



UTILIZATION MANAGEMENT

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Overview

'Ohana's (the Plan) Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and the state of Hawai'i while providing members access to high-quality, cost-effective medically necessary care.

The focus of the UM program is on:

- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the member's diagnosis and level of care required;
- Providing access to medically appropriate, cost-effective health care services in a culturally sensitive manner and facilitating timely communication of clinical information among providers;
- Reducing overall expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership;
- Facilitating communication and partnerships among members, families, providers, delegated entities and the Plan in an effort to enhance cooperation and appropriate utilization of health care services;
- Reviewing, revising and developing medical coverage policies to ensure members have appropriate access to new and emerging technology; and
- Enhancing the coordination and minimizing barriers in the delivery of behavioral and medical health care services.

Medically necessary services

Medically necessary services shall be as defined in Hawai'i Revised Statutes (HRS) 432E-1.4 *or* health interventions that health plans are required to cover within the specified categories that meet the criteria

identified below, whichever is the least restrictive:

- The intervention must be used for a medical condition;
- There is sufficient evidence to draw conclusions about the intervention's effects on health outcomes;
- The evidence demonstrates that the intervention can be expected to produce its intended effects on health outcomes;
- The intervention's beneficial effects on health outcomes outweigh its expected harmful effects; or
- The health intervention is the most cost-effective method available to address the medical condition.

Medical Condition: a disease, an illness or an injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness or injury.

Health Outcomes: outcomes of medical conditions that directly affect the length or quality of a person's life.

Sufficient Evidence: considered to be sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes and is reproducible both within and outside of research settings.

Health Intervention: an activity undertaken for the primary purpose of preventing, improving or stabilizing a medical condition. Activities that are primarily custodial, or part of normal existence, or undertaken primarily for the convenience of the patient, family or practitioner are not considered health interventions.

Cost-Effective: is cost-effective if there is no other



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available intervention that offers a clinically appropriate benefit at a lower cost.

Affirmative Statement

'Ohana's utilization management program includes components of prior authorization and prospective, concurrent and retrospective review activities, each designed to provide for evaluation of health care and services based on 'Ohana members' coverage and the appropriateness of such care and services and to determine the extent of coverage and payment to providers of care.

'Ohana does not reward its associates or any practitioners, physicians or other individuals or entities performing utilization management activities for issuing denials of coverage, services or care and financial incentives, if any, do not encourage or promote under-utilization.

Plan Criteria for UM Decisions

The UM program uses review criteria that is nationally recognized and based on sound scientific, medical evidence. Physicians with an unrestricted license in the state of Hawai'i with professional knowledge and/or clinical expertise in the related health care specialty actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

The UM program uses numerous sources of information including, but not limited to, the following when making coverage determinations:

- InterQual™
- Medical necessity
- Member benefits
- Local and federal statutes and laws
- Medicaid and Medicare guidelines
- Hayes Health Technology Assessment

The nurse reviewer and/or medical director apply medical necessity criteria in context with the member's



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individual circumstance and the capacity of the local provider delivery system. When the above criteria do not address the individual member's needs or unique circumstance, the medical director uses clinical judgment in making the determination.

The review criteria and guidelines are available to providers upon request. Providers may request a copy of the criteria used for specific determination of medical necessity by calling 'Ohana's Utilization Management department.

UM Process

The UM process is comprehensive and includes the following review processes:

- Notifications
- Referrals
- Pre-service review for prior authorizations
- Concurrent review
- Post-service review
- Discharge planning
- Pharmacy management

'Ohana forms for the submission of notifications and authorization requests can be found in the **Forms** section of this manual and on the 'Ohana Web site, www.ohanahealthplan.com.

Notification

Notifications are communications to the Plan with information related to a service rendered to a member or a member's admission to a facility. Notification is required for:

- Prenatal services, enabling 'Ohana to identify pregnant members for inclusion in the Prenatal Program and distinguish those who might benefit from the High Risk Pregnancy Program. OB providers are required to notify 'Ohana of pregnancies via fax using the Prenatal Notification Form within 30 days of the initial visit. This



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process will expedite case management and claims reimbursement.

- Member's admission to a hospital, allowing 'Ohana to log the hospital admission and follow up with the facility on the following business day to receive clinical information. The notification should be received by telephone and include member demographics, facility name and admitting diagnosis.
- Delivery of a newborn to an 'Ohana member. Please include baby's birth date, gender, type of delivery and mother's ID number and fax to 'Ohana health plan after delivery; No authorization is needed for a maternity admission. If the mother or baby remains hospitalized for treatment, authorization is required.

Referrals

A *referral* is a request by a PCP for a member to be evaluated and/or treated by a specialty physician. 'Ohana does not require referral documentation as a condition of payment. The referral process is a tool to ensure coordination of care and support the concept of the PCP as the "medical home" for the patient. Services requiring referral are identified on the Quick Reference Guide (QRG). 'Ohana may monitor for compliance with the referral process during routine provider quality audits.

Pre-Service Review for Prior Authorization

Prior authorization allows for efficient use of covered health care services and ensures that members receive the most appropriate level of care within the most appropriate setting. Prior authorization may be obtained by the member's PCP or treating specialist.

Reasons for requiring authorization may include:

- Review for medical necessity
- Appropriateness of rendering provider



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- Appropriateness of setting
- Case and disease management considerations

Prior authorization is the process of obtaining authorization in advance of a planned inpatient admission or an outpatient procedure or service. An authorization decision is based on clinical information provided with the request. 'Ohana may request additional information and include a medical record review.

Prior Authorization is **required** for elective or non-urgent services as designated by the Plan. Guidelines for prior authorization requirements by service type may be found on the **Quick Reference Guide** or by calling the Plan.

Some prior authorization guidelines to note are:

- The prior authorization request should include the diagnosis to be treated and the CPT code describing the anticipated procedure. If the procedure performed and billed is different from that on the request but within the same family of services, a revised authorization is not required.
- An authorization may be given for a series of visits or services related to an episode of care. The authorization request should outline the plan of care including the frequency and total number of visits requested and the expected duration of care.

The attending physician or designee is responsible for obtaining the prior authorization of the elective or non-urgent admission. An authorization is the approval necessary for payment of covered services and is provided only after the Plan agrees the treatment is necessary. Refer to the **Quick Reference Guide** for a list of services requiring prior authorization.

Post-service requests for authorization will be reviewed only if the service was provided urgently and submitted within a few days of the service. In all other



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circumstances, providers are expected to meet standard non-urgent prior authorization guidelines, and late submission of a request for authorization will result in a denial.

Concurrent Review

Concurrent review activities involve the evaluation of a continued hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, utilizing appropriate criteria. The concurrent review nurse follows the clinical status of the member through telephonic or on-site chart review and communication with the attending physician, hospital UM, service coordination staff or hospital clinical staff involved in the member's care.

Concurrent review is initiated as soon as the Plan is notified of the admission. Subsequent reviews are based on the severity of the individual case, needs of the member, complexity, treatment plan and discharge planning activity. The continued length of stay authorization will occur concurrently based on InterQual™ criteria for appropriateness of continued stay to:

- Ensure that services are provided in a timely and efficient manner;
- Make certain that established standards of quality care are met;
- Implement timely and efficient transfer to lower level of care when clinically indicated and appropriate;
- Complete timely and effective discharge planning; and
- Identify cases appropriate for case management.

The concurrent review process incorporates the use of InterQual™ criteria to assess quality and appropriate level of care for continued medical treatment. Reviews



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are performed by licensed nurses under the direction of the Plan medical director.

To ensure the review is completed in a timely manner, providers must submit clinical information on the first business day after the admission as well as upon request of the 'Ohana review nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

Discharge Planning

Discharge planning begins upon admission and is designed for early identification of medical and/or psycho-social issues that will need post-hospital intervention. The Concurrent Review Nurse/Service Coordinator works with the attending physician, hospital discharge planner, ancillary providers and/or community resources to coordinate care and post-discharge services to facilitate a smooth transfer of the member to the appropriate level of care.

Post –Service Review

Post-service review is performed when a service has been provided and no authorization has been given. Post-service authorization requests are reviewed to determine if any of the following circumstances exist:

- The provider was not able to determine the member's eligibility;
- The service was urgent in nature, and there was not time to submit a request prior to service delivery;
- The service is part of an ongoing plan of treatment for a newly eligible member; or
- Extenuating circumstances existed that precluded the provider from submitting a timely pre-service or concurrent review authorization.



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Providers are expected to adhere to the business rules for submission of service authorization requests; Post-service requests that do not meet one of the above conditions may be administratively denied. Upon submission of all pertinent information, the Plan will make a determination within 30 calendar days. In the event of an adverse determination, the provider may request an appeal (See Appeals and Grievances section).

Peer-to-Peer Reconsideration of Adverse Determination

In the event of an adverse determination following a medical necessity review, **Peer-to-peer reconsideration** is offered to the treating physician on the "Notice of Action" communication. The treating physician is provided a toll-free number to the Medical Director Hotline to request a discussion with the 'Ohana medical director who made the denial determination. Peer-to-peer reconsideration is offered within three business days after the receipt of the written review determination notification by the provider. The review determination notification contains instructions on how to use the peer-to-peer reconsideration process.

Services Requiring No Authorization

The Plan has determined that many routine procedures and diagnostic tests are allowable without medical review to facilitate timely and effective treatment of 'Ohana members.

- For routine office procedures, a "No Authorization Required" list is available on our Web site at www.ohanahealthplan.com.
- Certain diagnostic tests and procedures are considered by the Plan to routinely be part of an office visit, such as colposcopies, hysteroscopies and plain-film X-rays.
- Clinical laboratory tests conducted in contracted



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laboratories, hospital outpatient laboratories and physician offices under a CLIA waiver do not require prior authorization. There are exceptions to this rule for specialty laboratory tests that require authorization regardless of place of service:

1. Reproductive laboratory tests (89250-89356)
 2. Molecular laboratory tests (83890-83916, 83950)
 3. Cytogenetic laboratory tests (88230-88299)
- Certain tests described as CLIA-waived may be conducted in the physician's office if the provider is authorized through the appropriate CLIA certificate, a copy of which must be submitted to 'Ohana.

All services performed without prior authorization are subject to retrospective review by 'Ohana.

Second Medical Opinion

A second medical opinion may be requested in any situation where there is a question concerning a diagnosis, options for surgery or other treatment of a health condition. A second opinion may be requested by any member of the health care team, a member, parent(s) and/or guardian(s) or a social worker exercising a custodial responsibility.

The second opinion must be provided at no cost to the member by a qualified health care professional within network, or a non-participating provider if there is not a participating provider with the expertise required for the condition.

Members With Chronic or Life-Threatening Conditions

Members with chronic conditions are defined as adults and children who have:

- Any ongoing physical, behavioral or cognitive disorder, including chronic illnesses, impairments and disabilities;



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- An expected duration of a medical condition of at least 12 months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc.) and service use or need beyond that which is considered routine.

Physicians who render services to members who have been identified as having chronic or life-threatening conditions should:

1. Allow the members needing a course of treatment or regular care monitoring to have direct access through standing (referral) authorization or approved visits, as appropriate for the member's condition or needs:

- a) To obtain a standing (referral) authorization request, the provider should complete the Outpatient Authorization Request form and document the need for a standing authorization request under the pertinent clinical summary area of the form.
- b) The authorization request should outline the plan of care, including the frequency, total number of visits and the expected duration of care.

2. Coordinate with the Plan to ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily

responsible for coordinating the health care services furnished to the member; and

- a) Members may request a specialist as PCP through the Customer Service department or their service coordinator. The Plan will allow specialists or other



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healthcare practitioners to serve as PCPs for members with chronic conditions, provided:

- The member has selected a specialist with whom he or she has a historical relationship as PCP; and
- The specialist agrees, in writing, to assume responsibility as PCP.

The Plan also allows a clinic to serve as a PCP as long as the clinic is appropriately staffed to carry out PCP functions and so long as the clinic agrees, in writing, to assume the responsibilities of a PCP.

3. Ensure that members requiring specialized medical care over a prolonged period of time have access to a specialty care provider.

- a) Members will have access to a specialty care provider through standing (referral) authorization requests, if appropriate.

Standard, Expedited and Extensions of Service Authorization Decisions

Standard Service Authorization

'Ohana is committed to a timely turn-around time on requests for prior authorizations. 'Ohana will fax an authorization response to the provider fax number(s) included on the authorization request form. However, by contract the Plan has up to 14 calendar days from receipt of the request to determine whether non-urgent services are covered and medically appropriate. An extension may be granted for an additional 14 calendar days if the member or the provider requests an extension, or if 'Ohana justifies to the State of Hawai'i Department of Human Services a need for additional information and the extension is in the member's best interest.



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Expedited Service Authorization

In the event the provider indicates or 'Ohana determines that following the standard time frame could seriously jeopardize the member's life or health 'Ohana will make an expedited authorization determination and provide notice within no later than three business days.. 'Ohana may extend the three-day period up to 14 calendar days if the member or the provider requests an extension or if 'Ohana justifies to DHS the need for additional information. **Requests for expedited decisions for prior authorization should be requested by telephone, not fax.** Please refer to the **Quick Reference Guide** for the appropriate contact information.

Members and providers may file a verbal or written request for an expedited decision. To file a verbal or written request, the provider must call the Plan and request an expedited review.

Emergency/ Urgent Care

Emergency services are not subject to prior authorization requirements and are available to our members 24 hours a day, seven days a week.

An *Emergency Medical Condition* is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;



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- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions;
 1. That there is insufficient time to effect a safe transfer to another hospital before delivery, or
 2. That the transfer may pose a threat to the health or safety of the woman or the unborn child.

Urgent Care services are non-life-threatening services provided to treat an injury, illness or another type of medical or behavioral condition that should be treated within 24 hours. Urgent care services provided in urgent care centers are not subject to prior authorization requirements.

Transition of Care

Transition of Care-Routine

In the event a member entering the Plan is receiving medically necessary covered services in addition to or other than prenatal services (see below for members in the second and third trimester receiving prenatal services) the day before enrollment into 'Ohana, the Plan shall be responsible for the costs of continuation of such medically necessary services without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The Plan shall provide continuation of such services for the lesser of:

1. Ninety days for all members receiving HCBS and all children under the age of 21, and
2. One hundred and eighty days for all members living in a nursing facility and all



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members without a care plan

Or

1. Until members in these categories have had a health and functional assessment (HFA) from his or her service coordinator, had a care plan developed and have been seen by the assigned PCP who has authorized a course of treatment.

Transition of Care – Pregnant Women

In the event the member entering the health plan is in her second or third trimester of pregnancy and is receiving medically necessary covered prenatal services the day before enrollment, the health plan shall be responsible for providing continued access to the prenatal care provider (whether contract or non-contract) through the postpartum period.

After the initial transition of care requirements are completed, providers are required to follow 'Ohana's prior-authorization or concurrent-review requirements.

If a provider receives an adverse claim determination that they believe was a transition-of-care issue, the provider should fax the adverse claim determination to the Appeals Department with documentation of DHS/CMO approval for reconsideration. Refer to the **Quick Reference Guide** for the appropriate contact information.

Authorization Request Forms

'Ohana utilizes three authorization request forms and a Prenatal Notification Form to ensure receipt of all pertinent information and enable a timely response to your request.

The **Inpatient Authorization Request Form** is used for services such as planned elective/non-urgent inpatient, observation, skilled nursing facility and rehabilitation authorizations. All Inpatient Authorization Request forms should be submitted via fax to the number listed on the



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form. Refer to the **Quick Reference Guide** for the related contact information.

The **Outpatient Authorization Request Form** is used for services such as follow-up consultations, consultations with treatment, diagnostic testing, office procedures, ambulatory surgery, home-care services, radiation therapy, out-of-network services and transition of care. All Outpatient Authorization Request forms should be submitted via fax to the number listed on the form. Refer to the **Quick Reference Guide** for the related contact information.

The **Ancillary Authorization Request Form** is used for services such as DME, dialysis, PT/OT/ST and transition of care. All Ancillary Authorization Request forms for non-urgent/elective ancillary services should be submitted via fax to the number listed on the form. Refer to the **Quick Reference Guide** for related contact information.

To ensure timely and appropriate claims payment, the form must:

- Have all required fields completed;
- Be typed or printed in black ink for ease of review; and
- Contain a clinical summary or have supporting clinical information attached.

Incomplete forms are not processed and will be returned to the requesting provider.

If prior authorization is not granted, all associated claims will not be paid.

A **Prenatal Notification Form** should be completed by the OB/GYN provider during the first visit and faxed to 'Ohana within 30 days of initial visit. Notification of OB services enables 'Ohana to identify members for inclusion into the Prenatal Program and/or members who



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might benefit from 'Ohana's High-Risk Pregnancy Program. Refer to the **Quick Reference Guide** for the related contact information.

Non-Covered Services

The following list is a summary of non-covered services and procedures, and is not meant to be exhaustive (please refer to Section 12, Covered Services for a complete list):

- Services not considered to be medically necessary;
- Cosmetic surgery or mammoplasties for aesthetic purposes;
- Investigational or experimental services such as new treatment that has not been accepted universally as a form of treatment;
- Transplant services other than bone grafts and cornea transplants;
- All procedures listed in the CPT or HCPCS description as "unlisted" or "unspecified";
- Educational supplies, medical testimony, special reports, travel by the physician, no-show or canceled appointments, additional allowances for services provided after office hours or between 10:00 p.m. and 8:00 a.m. or on Sundays, holidays, calls, visits or consultations by telephone and other related services;
- Biofeedback or hypnotherapy;
- Services provided free of charge to QUEST Expanded Access members by county health departments, free clinics, or state laboratories, e.g., metabolic screens for members younger than one year of age, etc.;
- Services and/or procedures performed without



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regard to the policies contained in this manual;

- Hospital visits to members awaiting placement in a nursing home, unless medically necessary;
- Hospital visits if the hospital admission and/or length of stay are disallowed by 'Ohana;
- Tubal reanastomosis;
- Penile prosthesis;
- Infertility procedures and related services other than assessment;
- Thermography;
- Sensitivity training, encounter groups or workshops;
- Sexual competency training;
- Education testing and diagnosis;
- Marriage or guidance counseling; and
- Abortions or abortion-related services performed for family planning purposes.

Special Authorization Requirements

The following procedures have special requirements by the state of Hawai'i and the Plan:

Sterilizations, Hysterectomies

(refer to Section 12 – Covered Services)

State of Hawai'i Organ and Transplant (SHOTT) Program

The DHS will provide transplants through the SHOTT program that are not experimental or investigational and not covered by the health plan. The SHOTT program covers adults and children (defined as those from birth



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through the month of their 21st birthday for liver, heart, heart-lung, lung and allogenic and autologous bone marrow transplants. In addition, children will be covered for transplants of the small bowel, with or without liver.

Children and adults must meet specific medical criteria as determined by the state and the SHOTT program contractor. The state and the SHOTT program contractor will determine eligibility of individuals for transplants except those transplants provided by 'Ohana. If the DHS and the SHOTT program contractor determine the individual meets the transplant criteria, the individual will be disenrolled from 'Ohana and transferred to the SHOTT program.

The Plan will notify the member that he or she should submit a 1144 form to the MQD for authorization for an evaluation by SHOTT. The Plan will provide assistance to the member as needed. The Plan may resubmit the member for reconsideration if the member's condition changes to make him or her, a better candidate for a transplant. 'Ohana will continue to provide medical services to the member until acceptance into the SHOTT program.

Delegated Entities

'Ohana delegates some utilization-management activities to external entities and provides oversight and accountability of those entities.

In order to receive a delegation status for utilization-management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required utilization-management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of 'Ohana and the delegated entities.

Delegation of select functions may occur only after an initial audit of the utilization-management activities has been completed and there is evidence that 'Ohana's delegation requirements are met. These requirements include:



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- A written description of the specific utilization management delegated activities;
- Semi-annual reporting requirements;
- Evaluation mechanisms; and
- Remedies available to 'Ohana if the delegated entity does not fulfill its obligations.

On an annual basis or, more frequently, audits of the delegated entity are performed to ensure compliance with 'Ohana's delegation requirements.