

**Physician's Managed Care
Policy and Procedure
Utilization Management Plan**

Subject:	Utilization Management Program	Date
Reviewed and Approved by:	Executive Director	
Reviewed and Approved by:	Medical Director	
Reviewed and Approved by:	PMC Utilization Management/Quality Improvement Committee	
Reviewed and Approved by:	PMC Board of Directors	
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PURPOSE and PHILOSOPHY

Physician's Managed Care (hereafter referred to as "PMC") Utilization Management (UM) philosophy and approach are geared toward providing PMC members high quality and cost effective health care. This UM program is designed to achieve congruence with goals of member and provider satisfaction, efficiency and effectiveness. To this end, PMC's Medical Director and UM team work in collaboration with all providers.

PMC's interest is in assuring that systems and resources can adequately meet the quality of medical care and the service demands of our members in the most cost-effective manner. PMC ensures compliance with the National Committee for Quality Assurance (NCQA) standards, requirements of the PMC UM program, and appropriate data collection and reporting to meet member and provider needs through periodic updates and audits.

PMC views the UM function as directed toward comprehensive care of a patient rather than fragmented care, delivered and managed at different entry points into the health care delivery system. This system encourages and supports the development of cost-effective alternatives to traditional modes of medical practice without compromising the quality of care rendered to members.

Key components of utilization review and medical management have been outlined to include prospective, concurrent, and retrospective review, including case management.

It is PMC's expectation that the principles and requirements of this Utilization Management (UM) program will be met through:

- (1) PMC's coordinated efforts on an on-going basis; and/or

- (2) Guidance of the PMC Utilization Management / Quality Improvement Committee

GOAL:

It is the goal of the PMC UM program to assure appropriate levels of care and quality and cost effective services for all members in both inpatient and outpatient settings.

1. UTILIZATION MANAGEMENT PROGRAM DESCRIPTION:

The written UM program description outlines the program structure and accountability including but not limited to processes for evaluating medical necessity, the criteria utilized, information sources and the process utilized to review and approve the provision of medical services. Procedures are in place to support the major components of the UM program.

The UM program description is reviewed and approved by the PMC Utilization Management Quality Improvement Committee (UM//QIC) annually. The UM/QIC provides direction and oversight of the comprehensive UM program. PMC representatives are active participants of the UM/QIC.

Annual review of the UM program and its effectiveness includes measuring provider and member satisfaction to identify areas of dissatisfaction with the processes.

UM personnel are responsible for several health care products including HMO, PPO, and TPA (self-funded employer ERISA plans) lines of business. UM nurses are cross-trained in each line of business to maximize knowledge and expertise. Functions completed by the UM nurses include, but are not limited to prior authorization, concurrent review, discharge planning, and case management as described below.

All medical utilization decisions are made by qualified licensed professionals. The UM Department is comprised of the Director (RN), a second registered nurse, and clerical support. The clerical support staff is not involved in medical utilization decisions. The UM Nurses work under the direct supervision of the plan Medical Director.

For delegated Utilization Management functions, Inter-rater reliability testing of the Medical Director and licensed UM staff is conducted at a minimum annually. The purpose of the Inter-rater reliability testing is to assure consistency in the decision making process. The UM director will develop a corrective action plan for areas of deficiency.

The IPA **Medical Director** has an unrestricted Board Certified license, and is responsible for the implementation of clinical UM/QI. The Utilization Management, including behavioral health care aspects of the UM Program and quality improvement functions are under the direct supervision of the Medical Director. Medical effectiveness and utilization trends are shared with the medical staff on an ongoing basis to monitor under and over utilization. The IPA **Medical Director** is available by cell phone and will provide appropriate coverage if unavailable. The Medical Director may also designate a qualified, licensed senior physician to act in his absence, as necessary.

2. UTILIZATION MANAGEMENT PROGRAM FUNCTIONS:

A. Prospective Review:

Prospective review of (prior) authorization requests will include specialty consultations, selected medical treatments and services, hospital admissions, rehabilitative and ancillary services, home health care and hospice services and out-of-plan referrals.

B. Concurrent Review:

The care of hospitalized members is reviewed on a concurrent basis in order to determine that service delivery and the level of care are appropriate. The member's progress also is evaluated in order to plan for a timely discharge from the hospital. Appropriately licensed health professionals will conduct concurrent review on all hospitalized PMC members. Such review will include physician communication, telephonic review, on-site (including discussions with member and/or family members when appropriate) and chart review, and ongoing communication with other healthcare professionals who are involved in the member's care.

C. Retrospective Review:

The Utilization Management / Quality Improvement Committee, Medical Director or physician designee conducts retrospective review of cases which were not previously authorized and of claims which require authorization for payment. A senior physician has substantial involvement in the retrospective review process. The process also includes tracking, trending and analysis of utilization statistics and comparing current data to national benchmark data.

D. Confidentiality:

PMC and all its members recognize that confidentiality is vital for effective management of patient care, and therefore agree to respect and maintain the confidentiality of all discussions, deliberations, records and other information generated in connection with all committees and other activities. PMC and all of its members will not make any voluntary disclosure of such confidential information except to persons authorized to receive such information. PMC and its members will comply with all regulatory agency conditions pertaining to confidentiality.

E. Prior Authorization:

The basic elements of prior authorization review include; eligibility verification, benefit interpretation and administration, and medical necessity review of both in and outpatient services. Requests for services requiring prior authorization are reviewed and determinations made by the appropriate UM personnel. Behavioral health services are provided to our membership on a member self-referral basis (initial visit only) or as dictated by the members' plan design.

All recommended denials, regardless of the reason for the denial, require review and signature by the Plan Medical Director. Business hours are Monday through Friday 8:00 a.m. to 5:00 p.m. Twenty four hour confidential voice mail is available.

1. Request for Prior Authorization (PA) Requirements:

- a. Patient identification section is to be completely filled in
- b. History and clinical findings are to be briefly but clearly stated
- c. Diagnosis is indicated (CPT4, ICD9 codes are routinely required in the certification process)
- d. Purpose of the referral is clearly stated
- e. Result of evaluations and tests already performed have been included with the referral/PA request
- f. Appropriate diagnostic procedure codes are to be provided
- g. Second opinions are available if medically indicated and prior authorized. Second opinion requests are processed within the specified time frames
- h. Only pertinent patient information that will facilitate the authorization decision is included. Copies of medical records are not routinely requested on all patients reviewed. Patient information will be shared only with those entities who have authority to receive such information and shared only with those individuals within the IPA who need access to this information
- i. Services/treatments requiring prior authorization are processed in a timely manner:
 - **Emergent requests** – processed concurrently
 - **Urgent requests** – within 1 calendar day
 - **Routine and elective surgical requests** – processed within fifteen days (DOL standard)

For a comprehensive listing of information required on all PA requests, refer to the Physician's Managed Care utilization management Policy and Procedure entitled **Prior Notification / Authorization**.

2. Medical Director review of PA Request Requirements:

- a. Member eligibility for requested service(s) is confirmed and noted
- b. Benefit level is indicated
- c. There is indication of other insurance (COB), if applicable
- d. Prior authorization guidelines/clinical practice guidelines/medical necessity criteria are utilized
- e. Services/treatments requiring prior authorization are processed in a timely manner: (see section 3, Time frame)

3. Time Frames:

Time frames are mandated by state and federal regulations as well as industry standards and product requirements. Time frames are updated as necessary to remain in compliance with the above mentioned regulations, standards and requirements.

Prior Authorization Non-urgent Care (Standard):

- Authorization decisions for non-urgent care are made within fifteen (15) days of obtaining all the necessary information
- Notification of authorization decisions for non-urgent care is made and the practitioner is notified within one (1) business day of making the decision (Department of Labor allows 15 days)

Prior Authorization of Urgent Care (Expedited):

- For authorization requests for urgent care, decisions are made within **one** (1) calendar day of the request
- Providers are notified of the decision within **one** (1) business day of the decision (Department of Labor allows 72 hours)

Denials/Appeals:

- **Denials:** For all payors, PMC is responsible for recommendation of denial, which is forwarded to the payer for final determination
- **Appeals:** PMC is not delegated to address appeals made by the member or provider. If the member or provider chooses to appeal a denial determination for a requested service or payment, the appeal must be directed to the member's health plan or contract administrator. Addresses and phone numbers can be found on the back of the member's I.D. card

Concurrent Review (while patient is hospitalized):

- Concurrent review decisions are made within **one** (1) working day (24 hrs) from identification that continued stay is no longer medically necessary
- For Concurrent Review decisions, providers are notified of the decisions within **one** (1) business day after making the decision

Retrospective Review:

- Retrospective review decisions are made within thirty (30) working days of obtaining all the necessary information

Services referred to contracted and non-contracted practitioner/providers as specified in the PMC UM policy and procedure entitled **Prior Notification / Authorization** are subject to Medical Director review. The nationally recognized criteria used in the process include:

- **Milliman & Robertson**
- **InterQual Severity of Illness (SI), Intensity of Service (IS) criteria**
- **Medicare Guidelines**

These criteria sets are reviewed and updated, as needed, on an annual basis as part of the UM program review.

The most current version of nationally recognized criteria is obtained annually when available.

F. Emergency Services:

Care that is needed on an emergency basis is not subject to prior authorization, regardless of the time of day, day of the week or place of service.

Emergency Services necessary to screen and stabilize members are available without prior authorization in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.

G. Reporting Availability:

Standard UM reports include, but are not limited to the following.

1. Inpatient Bed Day Statistics Log
A report of current daily inpatient census activity which includes patient name, physician, group, facility, diagnosis, admission/discharge data, transfers between facilities, etc. An inpatient bed day log outlining inpatient activity by month is kept on file in the UM Department for reference
2. Denial Log
3. Transplant Log
4. Out of Plan Log
5. Expiration Log
6. Mental Health Follow-up Log
7. Special reports made available upon request

H. Evaluation of the Utilization Management Program:

The PMC UM program is formally evaluated on an annual basis and revised as necessary. The program is reviewed to add or modify activities as appropriate to improve the efficiency and effectiveness of the processes thus providing quality service to our customers.

The UM nurses coordinate referrals to the UM/QI committee which meets regularly. Trend reports are utilized to determine areas of need for corrective measures as well as areas that have shown improvement.

I. Discharge Planning:

Discharge planning is the process used to meet the patient's needs beyond the inpatient setting. Discharge planning is performed by RN case managers who work under the IPA/Medical Group's Medical Director. The case managers assist the member, the member's family and physicians in facilitating a discharge plan that is the most appropriate and least restrictive while affording quality health care. During the initial

chart review and/or patient interview, the member's potential discharge needs are assessed.

The case managers work closely with the hospital case managers to assist in developing and implementing a discharge plan that meets the patient's needs. The case managers assist with coordinating transfers and other needed services such as DME, home health, etc. They facilitate a plan prior to the member's discharge or transfer from a health care facility. Discharge planning also includes, when needed, the transition of patients to other resources for care when a benefit is ending.

When a member is out of area/out of network, the PMC case managers work closely via telephone/fax and email with the facility case manager to meet the member's needs beyond the inpatient setting, utilizing some or all of the methods described above.

J. Case Management:

Case management is a process of coordinating care for patients who are identified as having significant medical care needs that may be acute or chronic. It also involves the proactive management of anticipated medical situations. The case management process encompasses care coordination in all settings including ambulatory and institutional care settings.

Case management is performed by registered nurse case managers under direction of the PMC Medical Director. The case manager works with the patient, family and other interested parties in collaboration with the patient's physician and other allied health care providers to assist in facilitating the delivery of quality health care services in the most appropriate and least restrictive manner.

They authorize procedures and services, such as home health care and DME rental or purchase, and they help coordinate visits to physicians and other providers. Case managers assist when needed, in the transition of patients to other resources for care when a benefit is ending.

K. Out of Network/Out of Plan Review:

Out of network/out of plan is defined as any care or services rendered outside of the geographical service area, or care that is rendered by non-contracted providers. The PMC RN case managers monitor all known out of network/out of plan patients telephonically or via on-site visits, and follow the same guidelines as previously described in concurrent review, case management and discharge planning.

All cases requiring physician review or intervention are referred to the Medical Director. When appropriate, patients are transferred to in-network/in-plan contracted facilities and providers for continued care when medically safe to do so.

L. Behavioral Health Management:

Behavioral health services are designed to promote and assist every member in receiving quality care through utilizing adequate resources in the most cost effective manner. This is achieved through the evaluation and determination of the member, practitioner and provider use of behavioral health resources and the provision of any needed assistance to health care practitioners, providers and/or members. Behavioral health services are provided to members on a self referral basis and as defined by member's benefit plan. All care services are offered in the context of the member's benefit plan.

To ensure appropriate access to behavioral health care, PMC monitors performance against nationally recognized Managed Behavioral Healthcare Organization standards for hours of operation and service availability for behavioral health care for the following aspects:

- Life-threatening emergency
- Non-life threatening emergency
- Urgent Care
- Routine Care

PMC collaborates with contracted behavioral health practitioners through ongoing communication and collaboration. The following indicators are monitored and analyzed:

- Enhance continuity and coordination of care by promoting exchange of patient information between medical practitioners and behavioral health practitioners and providers
- Review of complaints and concerns regarding network access to behavioral health services

M. New Technology:

PMC evaluates the inclusion of new medical technologies and the new application of existing technologies. This includes medical procedures, drugs, and devices. The process includes a review of information from appropriate government regulatory bodies as well as published scientific evidence. The PMC Medical Director or designee has access to the internet for literature searches to assist in the evaluation to determine the status of technologies. PMC implements this process to assess new technologies and new applications of existing technologies.

Criteria for appropriateness of medical services are clearly documented and available, upon request, to participating practitioners, members, and facilities. Practitioners may contact PMC's UM Department to request specific criteria and the UM nurses will provide practitioners with a hard copy upon request.

Access to PMC practitioner consultants from the appropriate specialty areas of medicine and surgery are available as needed.

PMC's **Medical Director** will consult with board certified physicians in specific specialties to assist in making medical determinations as needed. External review agencies may be accessed as appropriate for expert opinion and determination as needed.

N. Delegation:

PMC will maintain compliance with the regulations set forth by the specific contracted member populations (E.G., commercial, Medicare, Medicaid, etc.). PMC will comply with all delegated UM Program requirements. PMC will support all delegates in meeting requirements of annual and other periodic audits by providing access to all records, policies, reports, and other documents necessary to show compliance with the delegated UM program.