



#5100 Utilization Management Plan

Product Line:	PCN	Effective Date:	02/01/2012	Approval Date:	03/06/12; 07/31/12; 01/02/13; 01/15/13; 07/27/12; 10/23/13; 01/14/14; 7/22/14; 11/18/14; 4/21/15; 5/29/15; 12/29/15; 12/20/16; 06/27/17
Review Date(s) with no changes:		Revision Date(s):	12/28/12; 01/07/13; 03/28/13; 04/16/13; 08/01/13; 10/11/13; 01/08/14; 01/14/14; 07/18/14; 11/7/14; 4/9/15; 12/29/15; 11/08/16; 4/21/17	Retirement Date:	
Review Period:	Annually	Regulatory Reference:	RFPS30034901600685, Sections: 2.5.5; 2.5.6; 2.5.8; ; 2.7.7; 2.9;	NCQA Reference(s):	UM1; UM2; UM3; UM4; UM5; UM6; UM7

PURPOSE:

The purpose and philosophy of the Pediatric Care Network's (PCN) Utilization Management Program is that care is clinically appropriate and medically necessary. While authorization rules and procedures must govern the appropriate notification and access to care, PCN will strive to partner with providers in an effort to make utilization review decisions that are based primarily on clinical factors rather than the adherence to administrative rules.

DEFINITIONS:

Action means the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service.

Administrative Denial means denial by PCN for medical and/or hospital services on the grounds that administrative procedures, explained in the PCN Provider Administration Manual, provider updates, or during provider education, were not followed by the provider.

Adverse Determination means a determination by PCN, or its designee utilization review organization, that an admission, availability of care, continued stay or other medical and/or hospital service has been reviewed and, based upon the information provided, does not meet PCN's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated.

Ambulatory Review means utilization review by PCN of medical and/or hospital services performed or provided in an outpatient setting.

Care Coordination means a method of coordinating the provision of health care so as to improve its continuity and quality.

Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care and cost effective outcomes. (adopted from The Center for Case Management). Case management involves the development of individualized treatment plans and ongoing communication and coordination with other systems of care. Treatment plans are developed with participation from the member's primary care provider, the member, and any consulting specialty providers. Care Coordination/Case Management is provided for members receiving both covered and non-covered services.

Certification, Pre-Certification or Prior Authorization means a determination by PCN, or its designee utilization review organization, that an admission, availability of care, continued stay, or other medical and/or hospital service has been reviewed and, based on the information provided, meets requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

Clinical Peer means a physician or other health care professional, engaged or approved by PCN, and who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

Clinical Review Criteria means the screening procedures, decision abstracts, clinical protocols, practice guidelines, and Medical Director's decision processes used by PCN to determine the necessity and appropriateness of medical and/or hospital services.

Concurrent Review means utilization review conducted by PCN during the member's hospital stay or course of treatment.

Discharge Planning means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a member will require following discharge from a facility. Discharge planning activities are generally conducted by the discharging facility but coordinated with PCN's Care Integration department to ensure compliance with Clinical Review Criteria, Medical Necessity, and the Covered Services provided under the member's Health Plan Contract.

Disease Management is the process of intensively managing a particular disease or syndrome. Disease management encompasses all settings of care and places a significant emphasis on prevention and maintenance. It is similar to case management, but more focused on a defined set of problems relative to an illness, disease, condition, or syndrome.

Emergency Medical, Behavioral Health and Substance Abuse Services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish those services and are needed to evaluate or stabilize an emergency medical condition. An emergency condition means a medical or behavioral health or substance abuse 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 one of the following:

1. 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
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part
4. Serious harm to self or others due to an alcohol or drug abuse emergency
5. Injury to self or bodily harm to others
6. With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child

Medical Necessity or Medically Necessary is defined as a service that meets one of the following:

1. Prevents, diagnoses, or treats a physical or behavioral health or injury;
2. Is necessary for the member to achieve age appropriate growth and development;
3. Minimizes the progression of disability;
4. Is necessary for the member to attain, maintain or regain functional capacity
5. Is a service identified by a Healthy Child and Youth (HCY) or Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screen for birth through age twenty (20) in Missouri, and birth through age twenty-one (21) in Kansas, and are necessary to treat or ameliorate defects, physical or behavioral health, or conditions identified as part of the screening. These services must be sufficient in amount, duration, and scope to reasonably achieve their purpose

A service is not considered reasonable and medically necessary if it can be omitted without adversely affecting the member's condition or the quality of medical care rendered.

Peer Review means an evaluation by a group of unbiased practicing physicians: (a) of the effectiveness and efficiency of care rendered, or (b) of the appropriateness of decisions made by another practicing physician or group of practicing physicians, generally relative to the approval or denial of care or the approval or denial of participation in a network.

Post-stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

Prospective Review means utilization review conducted by PCN prior to authorization for medical and/or hospital services.

Retrospective Review means utilization review of Medical Necessity for medical and/or hospital services that are conducted by PCN after services have been provided to a member. It does not include the review of a claim when it is limited to an evaluation of reimbursement levels, verification of documentation, accuracy of coding, or adjudication of payment.

Second Opinion means an opportunity or requirement for a member, authorized by PCN, to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed medical and/or hospital service to assess the Medical Necessity and appropriateness of the initial proposed service.

Utilization Management Program means a set of formal techniques designed and/or approved by PCN to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, medical and/or hospital services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. The Utilization Management policies include protocols for denial of services and prior authorization.

POLICY:

It is the policy of PCN that the medical services provided to all PCN members will be monitored under the Utilization Management Plan. The Utilization Management Program will oversee the process by which members receive access to appropriate services with effective and efficient coordination of care to promote an assurance against under-utilization or over-utilization.

PROCEDURE:

I. Utilization Management Program Objectives

Fulfillment of the following program objectives is a continuous process, to be undertaken consistent with the requirements of federally mandated peer review organizations, state regulatory bodies, and other delegation agreement requirements. The Utilization Management Program objectives include:

- A. Ensuring that medical necessity and appropriateness of care are the paramount drivers in decisions made concerning the authorization of medical services to members. Criteria utilized for evaluation and determination is outlined in the PCN Use of Clinical Guidelines for Decision Making policy
- B. Ensuring effective utilization of resources for hospital and ambulatory care by reviewing, monitoring, reporting and acting upon issues of over-utilization, under-utilization, and inefficient or inappropriate utilization of resources and services
- C. Ensuring that members receive required and appropriate medical services by monitoring the appropriateness and medical necessity of admissions and continued stays, based upon application of nationally recognized criteria, and the provision of screening, prior authorization and concurrent reviews for hospital admissions and certain outpatient procedures
- D. Monitoring and assisting in the promotion and maintenance of high quality care in all areas, through prospective, concurrent and retrospective review, and the identification of possible quality of care concerns related to the Utilization Management Program
- E. Reviewing and monitoring the appropriateness and ongoing medical necessity of durable medical equipment, home health care, and other home health services
- F. Assuring systematic data collection, analysis, and evaluation of standard provider performance measurements and targeted analysis of member outcomes in selected areas
- G. Assuring the presence of a program of utilization review that is a collaborative effort with the physicians and other health professionals, which includes interpretation of available data and collaboration with providers on any identified areas of change if needed
- H. Assessing, coordinating and monitoring appropriate discharge planning needs, and assuring that care teams are aware of members who have significant or special needs
- I. Establishing protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective reviews
- J. Consistent application of policies and procedures
- K. Monitoring use of emergency services
- L. Identification of over and under-utilization for inpatient and outpatient services and developing appropriate actions to correct issues and provide ongoing monitoring
- M. Coordination of services for both covered and non-covered benefits
- N. Ensuring that provider compensation is not structured to provide direct financial incentives for the provider

to deny, limit, or discontinue medically necessary services to any member. Annual notification of non-incentive statement is provided annually to PCN staff via email. This information is available to providers on PCN's public intranet site at <http://www.cmpcn.org>.

II. Utilization Management Program Scope

Benefit coverage for PCN members is established by the Health Plan. The following covered services are monitored under the PCN Utilization Management Program:

- A. Ambulatory Surgical and Birthing Center Services
- B. Certified Nurse Midwife Services
- C. Comprehensive Day Rehabilitative Services
- D. Core services provided by Local Public Health Departments
- E. Corneal Transplants
- F. Durable Medical Equipment
- G. Early and Periodic Screening, Diagnostic and Treatment Services
- H. Emergency Room Services
- I. Home Health Services
- J. Hospice Services
- K. Hospital; Inpatient and Outpatient Services
- L. Laboratory, Radiology, and other diagnostic Services
- M. Maternity Benefits
- N. Personal Care Services
- O. Physician and Advanced Practice Nursing Services
- P. Podiatry Services
- Q. SAFE-CARE Exams (in-network or out-of-network)
- R. Transplant Services (other than corneal): before and after admission for transplant, including evaluation (in-network and out-of-network)

Comment [AP1]: UM 1 A 5

III. Utilization Management Program Oversight and Accountability

A. Committee Structure

1. PCN Board of Directors
PCN's Board of Directors is ultimately responsible for Utilization Management activities. Utilization Management activities are reported to the Board of Directors at least annually by the PCN Senior Medical Director, who serves as chair of the Clinical Quality Committee.
2. PCN Clinical Quality Committee
PCN's Clinical Quality Committee has delegated authority from the Board of Directors to direct the development and implementation of the Utilization Management Program.
3. PCN Quality Committee
PCN's Quality Committee includes external physician consultants who provide input into the Utilization Management Program, approve criteria and guidelines, review key metrics at least annually and recommend changes or improvements to the Program.
4. PCN Medical Management Committee
PCN's Medical Management Committee is an internal committee responsible for development of internal guidelines and criteria, which are evidence-based and utilized to assist the UM staff in making decisions.

Comment [AP2]: UM 1 A 1

B. Staff Qualifications and Responsibilities

1. Medical Director(s)
PCN Medical Directors have unrestricted licenses to practice in the state. They are board-certified and have sufficient experience in their field or specialty to be determined qualified. The Senior Medical Director provides oversight of the Utilization Management Program and annual approval of the Program and related policies. The Senior Medical Director's responsibilities include:
 - Assure compliance with applicable state, federal, contract and/or NCQA requirements and standards
 - Oversee implementation, monitoring, evaluation and improvement initiatives related to the Utilization Management Program
 - Serve as a liaison between PCN and contracted Health Plans and network providers
 - Participate with the Care Integration staff in the review process, providing timely, written determinations with reference to appropriate criteria and standards, as well as rationale for decision-making.

- Maintain proficiency with the variety of resources used within PCN for the Utilization Management program
2. Director, Complex Care
The PCN Director of Complex Care provides day-to-day supervision of assigned clinical and non-clinical staff. Responsibilities include:
- Conduct ongoing staff training on documentation standards, NCQA and state requirements, and general process
 - Oversees ongoing audits of the clinical and non-clinical staff for accuracy and provide feedback to the Care Integration team and the Health Plans
 - Evaluate prior authorization processes and implement performance improvement initiatives, as needed
3. Utilization Management Staff
PCN utilizes both non-clinical and clinical staff for the Utilization Management Program functions. Non-clinical staff perform initial screening of calls and review of service requests for completeness of information, collection and transfer of non-clinical information, acquisition of clinical data, and other activities that do not require evaluation or interpretation of clinical information. PCN does not issue non-certifications based on initial screening. Clinical staff, Registered Nurses with unrestricted licenses to practice in the states of Kansas and Missouri, are utilized to make decisions requiring clinical judgment and use of clinical criteria and guidelines. All adverse determinations are performed by a Medical Director and not by the clinical nursing staff.
- PCN does not provide financial or other types of incentives or rewards to practitioners, employees, or other individuals to encourage decisions resulting in issuance of denials or coverage of care, or underutilization.**

Comment [AP3]: UM 1 A 3, UM 1 B

Comment [AP4]: UM 4 A

Comment [AP5]: UM 4 B

Comment [AP6]: UM 4 G

C. Staff Availability

1. Medical Director

A Medical Director is available to clinical staff during all regular business hours, which are Monday through Friday, 8am to 5pm, excluding holidays. In the event a Medical Director will not be available for an extended period of time, he/she will arrange for a board-certified physician, licensed to practice in the state, to accept calls on his/her behalf. Such arrangements are communicated in advance to the Director of Complex Care.

Comment [AP7]: UM 7 A

2. Utilization Management Staff

PCN Utilization Management staff is available to members and providers Monday through Friday, 8am to 5pm, excluding holidays, for inbound and outbound communication, as well as after-hours 24 hours/7 days a week for urgent or emergent authorization requests. UM staff can also receive inbound communication issues after business hours through voice messaging and fax. 24 hour/7 day a week access to clinical nursing staff is provided to all PCN members for information on how to access emergency, urgent, and routine care and/or home care advice through the Children's Mercy Hospital Nurse Advice Line. The availability of Nurse Advice services is communicated to members through Primary Care Providers, the PCN Care Integration staff, the PCN website, the member ID card, and targeted pamphlets and education materials. For members with language or hearing barriers, a TDD line and translation service is available for communication with PCN. UM staff identifies themselves by name, title and organization name when initiating, answering and returning calls. The Utilization Management staff can be accessed through an ACD line as follows:

Comment [AP8]: UM 4 E

- Prior Authorization and Inpatient Review Phone: 1-877-347-9367 (Toll Free)
- Fax: 1-888-670-7260

Comment [AP9]: UM 3 A

Call answering statistics are monitored and reviewed on a monthly basis to ensure adherence to the standards. Call answering standards are: Average Speed to Answer - <30 sec; Call Abandonment Rate - <5%; and Overall Service Performance - >90%.

D. Tools Used to Support Utilization Management Program Functions

1. Clinical Criteria and Guidelines

PCN maintains written criteria sets (i.e. Milliman Care Guidelines®, Interqual®, and PCN-adopted written guidelines) that are objective, scientifically derived and evidence-based, as well as developed and/or approved with the input of providers. Members and providers are offered a copy of the criteria or guideline used in making a determination through a well-publicized process, which includes the adverse determination letter, member and provider Health Plan handbooks, the PCN website, and Health Plan newsletters.

Comment [AP10]: UM 2 A 1

2. Resource Tools

In addition to the clinical criteria and guidelines, Care Integration staff has access to the following tools to determine coverage for services:

- State Fee Schedule (internet-based, external tool)
 - PCN Benefit Guideline Matrix (internal tool)
 - Prior Authorization Code Search (intranet based, internal tool)
 - State guidelines and policy statements (internet-based, external tool)
3. CARE Utilization Management documentation system has the following capabilities:
- Ability to verify member eligibility
 - Ability to identify providers and verify participation status
 - Documentation of approval or denial of outpatient prior authorizations and inpatient initial and concurrent reviews
 - Documentation of member and provider inquiries as well as education provided on benefits and authorizations

Comment [AP11]: UM 1 A 5,6

E. Information Needed to Support UM Determinations

Relevant clinical information to support UM decision making includes but is not limited to the following:

1. Clinical exam
2. Consultations with treating practitioners
3. Diagnostic testing results
4. Operative and pathological reports
5. Photographs
6. Rehabilitation evaluations
7. Treatment plans and progress notes

Comment [AP12]: UM 2 A 2

F. Adverse Determinations/Notice of Action Letter Requirements

Adverse Determination or Notice of Action letters (state approved template), provided to members and providers, meet the following state requirements, at a minimum:

1. Printed in at least twelve (12)-point type font
2. Written at the sixth-grade reading level
3. Explanation of the action taken
4. Explanation of the reason for the action
5. Explanation of the specific regulation(s) that support, or the change in federal or state law that requires, the action
6. Reference to clinical criteria for medical necessity denials, or evidence of coverage for benefit denials
7. Explanation that, upon request, members and providers can obtain a copy of the criteria or guideline on which the denial was based
8. Explanation of how to initiate an appeal review with the Health Plan, including an expedited review when appropriate
9. Explanation that an expedited external review can occur concurrently with the internal appeals process for urgent and ongoing treatment
10. Explanation of how to initiate a State Fair Hearing, if applicable, and description of how to obtain and submit additional information, including but not limited to medical records, for consideration in the review
11. Explanation of the member's right to have benefits continue pending resolution of an appeal, including how a member can request benefits to be continued and the circumstances under which the member may be required to pay the costs of the services
12. Explanation of the member's right to represent himself/herself, have an authorized representative, legal counsel, a relative, a friend, or the member's provider, file a grievance or appeal on his/her behalf
13. Offering to have PCN give any reasonable assistance to the member or representative in completing forms and taking other procedural steps, including but not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

Comment [AP13]: UM 7 B, C,

G. Information Collection and Confidentiality

All information and records collected in the process of performing UM activities are maintained in a confidential manner that complies with applicable state, federal, and local laws, rules and regulations regarding such information and records. Information is also compiled, aggregated and used to evaluate the performance or practice of providers. Profiling data and analyses are provided in aggregate and do not identify individual members, and are reported in such a manner as to protect the identity of individual members. PCN documentation, including criteria used for reviews, is maintained in the PCN computer system and hardcopy files, if applicable. Files are maintained for a minimum of seven (7) years.

IV. Utilization Management Program Description

Comment [AP14]: UM 1 A

A. Prior Authorization

PCN has determined that specific services and/or procedures require prior authorization. A current list of procedures and services requiring prior authorization is available on the Prior Authorization Quick Guide, the PCN website, and by calling the Care Integration Department. Prior authorization is NOT required for emergency medical, behavioral health or substance abuse services.

1. Direct Access and Standing Referrals

Members may self-refer for the following in-network services:

- Eye exam, routine
- Family planning services
- Obstetrical care
- Public health services (i.e. immunizations, tuberculosis, sexual transmitted disease, HIV testing, etc.)
- Well woman exams (including breast exams, pelvic exams, mammograms, and PAP smears)

Members with ongoing medical conditions or life threatening conditions or disease may obtain a standing referral to a specialist or specialty care center, as appropriate, and use the specialist as their Primary Care Provider.

2. Timeframes

Timeframes accommodate the clinical urgency of the situation in order to minimize any disruption in the delivery of health care services.

a) Expedited requests

Expedited review is used if the standard of time for review would seriously jeopardize the member's life, physical or behavioral health, or the member's ability to regain maximum function, as determined by the PCN Medical Director. Expedited reviews can be requested verbally or in writing by the member or provider and a determination will be made within one (1) business day of the request as to whether the review meets the criteria to be processed as an expedited request. Expedited request determinations are made within one (1) business day of the request, once determined to meet expedited review criteria.

b) Urgent/Concurrent requests

Approval or denial of verbal or written requests for services determined to be urgent by the treating provider will be provided within twenty-four (24) hours of the request.

Routine requests

Approval or denial of verbal or written requests for routine services will be provided within thirty-six (36) hours, including one (1) business day, of obtaining all necessary information needed to make a determination. If additional information is needed, PCN will notify the requesting provider within thirty-six (36) hours, including one (1) business day. In no case will PCN exceed fourteen (14) calendar days following receipt of a request for service to make a determination.

Comment [AP15]: UM 5 A 2

Comment [AP16]: UM 5 A 1

PCN will ensure that member's treatment regimens are not interrupted or delayed due to the prior authorization process. When necessary, interim medical supplies and/or medical services will be authorized while a determination for medical necessity of ongoing services or supplies is being made.

PCN will make any necessary arrangements to fulfill the requirements of review (i.e. scheduling appointments, providing comprehensive lists of available providers, etc.). If such arrangements cannot be made in a timely manner, the requested service(s) will be approved, so as not to impede timely delivery of medically necessary services.

3. New Technology

PCN will accept requests for new technology, experimental, or investigational treatment and devices. All requests received will be sent to the PCN Medical Director, who will coordinate a determination with the Health Plan Medical Director by phone and will forward the request to be reviewed via secure email. The determination will be documented in the medical review section of the PCN documentation system. The contracted Health Plan makes the final determination of coverage for new technology, experimental, or investigational treatment and devices.

4. Clinical Trials

PCN considers clinical trials to be experimental or investigational and is not responsible for covering services included in clinical trials. PCN will authorize any services that are part of the pre-trial work-up.

5. Out of Network/Out of Area Services

Referral to a non-participating provider requires prior authorization. PCN will approve such referrals if:

- A network provider is unavailable or unable to provide the medically necessary, covered service which is required for the member within a medically acceptable timeframe, as determined by the requesting provider and/or
- The non-participating provider agrees to accept the negotiated payment rate and hold the member harmless for the amount in excess of PCN's allowable payment.

Newly enrolled members will be provided with assistance and sufficient time to transition ongoing care and services from a non-participating provider to a participating provider. In some circumstances, members will be allowed to continue services with a non-participating provider, as deemed appropriate, such as second and third trimester pregnancy, ongoing cancer treatment, active transplant treatment, etc. PCN will pay for services outside its region to the same extent that it would pay for services furnished within its region.

6. Second and Third Opinions

a) Second Opinions

Second opinions are available upon request from the member or a provider for non-emergency medical services. The second opinion must be for a covered service and the second opinion provider must be a network provider. When a network provider is not available to perform the second opinion, PCN will authorize an out-of-network provider to provide the second opinion. The member or provider requesting the second opinion may indicate his/her preference for the out-of-network provider, subject to PCN approval.

b) Third Opinions

PCN, using the same basic protocols for second opinions noted above, will review requests for a third opinion on a case-by-case basis. A third surgical opinion, provided by a third provider, will be approved if the second opinion fails to substantively agree with the initial recommendation on the medical need for or against a specific surgical intervention, and if the member desires the third opinion to determine what course of action to take.

7. Determinations

a) Approvals

If the decision is to approve a service request, the Care Integration staff will issue a prior authorization number to the requestor by telephone or fax at the time of the determination, and issue an approval letter to the member and provider if required by the Health Plan.

All prior authorizations are contingent on the member's eligibility with the Health Plan and PCN on the date of service. The reason for the decision and criteria used to make the determination, if applicable, is documented in the online computer system and assigned a reference number. Documentation of any alternative service(s) approved in lieu of the original request is also maintained in the online system.

If PCN approves purchase of a custom or power wheelchair, eyeglasses, hearing aids, custom HCY/EPST equipment, augmentative communication devices, placed within six months of approval, which is delivered or placed after enrollment with the Health Plan and/or PCN ends, PCN will be responsible for payment.

In addition, PCN will not subsequently retract an authorization after the services have been provided or reduce payment for an item or service unless:

- Authorization is based on material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
- PCN's contract terminates before the medical service(s) are provided; or
- The covered person's coverage under PCN terminates before the medical service(s) are provided

b) Adverse Determinations

PCN allows providers five (5) business days from the date of a denial to request a peer-to-peer discussion with the Medical Director who performed the review, or to submit additional information on cases resulting in an adverse determination. The peer-to-peer discussion is made available to the requesting provider within one (1) business day of the request. If the original reviewer is not available to perform the peer-to-peer discussion, an alternative clinical peer reviewer will be made available. If the peer-to-peer conversation

does not result in an approval of the requested service(s), the requesting provider is informed of the process to file an appeal.

All adverse determinations are communicated by telephone or fax to the requestor at the time of the determination and followed by written notification to the member, facility, and/or provider within one (1) business day. The written notification will meet, at a minimum, the state requirements detailed in section III.F. of this policy.

For services previously authorized, PCN will mail the notice of adverse determination to the member and requesting provider at least ten (10) calendar days before the date of the action for termination, suspension, or reduction of the previously authorized service(s).

Comment [AP17]: UM 7 A

B. Initial, Concurrent and Retrospective Review of Inpatient Stays

PCN requires notification of all inpatient stays in order to monitor the hospitalization and to assist with discharge planning services. Care team clinical staff screens all inpatients according to internal criteria for post-discharge follow up. Care team clinical staff review clinical documentation and work collaboratively with the inpatient team for a successful discharge. Clinical review and coordination of care for these members is clearly documented in the online computer system and assigned certification numbers for reference. Any alternative service(s) approved in lieu of the original request are documented.

1. Initial Reviews

Initial inpatient authorizations are assigned an authorized length of stay based on the applied internal criteria. Re-authorization is required when the hospital/provider determines that an additional period of confinement is required, but not later than the day on which the prior authorization has expired. Hospital utilization review staff should make requests for re-authorization during normal business hours.

2. Concurrent Reviews

Concurrent review determinations are rendered by a Care Integration staff member verbally or in writing to the facility and/or provider of services. Concurrent review decisions are issued within one (1) business day of receiving all necessary information required to make a decision. When a Care Integration staff member is not able to approve the ongoing service, the case is referred to a Medical Director, who will issue a determination within the same business day. All determinations are communicated to the requestor by telephone or fax at the time of determination. PCN ensures that the frequency of review for the extension of initial determinations on an inpatient stay is based on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity.

a) Extension of Concurrent Reviews

PCN ensures that the frequency of review for the extension of initial determinations on an inpatient stay is based on the severity or complexity of the member's condition or on necessary treatment and discharge planning activity.

b) Onsite Reviews

PCN requires all staff to identify themselves by name, title, and organization name and upon request, informs members, family/caregivers, facility personnel, and health professionals of specific utilization management requirements and procedures. All onsite reviewers carry a picture ID with full name and the name of the organization. PCN staff schedule reviews at least one (1) business day in advance, unless otherwise agreed, and they follow reasonable hospital and facility procedures, including checking in with designated hospital or facility personnel.

Comment [AP18]: UM 5 A 1

Comment [AP19]: UM 6 A

3. Retrospective Reviews

PCN may perform retrospective review in some situations. These situations include, but are not limited to:

- Claims identified as having potential for fraud and abuse
- Hospital not notifying PCN of an admission until after discharge has occurred
- Random claims selections for the purposes of quality monitoring
- Targeted reviews of specific procedures or services in an effort to substantiate services were performed

Retrospective reviews are performed within one (1) year of the date of service. All retrospective reviews will be completed within thirty (30) business days after receiving all necessary information required to perform the review. All retrospective review decisions are communicated following section IV.B.6 of this policy.

Comment [AP20]: UM 5 A 4

4. Maternity Stays and Newborns

PCN provides coverage for a minimum of forty-eight (48) hours of inpatient services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient services following a cesarean

section delivery for a mother and her newly born child. Newborns are deemed certified/approved if they are discharged with the mother. If a newborn is going to remain an inpatient after the discharge of the mother, notification to PCN is required.

PCN offers post-discharge care for newborns and their mothers in the home. The post-discharge care consists of a minimum of two (2) visits by a Registered Nurse with experience in maternal and child health nursing or a physician, when ordered by a physician. The first post-discharge visit will occur within twenty-four (24) to forty-eight (48) hours of discharge. Post-discharge visits include, but are not limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations and well-baby care, and the performance of any necessary and ordered clinical tests.

5. Discharge Planning

The Care Integration staff, in cooperation with the member's attending physician(s) and the hospital discharge planning personnel, facilitate appropriate and timely discharge from inpatient care to home or alternative levels of care. Care Integration staff assists hospital staff to identify, based on the member's needs, community resources needed to assist member in post-inpatient care transition. Discharge planning is initiated through communication with the hospital, member, family/caregiver, and Care Integration staff beginning at the time of admission to ensure continuity of care and to provide an appropriate level of support services to the member upon discharge.

When a member is identified as needing ongoing coordination of services post-discharge, a referral is made to a PCN care team to initiate care coordination services prior to discharge.

Transitional Care Program

Based on established criteria, members at high risk for re-admission to the hospital and/or post discharge emergency room (ER) visits are referred to the PCN's transitional care program. Within 1-3 days of discharge from an inpatient facility, members meeting the criteria receive a post-discharge screening and education call. If barriers are identified on the initial call which could impact a member's ability to be successful in their transition to home, the member is referred for subsequent follow-up at 10-14 days post-discharge. If the concerns about barriers to care continue to exist or a member is identified as needing more intensive, ongoing monitoring, the member is referred to the appropriate care team member for further interventions. The goal of the Transitional Care program is to reduce post-discharge ER visits and readmissions for same/similar diagnoses and to assist members and their caregivers in being successful with their transition to home and follow up care. If the member has a new diagnosis, new medications, or the care team has been unable to reach the member during the post-discharge calls, a referral is sent to a partner home health agency for a home visit to be completed. The home health agency nurse will contact the member by phone and/or conduct a drive-by visit in an attempt to engage the member. During a successful home visit, the nurse will review the discharge plan with the member, reconcile medications and assist the member with establishing post-discharge appointments.

6. Health Home Notification (Missouri only)

On a monthly basis, the state of Missouri sends a file of members receiving Health Home services to the Health Plan. All identified PCN members are flagged in the online documentation system to identify members assigned to a Health Home. The Care Integration staff identifies a Health Home member through the flag in the online documentation system when entering admission and discharge information. Within twenty-four hours of an admission and/or discharge notification, the Care Integration staff notifies the contact at the Health Home of the member's admission and/or discharge. The notification is documented in the Transition Planning tab of the online documentation system.

7. Determinations

a) Approvals

If the decision is to approve a service request, the Care Integration staff will issue a prior authorization number to the requestor by telephone or fax at the time of the determination. All prior authorizations are contingent on the member's eligibility with the Health Plan and PCN on the date of service. The reason for the decision and criteria used to make the determination, if applicable, is documented in the online computer system and assigned a reference number. Documentation of any alternative service(s) approved in lieu of the original request is also maintained in the online system.

PCN will not subsequently retract an authorization after the services have been provided or reduce payment for an item or service unless:

- Authorization is based on material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or

- PCN's contract terminates before the medical service(s) are provided; or
- The covered person's coverage under PCN terminates before the medical service(s) are provided

b) Adverse Determinations

PCN allows providers five (5) business days from the date of a denial to request a peer-to-peer discussion with the Medical Director who performed the review, or to submit additional information on cases resulting in an adverse determination. The peer-to-peer discussion is made available to the requesting provider within one (1) business day of the request. If the original reviewer is not available to perform the peer-to-peer discussion, an alternative clinical peer reviewer will be made available. If the peer-to-peer conversation does not result in an approval of the requested service(s), the requesting provider is informed of the process to file an appeal.

All adverse determinations are communicated by telephone or fax to the requestor at the time of the determination and followed by written notification to the member, facility, and/or provider within one (1) business day. The written notification will meet, at a minimum, the state requirements detailed in section III.F. of this policy.

For services previously authorized, PCN will mail the notice of adverse determination to the member and requesting provider at least ten (10) calendar days before the date of the action for termination, suspension, or reduction of the previously authorized service(s).

Comment [AP21]: UM 7 A

C. Emergency Services and After Hours Access

1. Access to Emergency Room Services and Post-stabilization Care

It is the policy of PCN to ensure appropriate access to emergency services and post-stabilization services for all members. PCN allows members access to a network of hospital-based emergency rooms and urgent care centers throughout its geographical area. Members are instructed, through their Health Plan member handbook, as well as the PCN website and educational materials, such as brochures, to present directly to the nearest emergency room or to call 9-1-1 in case of life-threatening emergency situations or in situations where a prudent layperson, acting reasonably, would believe that an emergency medical condition exists.

A prior authorization is not required for emergency medical services.

2. Payment for Emergency Room Services and Post-stabilization Care

PCN will not refuse to cover emergency services due to lack of notification of the member's screening and treatment from the emergency room, provider, hospital, or fiscal agent. PCN will pay for emergency services from any provider, regardless of whether the provider that furnishes the service(s) has a contract with PCN or the Health Plan, at the current Medicaid payment rates in effect at the time of the service(s). In addition, post-stabilization services provided to maintain the member's stabilized condition, whether in or out of the network, will be paid until the attending physician determines the member is stable for transfer or discharge. PCN will negotiate mutually acceptable payment rates and timeframes with out-of-network providers for post-stabilization services.

3. Retrospective Emergency Room Reviews

PCN encourages appropriate emergency room utilization through various procedures, including retrospective review of emergency room visits and presenting symptoms, utilization and cost trending analysis, and identification of members who sought emergency room care for non-emergent or non-urgent services in an effort to provide education and to facilitate the establishment of a medical home for seeking non-emergent care.

4. Nurse Advice Services

PCN contracts with nurse telephone triage services for members to utilize 24 hours per day, 7 days a week. Based on the information provided, the Nurse Advice staff use clinical protocols to triage the situation and determine the most appropriate advice for the member's situation. The advice given could be to direct the member to seek services at the nearest emergency room or urgent care center, recommend they see their Primary Care Provider within a specified timeframe, or provide home advice to treat the symptoms described. Nurse Advice staff has access to PCN's member eligibility information for reporting of call statistics and outcomes to PCN on a quarterly basis.

D. Pharmacy Services

Pharmacy services are carved out and reimbursed by the state of Missouri. PCN will coordinate with the state to ensure members receive pharmacy services without interruption. Pharmacy services include all medications administered on an outpatient basis, including physician-administered drugs, covered over-the-counter products, all drugs dispensed by outpatient pharmacies, and medications administered in the outpatient hospital setting.

E. Coordination with Behavioral Health

PCN Care Integration staff work with the contracted Health Plan's Behavioral Health team to coordinate care for members identified as having co-existing medical and behavioral conditions and for notification and referral on cases identified as needing behavioral health services.

F. Appeal, Grievance and Quality of Care Concerns

PCN is not delegated to perform appeal, grievance and quality of care concerns for the Health Plan. However, a process is established with each Health Plan to ensure timely referral and processing of any identified grievance, appeal or quality of care concerns. See PCN policy for Coordination of Appeal, Grievance and Quality of Care Concerns with the Health Plan. The member and provider appeal rights are communicated to members by the Health Plan through the member handbook, as well as the PCN website, and adverse determination letters.

G. Program Evaluation

1. Program Metrics

- Provider Satisfaction with UM – measured by Health Plan
- Member Satisfaction with UM – measured by Health Plan
- Inpatient Re-admission within thirty (30) days
- Rate of Hospitalizations - at least quarterly
- Rate of Emergency Room Visits – at least quarterly
- Consistency in Application of Criteria and Guidelines – at least semi-annually
- Compliance with timeframes and notification requirements – monthly

2. Annual Review

The Utilization Management Program is reviewed and evaluated at least annually by the Clinical Quality Committee and the Board of Directors. Annual review includes a review of all activities within the past year, including significant findings, recommendations, actions taken, and utilization issues forwarded to the PCN Clinical Quality Committee. The overall effectiveness and efficiency of the Utilization Management Program is evaluated and reported as part of the Annual Utilization Management Program Evaluation.

Comment [AP22]: UM I D

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5/27/14
5/29/15; 2/09/16

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Date