criteria utilized, to facilitate consistency in Utilization Management (UM) decision making.**

Scope: **MedStar Family Choice (MFC), Maryland**

Policy: **MedStar Family Choice follows documented UM criteria to facilitate consistency in UM decision making. All criteria utilized in utilization management are available upon request. The request can be made independent of a specific case. Reviewers and Medical Directors are also available to discuss any and all utilization management decisions, questions or issues. To request specific utilization management criteria or to speak with a Medical Director, please contact us by phone during our normal business hours, 8:30 AM to 5:00 PM Monday through Friday, at 800-907-1722 or 410-933-2200. The fax number is 410-933-2274. Messages received outside of normal business hours will be addressed the following business day.**

UM decision making is based only on appropriateness of care and service and existence of coverage. MFC does not specifically reward practitioners or other individuals for issuing denials of coverage. In addition, there are no financial incentives for UM decision makers that would encourage decisions that result in underutilization.

MFC may provide the treating practitioner the opportunity to discuss a pending medical necessity denial with a UM reviewer and/or Medical Director prior to the denial.

Procedure:

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

A. Pre-Authorization, Retrospective Review, Requests for Continuation of Outpatient Services:
    1. MFC follows a basic pre-authorization process: A member's practitioner forwards clinical information and requests for services to MFC by telephone, fax or infrequently by mail. Telephones are manned on business days from 8:30am-5pm at 410-933-2200 or 1-800-905-1722. Our fax number is 410-933-2274 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 the telephone number for MFC representative who is on call after hours, weekends and holidays to process pharmacy requests in a timely manner.

    2. All appropriate ICD-10/CPT/HCPCS, along with supporting clinical information, must be included in requests for pre-authorization. Requests for authorization can be included on the Maryland Uniform Consultation Referral Form or the MFC Prior Authorization Form with clinical information attached. Our experienced clinical staff reviews all requests. MFC pre-authorization decisions are based on the following criteria:
        a. MFC Protocols
        b. MFC Pharmacy Policies and Procedures
        c. InterQual
        d. Medicare and Medicaid Guidelines
        e. Code of Maryland Regulations (COMAR)
        f. MFC MCO benefit coverage
        g. MFC Provider Manual
        h. MFC Member Handbook
        i. Food and Drug Administration (FDA) Approval
        j. Maryland Medicaid DMS/DME Program Approved List of Items
        k. Availability of services within the MFC network
        l. MFC Continuity of Care Policy
        m. Pain Management Contracts

n. UM Criteria Policy
o. Maryland Medicaid Medical Laboratory and Professional Services Program Approved List of Items
p. National and International Professional Medical Society Guidelines, including but not limited to:
    i. National Comprehensive Cancer Network (NCCN)
    ii. NCCN Biomarkers Compendium
    iii. National Institutes of Health
    iv. National Cancer Institute
q. U.S. Preventive Services Task Force (USPSTF)

3. A limited number of services require authorization from MFC. These are included on the Quick Authorization Guide that can be found on the MFC website.

4. MFC reserves the right to direct services to participating providers and facilities. Services outside the network may need approval. Approval will be based on the availability of services in the network and for issues of continuity of care.

5. MFC's utilization management decision making is based on the medical necessity of the service and the existence of Managed Care Organization (MCO) enrollment and coverage.

6. MFC requires up to two business days to process a complete, non-urgent pre-authorization request. Requests are considered complete when all necessary clinical information is received from the requesting practitioner. The final decision cannot take longer than fourteen days, whether or not all clinical information has been received. For all covered outpatient pre-service pharmacy and concurrent pharmacy drug authorization requests a decision to approve, deny or request further information will be made within 24 hours of the request. If the service requested is denied the practitioner may contact our Care Management Department to discuss the decision with the appropriate Medical Director.

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

8. 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 was urgent/emergent, a COMAR defined self referral service, or a continuity of care issue.

9. DME and services that are carved out to the State of Maryland Medicaid, which include, but are not limited to, pediatric outpatient rehabilitation services and behavioral health care (mental health and substance abuse) are subject to administrative denial since they are not the liability of the MCO.

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

11. Upon review for medical necessity, requests for ongoing services or treatment that have not demonstrated improvement in condition or benefit to the member will be subject to denial as 'not medically necessary.'

B. Pharmacy:

1. MFC pays for a wide variety of medications as outlined in our formulary. If a practitioner feels it medically necessary to prescribe a medication not on the formulary, the practitioner 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 Medical Director. The Medical Director will make a determination to approve, deny or request further information based on pharmacy policies and procedures and current regulations within 24 hours of the request. MFC does not guarantee coverage of medications that do not meet medical necessity, Policies & Procedures, or regulatory guidelines. Practitioners may call MedStar Family Choice at 410-933-2200, or fax requests to 410-933-2274.

2. 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. The Statement of Medical Necessity form may be found on the MFC web site.

3. Requests for Hepatitis C medications require a completed "Hepatitis C Therapy Prior-Authorization Form and Prescription." This form may be found on the MFC website. Maryland Department of Health (MDH) processes and criteria will apply.

4. Requests for medications listed in the MDH Opioid DUR (high dose and/or long acting narcotics, methadone for pain and fentanyl) will require a completed Prior Authorization form. This form may be found on the MFC website. MFC will also accept the universal form developed by the MDH and Maryland MCOs.

5. Medications covered by the MDH, such as HIV/AIDS medications and behavioral health drugs, are not covered by the MFC MCO. These requests are subject to administrative denial since they are not the liability of the MCO.

C. Concurrent Review:

1. MFC utilizes the following criteria to make concurrent review decisions:
    a. InterQual
    b. Medicare and Medicaid Guidelines
    c. COMAR
    d. MFC benefit coverage

e. Availability of services within the MFC network

2. MFC reviews clinical documentation for timeliness of care and appropriate level of care. Clinical denial determinations may be issued by our Medical Directors 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.

3. 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. Services that are carved out to the State of Maryland Medicaid, which include but are not limited to behavioral health care, are subject to administrative denial since they are not the liability of the MCO.

D. Emergency Care:

1. In accordance with the Emergency Medical Treatment & Labor Act (EMTALA), MFC will pay claims 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.

2. In accordance with the Balanced Budget Act of 1997, 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.

3. MFC requires and fully reviews emergency department clinical documentation for evidence of a medical screening exam, prudent layperson guidelines, as well as evaluation of assigned treatment levels based on HSCRC guidelines for reasonable Clinical Care Time. Services that are carved out to the State of Maryland Medicaid, which include but are not limited to behavioral health care, are subject to administrative denial since they are not the liability of the MCO.

E. Request for Criteria:

1. Providers may request the UM criteria for UM decision making by calling the MFC Care Management Department at 1-800-905-1722 or 410-933-2200. We are available Monday-Friday 8:30am-5pm.

MARYLAND
Department of Health
Larry Hogan, Governor · Boyd Rutherford, Lt. Governor · Dennis Schrader, Secretary

MEMORANDUM

TO: MCOs

FROM: Susan J. Tucker, Executive Director
Office of Health Services

RE: Hepatitis C Medication Approval Timeline

DATE: December 7, 2017

In response to inquiries from several HealthChoice MCOs, Maryland Department of Health (MDH) would like to clarify the CMS Managed Care Rule for providing responses to requests for covered outpatient drugs within 24 hours.

Hepatitis C medication and review is outside of the normal HealthChoice program process regarding outpatient drug coverage and is, accordingly, not subject to the covered outpatient drug rule (42 CFR 438.210 (d)(3)). MCOs should provide a response by telephone or other telecommunication device within 24 hours of receiving all required information, including the MDH response to clinical criteria review.

For drugs other than Hepatitis C, the time limit for a response for all covered outpatient drugs begins when the MCO or the MCO's Pharmacy Benefits Manager (PBM) receives the completed preauthorization form or a phone call from the provider or patient. MCOs then must approve, deny, or request further information within 24 hours. Responses may be provided by telephone or other telecommunication device. If MCOs request further information, a response should be provided within 24 hours of receiving further information and no more than 14 days from initial request, in accordance with the standard authorization timeframe.

Summary of Changes:	**07/18:** • Updated NCQA Year. • Added to Regulatory Reference- MDH Memorandum dated 12-7-2017 RE: Hepatitis C Medications Approval Timelines (Also includes drugs other than Hepatitis C). • Added to Section A, 2 the following criteria we follow: Maryland Medicaid Medical Laboratory and Professional Services Program Approved List of Items, National Comprehensive Cancer Network (NCCN), NCCN Biomarkers Compendium, National Institutes of Health, National Cancer Institute, U.S. Preventive Services Task Force (USPSTF). • Modified Effective Date to Initial Effective Dates; added Historical Revision Dates and Revision Effective Dates; and added Historical Review Dates and Review Effective Dates. **01/18:** • Under Procedure Section A iii added language for the Quick Authorization guide. • Under Procedure Section A vi- updated 7 calendar days to 14 calendar days. • Added language to indicate that a decision or determination to approve, deny or request further information will be made on all pre-authorization and concurrent pharmacy requests within 24 hours of the request. • Under Pharmacy Section B iv added text for the MDH DUR authorization form requirements. • Replaced mental health with behavioral health. **07/17:** • Updated NCQA Year and reference to UM 11E from 12E • Changed Approved by from Carol Attia to Theresa Bittle and updated Dr. Toye's title from Sr Medical Director to Chief Medical Officer. • Physician Advisor to Medical Director. • Added MFC Prior Authorization Form to A ii. • Added to Section A ii last bullet- National and International Professional Medical Society Guidelines to the criteria we follow. • In section B iv, changed Department of Health and Mental Hygiene to Maryland Department of Health (MDH). **10/16:** • Updated Regulatory References. • Delete reference to utilizing Fee For Service rules for inpatient days while awaiting guardianship. **10/15:**

	• References to ICD-9 updated to ICD-10. • Removed Substance Abuse section since now carved out from MCO to State of Maryland.