SECTION 7

UTLIZATION MANAGEMENT PROGRAM

Utilization Management Program

Determination of Medical Necessity

Objective criteria are used in making utilization decisions and are reviewed and updated as necessary, but no less than yearly. The sources of criteria are:

- Milliman Care Guidelines
- Hayes Medical Technology Directory
- Federal Medicare Guidelines
- National standards reflecting best practice
- On-line searches for national and community best practices
- Other sources as appropriate and available

Sufficient member specific medical information is required o make a determination of medical necessity. Physicians from appropriate specialty areas of medicine and surgery, either board certified or equivalent, are available to review cases pertaining to their specialty. The UR/Case Managers and physician advisors perform interrater reliability studies at least annually to assure the consistent application of the criteria.

Inpatient Review

Admissions are reviewed on the first working day following admission, using Milliman Care Guidelines. If admission or continued stay does not meet criteria outlined in the guidelines and the individual member circumstance, the Nurse Reviewer will refer the case to the Medical Director.

Medical information is requested before admission, on admission or concurrently and, in some cases, retrospectively to authorize inpatient care. Authorized lengths of stay are determined by medical necessity. Continued stay may not be denied without concurrent review except in the case when a facility fails to provide timely medical information on which to base the review.

Discharge Planning

Discharge planning begins on admission when goals and treatment plans are identified. Based upon the member's needs, post hospital services are arranged when the patient is medically stable for discharge.

Retrospective Review

When inpatient services have been provided without prior authorization, medical information shall be obtained from the provider to determine whether the services were medically necessary. The determination shall be made within 30 days of receipt of all information.

Inpatient/Outpatient Case Management

Case management is a comprehensive, multidisciplinary process that coordinates timely, medically appropriate, quality care in the most appropriate setting. Case management maximizes benefit and community resources by providing assessment, problem identification, planning, outcome monitoring, and re-evaluation to meet the needs of a specific, targeted population with complex health care needs. The case manager is the link between the individual, the provider, the payer and the community.

Outpatient Services

Outpatient services, including ambulatory services, diagnostic studies and specialty referrals are authorized based upon medical necessity by the UR/Case Manager. Referrals to medical group specialists for up to four visits per calendar year do not require authorization. If the medical group cannot provide a needed specialty service, authorization for a non-contracted provider shall be given.

Emergency Services

Prior authorization is not required for provision of emergency services. Emergency services, including emergency ambulance transportation, are authorized without medical review.

Authorization Process Turnaround Standards

Outpatient Review

Utilization decisions are made in a timely manner depending on the urgency of the request. For routine authorizations, decisions are made within seven calendar days of obtaining all necessary information. Urgent decisions are made within one business day. A tracking system for identifying the status of all authorization requests is established. The provider is notified within one working day of the decision. If denied, the member and practitioner are given written or electronic conformation of the denial within two working days of making the decision. If an urgent case is denied, the

member and practitioner are notified as to how to initiate an expedited appeal at the time they are notified of the denial.

Concurrent Review

For concurrent review, decisions are made within one working day of obtaining all information and providers are notified by telephone within one working day of the decision.

Retrospective Review

Medical necessity decisions in retrospective situations are resolved within 30 working days of obtaining all necessary information. Members and providers are informed of retrospective denials within five days of making the decision.

Denial/Appeal Process

Physician reviewers from the appropriate specialty conduct and document medical appropriateness reviews on any denial file. A psychiatrist, doctoral-level clinical psychologist, or certified addiction medicine specialist reviews any behavioral health care denials that are based on medical necessity. A description of the reason that the service is denied is documented clearly and the criteria on which the denial is based are available to the practitioner and member on request.

Conflict of Interest

No person may participate in the review, evaluation or final disposition of any case in which he/she has been professionally involved or where judgment may be compromised. If it is necessary to seek outside physician reviewers in order to eliminate conflict of interest and assure an objective determination, such will be done.