



## UTILIZATION MANAGEMENT

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#### Overview

The Plan's Utilization Management (UM) Program is designed to meet contractual requirements and comply with federal regulations while providing members access to high quality, cost effective medically necessary care and ensuring prompt and accurate payment to our providers.

The focus of the UM program is to:

- Evaluate requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the member's diagnosis and level of care required;
- Provide access to medically appropriate, cost effective health care services in a culturally sensitive manner and facilitate timely communication of clinical information among providers;
- Reduce overall health care expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership;
- Facilitate 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;
- Review, revise and develop medical coverage policies to ensure members have appropriate access to new and emerging technology; and
- Enhance the coordination and minimize barriers in the delivery of behavioral health and medical health care services.

*Medically necessary* services are defined as services that include medical or allied care,



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goods or services furnished or ordered to:

1. Be necessary to protect life, prevent significant illness or significant disability or to alleviate severe pain;
2. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the member's needs;
3. Be consistent with the generally accepted professional medical standards and not be experimental or investigational;
4. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker or the provider.

Medically necessary or medical necessity for those services furnished in a hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended or approved medical or allied goods or services does not, in itself, make such goods or services medically necessary, a medical necessity or a covered service/benefit.



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#### UM Process

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

- Notifications
- Referrals
- Prior Authorizations
- Concurrent Review
- Retrospective Review

Please refer to the 'Ohana Web site Provider area ([ohanahealthplan.com](http://ohanahealthplan.com)) to:

- Access various forms used by the Plan
- Complete certain authorization requests

#### Notification

*Notifications* are communications to the Plan that inform the Plan of a service rendered or admission to a facility. Notification of hospitalization is required by the next business day.

Notification of prenatal services enables the Plan to identify members for inclusion into the Prenatal Program and identify members who may benefit from the High Risk Pregnancy Program. OB providers should notify the Plan of pregnant members via fax, using the Prenatal Notification Form, within 30 days of the initial visit to expedite case management and ensure timely claims reimbursement.

#### Referrals

*Referrals* are requests by a PCP for a member to be evaluated and/or treated by a participating specialty physician. The PCP must document the reason for the referral and the name of the specialist on the member's medical record. The specialist, in turn, must document the receipt of a request for a consultation. The Plan does not require a written referral as a condition of



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payment. No communication with the Plan is necessary.

Certain diagnostic tests and procedures that are considered by the Plan to be routinely part of an office visit may be conducted as part of the initial visit without authorization. For general authorization information, you may refer to the state-specific **Quick Reference Guide**.

Point of Service option - authorization is required when using out-of-network clinicians or facilities.

#### **Prior Authorization**

Prior authorization allows for efficient use of covered health care services and helps ensure that members receive the most appropriate level of care within the most appropriate setting. Prior authorization must be obtained by the member's PCP or, in certain markets, by the treating physician.

Authorization is required to:

- Review for medical necessity
- Determine the appropriateness of the rendering provider
- Determine the appropriateness of the setting
- Case and disease management considerations

*Prior authorization* is the process of obtaining approval in advance of a planned inpatient admission or rendering of an outpatient service. The Plan will make an authorization decision based on the clinical information provided in the request. The Plan may request additional information that may include a medical record review.



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Prior authorization is **required** for elective or non-urgent services as designated by the Plan. Guidelines for prior authorization requirements by service type and/or code are available by calling the plan, or by referring to the state-specific **Quick Reference Guide** found in the Provider area of the 'Ohana Web site at [ohanahealthplan.com](http://ohanahealthplan.com).

Point of Service option – authorization is required when using out-of-network clinicians or facilities.

- The attending physician or designee is responsible for obtaining the prior authorization for the elective or non-urgent procedure or admission.
- The prior authorization request should include the patient's diagnosis and the CPT code pertaining to 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* is the approval necessary to be granted payment for covered services and is provided only after the Plan agrees the treatment is necessary and a covered benefit.
- PPO Plans - An authorization is not required when using Out-of-Network facilities or clinicians. Authorization is required when using In-Network clinicians or facilities.

An Authorization Request form must be completed by the provider in order to obtain an authorization from the Plan. A copy of this form is included in the **Forms** section of the manual.



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- This form must be filled out completely and legibly in order for it to be processed quickly.
- A valid and operating fax number with area code must be included in order to receive an authorization number.
- Point of Service option - Authorization is required when using out-of-network clinicians or facilities.
- PPO Plans – Authorization is required when using In-Network clinicians or facilities.

Providers may request a “*stat*” authorization (for services that are urgent in nature) by:

- Calling the Plan (have the member’s name, ID number, diagnosis and service available when calling).

#### **Services Requiring No Authorization**

The Plan has determined that many routine procedures and diagnostic tests may be performed without medical review to facilitate timely and effective treatment of members.

Certain diagnostic tests and procedures are considered by the Plan to be routinely part of an office visit, such as colposcopy, EKG and plain film x-rays (refer to the state-specific **Quick Reference Guide**).

#### **Concurrent Review**

Concurrent review activities involve the evaluation of a continued hospital, skilled nursing or acute rehabilitation stay for medical appropriateness. The concurrent review process



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is initiated as soon as the Plan is notified of the admission.

Concurrent reviews are performed by licensed nurses under the direction of the Plan's medical director.

The Concurrent Review Nurse follows the clinical status of the member through telephonic or onsite chart review and communication with the attending physician, hospital UM, case management staff or hospital clinical staff involved in the member's care.

Subsequent reviews are based on the severity of the individual case, needs of the member, complexity of the treatment plan and discharge planning activity. The authorization of a continued stay is based on medical appropriateness using InterQual™ criteria. The review insures that:

- Services are provided in a timely and efficient manner;
- Established standards of quality care are met;
- Timely and efficient transfers to lower level of care, when clinically indicated and appropriate, occurs;
- Timely and effective discharge planning occurs; and
- Cases are appropriately identified for case management.

Medicare criteria will be used in the event that InterQual™ is silent on a particular service.

To ensure the request is completed in a timely

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manner, providers must submit relevant clinical information along with the request for authorization and upon request of the Plan's review nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

#### **Discharge Planning**

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

#### **Retrospective Review**

The Plan performs two types of retrospective reviews.

- 1. Retrospective Review initiated by the Plan**

The Plan requires documentation and coding in the medical record which justify and support the diagnosis, treatment and clinical outcomes accurately. Medical records are subject to retrospective audit by the Plan to assure accurate coding and claims submission.

- 2. Retrospective Review initiated by Providers**

In exceptional circumstances when a service has been provided, but no authorization from the Plan has been obtained, a provider may request authorization for the service prior to the submission of the claim. Upon submission of pertinent information, the Plan will make a determination within 30 calendar



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days of receipt of the information. In the event of an adverse determination, the provider may request an appeal (See **Appeals and Grievances** section).

#### **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, professional knowledge and/or clinical expertise in the area, 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 list when making coverage determinations:

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

The nurse reviewer and/or medical director apply medical necessity criteria in context with the member's individual circumstance and 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 will use clinical judgment in making the determination.

Providers may request a copy of the criteria used for a specific determination of medical necessity.



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#### **Standard, Expedited and Extension of a Service Authorization Decision or Organization Determination**

#### **Standard Service Authorization or Organization Determination**

The Plan has 14 calendar days from the receipt of the request to determine the medical necessity and/or benefit coverage for routine, non-urgent services.

The Plan strives to turn around the majority of requests within two to five business days. Providers can obtain urgent authorizations on any service occurring within a 48-hour timeframe by contacting the Plan via phone.

Routine requests are encouraged to be submitted via fax. Urgent responses are usually communicated to the provider verbally and routine responses are sent via fax to the provider(s).

An extension may be granted for an additional 14 calendar days if the member or the provider requests an extension or if the Plan justifies a need for additional information and the extension is in the member's best interest.

#### **Expedited Service Authorization**

Providers or members have the right to request an expedited determination if it's felt that the standard timeframe could seriously jeopardize the member's life or health.

If the Plan agrees that the member's life or health is in jeopardy, a determination will be rendered within 24 hours. The Plan may extend the period to up to 14 calendar days if the member or the provider requests an extension or if the Plan justified the need for additional time to make the determination.

Requests for expedited decisions should be made via phone. For specific contact information,



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please refer to the state-specific **Quick Reference Guide**.

#### **Reconsideration Request**

A provider may submit a Reconsideration Request for services denied for lack of medical necessity. A request for reconsideration must be submitted to the Utilization Management department within three days of receipt of the Plan's Notice of Proposed Action.

#### **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 condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson could reasonably expect that the absence of immediate medical attention could be expected to result in any of the following:

- Serious jeopardy to the health of the member, including a pregnant woman or fetus;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part.

Emergency medical situation related to a pregnant woman having contractions include

- That there is inadequate time to effect a safe transfer to another hospital prior to delivery,



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- That a transfer may pose a threat to the health or safety of the woman or the fetus, or
- That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

*Urgent Care* services are for conditions that, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or could substantially restrict the member's activity (e.g., infectious illness, flu, respiratory ailments, etc.).

#### **Transition of Care**

For Medicare Advantage members, the Plan will honor any written documentation of prior authorization of ongoing covered services for a period of one month after the effective date of enrollment or until the PCP assigned to that member reviews the member's treatment plan, whichever comes first.

#### **Second Medical Opinion**

In accordance with regulatory and state requirements, members may request a second medical opinion concerning surgical procedures, serious injury or illness. The member may choose a physician that participates with the Plan or a non-participating physician within the Plan's service area. It is the responsibility of the PCP to coordinate tests ordered as a result of a second opinion with participating providers and develop a treatment plan for the member after review of the second medical opinion.

#### **Members with Special Health Care Needs**

*Members with special needs* are defined as adults and children who face daily physical, mental or environmental challenges that place their health at risk and whose ability to fully



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function in society is limited.

They include members with the following conditions:

- Mental retardation or related conditions;
- Serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders;
- Disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes; or
- Certain environmental risk factors such as homelessness or family problems that could result in possible placement in foster care.

Following is a summary of responsibilities specific to physicians who render services to Plan members who are identified with special health care needs. Physicians will:

1. Assess members and develop plans of care for those members determined to need courses of treatment or regular care;
2. Coordinate treatment plans with members, family and/or specialists caring for members;
3. Insure that the plan of care adheres to community standards and any applicable agency quality assurance and utilization review standards;
4. Allow the members needing courses of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as



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appropriate for the members' conditions or needs;

5. Coordinate with the Plan, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished;

- Members may request a specialist as a PCP through Customer Service or their case manager. If the medical director agrees that the specialist is appropriate as a PCP and the specialist agrees to act as the PCP, the member will be assigned to that specialist by the Customer Service department.

6. Coordinate services with other managed care organizations to prevent duplication of services and share results on identification and assessment of the member's needs; and

7. Ensure the member's privacy is protected as appropriate during the coordination process.

### Special Authorization Requirements

The following authorization requests have special requirements required by the Plan.

#### Sterilizations

- The individual is at least 21 years old at the time consent is obtained;
- The member is mentally competent;



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- The individual voluntarily gave informed consent in accordance with the provisions of this section, and a properly executed “Sterilization Consent Form” is submitted;
- At least 30 calendar days, but not more than 180 calendar days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery;
- An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be provided on the consent form);
- Interpreters are provided when language barriers exist; and arrangements are made through our Customer Service department to effectively communicate the required information to an individual who is visually impaired, hearing impaired or otherwise handicapped; and
- The individual was not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

#### Hysterectomies

- The properly executed Hysterectomy Acknowledgement form is attached to the claim form submitted to the Plan;
- The individual is informed, verbally and in writing, prior to the hysterectomy that she will be permanently incapable



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of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);

- Prior to the hysterectomy, the member/individual and the attending physician must sign and date the Exceptions to Hysterectomy Acknowledgement form except in the case of prior sterility or emergency hysterectomy. This informed consent must be obtained regardless of diagnosis or the member's (individual's) age.

Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered if the hysterectomy is:

- Performed solely for the purpose of rendering a member permanently incapable of reproducing;
- Performed for more than one purpose, but the primary purpose was to render the member permanently incapable of reproducing; or
- Performed for the purpose of cancer prophylaxis.

### Abortions

Abortions are covered services if the provider certifies that the abortion is medically necessary to save the life of the mother or if pregnancy is the result of rape or incest. The Plan will cover treatment of medical complications occurring as a result of an elective abortion and treatments for spontaneous, incomplete or threatened abortions and for ectopic pregnancies.



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An Abortion Certification form certifying the above situation must be properly executed and attached to the claim form when submitted to the Plan.

Abortions are not covered if used for family planning purposes.

The Sterilization Consent form, the Hysterectomy Acknowledgement form, the Exceptions to Hysterectomy Acknowledgement form and Abortion Certification Form are the only forms accepted by the Plan in the reimbursement of sterilizations, hysterectomies, abortions and prior approved medical services. Contact your Provider Relations representative to obtain the appropriate copies.

**NOTE:** Reimbursement is not available for sterilizations, hysterectomies or abortions performed without the documentation required by federal regulations as such, claims for payment submitted without the required documentation or with incomplete or inaccurate documentation will be denied.

#### **Medicare QIO Review Process of SNF/HHA/CORF Terminations**

Providers should ensure delivery of written notification two days in advance of services ending for Skilled Nursing Facilities, Home Health Agencies or Comprehensive Outpatient Rehabilitation Facilities.

In the event a member appeals the termination of services, the Plan will work collaboratively with the provider to obtain medical information necessary to review these cases and respond based on timelines and other requirements as set forth by CMS for QIO reviews.



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#### **Notification of Hospital Discharge Appeal Rights – Acute Care/Long Term Care & Behavioral Health**

Providers are required to notify members of their hospital discharge appeal rights. This notification must be delivered at pre-admission or within two calendar days of admission, using the standardized notice CMS-R-193.

The notice must be signed by the member. Copies are retained by both the member and the hospital.

The member is eligible to submit a request for QIO review no later than midnight of the day of discharge. The Plan will work collaboratively with the provider to obtain the medical information necessary to review these cases and respond based on timelines and other requirements as set forth by CMS for QIO reviews.

#### **Hospitalist Program**

Hospitalists provide attending physician coverage in selected markets for members admitted to contracted facilities. Hospitalists provide the following services:

- Emergency room assessment of a member;
- Direct admissions to facilities where the PCP may not provide that service;
- Manage care as needed throughout the inpatient medical admission for members 16 years of age and older, excluding obstetrical and gynecological cases; and
- Refer members to the PCP upon discharge for follow-up care and communicating the treatment or discharge plan verbally within 24 hours and in writing within seven days.



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#### After-Hours Utilization Management

The Plan provides authorization of inpatient admissions 24 hours a day, seven days a week. Physicians requesting after-hours authorization for inpatient admission should refer to the state-specific **Quick Reference Guide**.

#### Delegated Entities

The Plan 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 the Plan 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 the Plan's delegation requirements are met. These requirements include; a written description of the specific utilization management delegated activities, semi-annual reporting requirements, evaluation mechanisms and remedies available to the Plan if the delegated entity does not fulfill its obligations.

Audits of the delegated entity are performed annually or more frequently to ensure compliance with the Plan's delegation requirements.

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<sup>1</sup>Ohana Health Plan  
*A plan offered by WellCare Health Insurance of Arizona, Inc.*