POLICY AND PROCEDURE

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Effective Date: 04/01/17
Last Revised: April 2020
User Note:

COMMUNITY HEALTH CHOICE
COMMUNITY CARES

TITLE: UTILIZATION MANAGEMENT PROGRAM PROCESS

Department:	Medical Affairs Utilization Management	**Department Head:** (Name and Signature)	Dr. Lisa Fuller
Approval Date:	04/06/2020	**Next Review Date:**	April 2021
Compliance/Executive Approval:			
Name : Delwin Beene		**Date:** April 2020	

APPLIES TO: ☒ **MEDICAID** ☒ **CHIP/ CHIP P** ☒ **HEALTH INS MARKETPLACE** ☐ **MEDICARE**

☒ **STAR+PLUS** ☐ **OTHER** ☐ **ALL MEDICAID**

PURPOSE:

Utilization Management is an evaluation and determination of medical necessity and the appropriateness of use of medical care resources. It includes the provision of any needed assistance to the clinician and/or the member. This will ensure that the use of resources are leveraged in a consistent manner. Utilization Management includes prior authorization/prospective review, concurrent review, retrospective review, and discharge planning. This policy discusses the process of Utilization Management at Community Health Choice, Inc. (Community).

POLICY:

The Utilization Management Program process is reviewed annually and revised to reflect the current program policies and procedures in Medical Affairs Department. Community's Medical Affairs Department also has a Utilization Management Program Description and Plan that is reviewed and revised annually. This Policy and Procedure will describe the process of Utilization Management.

DEFINITIONS:

See listing of common use definition of terms for Community's Policy and Procedures.

PROCEDURE:

Responsible Party (Who)	Step	Action Taken (Does What)
Medical Affairs Nursing Staff OR Coordinator	(A)	Receives a request for authorization of services or information of admission into an acute hospital setting via phone, fax or Community's web portal.
Medical Affairs Nursing Staff OR Coordinator	(B)	-Verifies: a) member identity b) member eligibility c) provider network participation status - Creates a computer based authorization request in Community's managed care platform. - Attaches all information, notification and/or clinical information that is received into the computer-based platform. If information is received verbally, the information is documented in the notes section of the computer based platform. If clinical information is not included with the request, verbally and/or by fax, the coordinator or Medical Affairs Nursing Staff requests that clinical information to support the request be sent to Community via a fax note or telephonically. - The authorization request is then placed in a status of "pending" and assigned in Community's managed care platform to designated Medical Affairs Nursing Staff for initial clinical review and determination. - The above information and actions will be documented appropriately in Community's computer based managed care platform.
Medical Affairs Nursing Staff	(C)	**For retrospective reviews** the provider will be notified via a fax note or telephonically that the records must be received within 30 days of notification in order to perform a retrospective review. If a claim is submitted prior to Community receiving a request for authorization determination, the provider is advised they must follow the claim appeal

<table>
<tr><th>Responsible Party (Who)</th><th>Step</th><th>Action Taken (Does What)</th></tr>
<tr><td></td><td></td><td>process.

If the request for authorization does not require authorization, Medical Affairs Nursing Staff will contact the requesting provider via fax or telephonically to alert the provider that the services requested do not require authorization.

The above information and actions will be documented appropriately in Community's computer based managed care platform.</td></tr>
<tr><td>Medical Affairs Nursing Staff</td><td>(D)</td><td>For ALL requests for authorization and retrospective authorization or extension of services that require authorization including inpatient hospital admissions and concurrent hospitalizations see below:

If the services requested requires prior authorization for provision of services:

- Ensures that a determination is made regarding the request for authorization verbally or electronically within the required turn-around response times based on the type of authorization request. If the request is received outside of the period requiring the availability of appropriate personnel as required below, the determination must be issued and transmitted the next time period requiring such personnel.
<table>
<tr><td>Type of authorization Request</td><td>Turn-Around Response Timeframe</td></tr>
<tr><td>Routine</td><td>3 Business Days</td></tr>
<tr><td>Urgent</td><td>1 business Day</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Concurrent (Inpatient)</td><td>1 business day with verbal or electronic notice.
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<tr><td>Retrospective</td><td>30 days after receipt of request .</td></tr>
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Responsible Party (Who)	Step	Action Taken (Does What)
Medical Affairs Nursing Staff	(E)	For ALL requests for authorization of services that require authorization including inpatient hospital admissions and concurrent hospitalizations and retrospective hospitalizations Verify a) member identity b) member benefit plan type c) provider network participation status d) member eligibility status e) benefit limitations f) clinical information is available for review If the member's identity cannot be verified: Contact requesting provider via fax or telephonically to verify member identity and confirm participation and/or non-participation with Community's benefit plans. If requested services are received for a non-participating or "out-of-network" provider: Refer to and follow policy and procedure Referrals to Non-participating Providers and work with Provider Contracting as needed. If the member is ineligible for the benefit plan for the dates of service, the services requested are not a benefit of the members benefit plan or clinical information was NOT received verbally or electronically regarding the request for authorization for services: Perform an Administrative denial determination. Generate and issue the applicable notice of administrative denial via fax to the requesting provider due to lack of clinical information provided, ineligible status or non-covered benefit. Generate a formal letters of administrative denial to the requesting provider and other entities as required via Community's managed care platform.

Responsible Party (Who)	Step	Action Taken (Does What)
UM Letter Team	(F)	Print all formal notice letters including administrative denial notices from Community's managed care platform and forward via US Mail as indicated. These letters are mailed to the member, any person acting on behalf of the member, the facility, and the treating physician not later than two working days after the date the letter is generated in Community's managed care platform by the Medical Affairs Nursing Staff.
Medical Affairs Nursing Staff	(G)	**Utilization Review**: Clinical information is reviewed to identify medical necessity criteria utilizing evidence based screening guidelines, Evidence of Coverage, Member Contracts, Benefit limitations or Community Policies. If the requested authorization for service(s) is supported by the evidence-based medical necessity screening criteria, Evidence of Coverage, Member Contracts, or Community Policies: a) Approve the authorization request b) Fax the notification of approval to the requesting provider. c) Generate an approval letter notification as applicable via Community's managed care platform. d) Make appropriate referrals such as CPS, Quality, Case Management and Disease Management and Behavioral Health. e) Document actions appropriately in Community's computer based managed care platform.
UM Letter Team	(H)	Print all formal notice letters from Community's managed care platform and forward via US Mail as indicated. These letters are mailed to the member, any person acting on behalf of the member, the facility, and the treating physician not later than two working days after the date

Responsible Party (Who)	Step	Action Taken (Does What)
		the letter is generated in Community's managed care platform by the Medical Affairs Nursing Staff.
Medical Affairs Nursing Staff	(I)	Assesses the clinical information to evaluate if the requested authorization for service(s) is for Private Duty Nursing or does not appear to be supported by clinical information, evidence-based medical necessity screening criteria, Evidence of Coverage, Member Contracts, or Community Policies, and/or the medical information received is not sufficient to make a determination. **Alberto-N Process** - For Star Medicaid Members younger than 21 years old with requests for prior authorization for Physical, Occupational or Speech Therapy Services, Durable Medical Equipment, Skilled Nursing Services, Private Duty Nursing Services follow the Prior authorization for health services /treatment Policy and Procedure for direction on these Alberto N related requests). -Contact the requesting provider as needed via fax or telephonically and request a clarification of information and/or additional clinical information be provided electronically or verbally If no clinical information is provided, after a good faith effort to obtain the information the nurse may administratively deny the request. After a good faith attempt to obtain If sufficient clinical information is not provided to make a determination or does not support the requested services: -Fax a notification to the requesting provider

Responsible Party (Who)	Step	Action Taken (Does What)
		with the offer of and availability of a peer-to-peer discussion regarding the request for authorization of services. **Initiates Medical Director Review (MDR) Process:** Forward information to the Medical Director or Physician Reviewer for review in the appropriate "MEDREVIEW" (MDR) format and attaching the applicable clinical information. Forward the electronic request for authorization via Community's managed care platform. Document actions appropriately in Community's computer based managed care platform.
The Medical Director OR Physician Reviewer	(J)	**Medical Director Review:** The Medical Director or Physician Reviewer makes the final favorable or adverse determination. Medical Necessity Denials and /or (adverse determinations) are only made by Medical Directors or Physician Reviewers. Peer Clinical Reviewers are located in the state or territory of the United States when conducting a peer clinical review. - Prior to an adverse determination, Community will afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician during a peer to peer discussion. The discussion will include, at a minimum, the clinical basis for the Community's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal,

Responsible Party (Who)	Step	Action Taken (Does What)
		might lead to a different utilization review decision. - (A) no less than one working day prior to issuing a prospective utilization review adverse determination; - (B) no less than five working days prior to issuing a retrospective utilization review adverse determination; or - (C) prior to issuing a concurrent or post-stabilization review adverse determination. The Medical Director will respond to requests for Peer-to-Peer reviews with requesting providers within 1 business day of request to obtain clarification, additional clinical information or other pertinent information before rendering an adverse medical determination. Peer-to-Peer reviews can also be initiated by Community's utilization management/case management and medical staff to attending and/or ordering physicians. If the Medical Director Review results in an Adverse Determination, the benefit plan applicable Adverse Determination Policy and Procedure will be followed. The referring Provider, member, any person acting on behalf of the member/enrollee and provider of record will be informed of clinical basis for the decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision and the appeal and expedited appeal rights and processes. If the adverse determination involves an urgent/emergent

Responsible Party (Who)	Step	Action Taken (Does What)
		situation, the Expedited Appeal process will be followed when requested by the provider or member. This information is included in all adverse determination letters. If there is an adverse determination, Medical Director or Physician Reviewer documentation will annotated in Community's managed care platform. Generate and issue an appropriate adverse determination notice via fax to the requesting provider. Generate a formal letter of adverse determination to be mailed to the member, any person acting on behalf of the member, the facility, and the treating physician.
Appeals Staff	(L)	Expedited appeals with an adverse determination are completed with verbal notification within one (1) working day of the request followed by formal notice letter that is mailed within 3 working days of the adverse determination to the member, any person acting on behalf of the member/enrollee and provider of record. Refer to Appeals policy-2020CM014,015 and 016
UM Letter Team	(M)	Print all formal notice letters including adverse determination notices from Community's managed care platform and forward via US Mail as indicated. These letters are mailed within 3 business days of the determination and generation via Community's managed care platform.
Senior VP of Medical Affairs	(N)	The Senior VP of Medical Affairs is responsible for all activities of the Medical Directors/Physician Reviewers and for strategic guidance of UM processes.

MONITORING:

Monthly Audits are conducted by the UM leadership team
Inter-Rater Reliability Assessments are conducted at least annually

REPORTING:

Name of Report	Frequency of Report	Owner
Turn-around time Report UM Denial Report Exception report UM Nurse Productivity Report UM Coordinator Template Created Report	Daily /Monthly/Quarterly	UM Leadership Team

REGULATORY CITATIONS:

ATTACHMENT(S): N/A