Clinical Criteria for Utilization Decisions Desk Procedure

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

Network Health Plan/Network Health Insurance Corporation/Network Health Administrative Services, LLC's (NHP/NHIC/NHAS) Utilization Management (UM) Department applies nationally recognized utilization criteria and regionally developed medical policy and standards of care to utilization management reviews.

Procedure Detail:

I. The Utilization Management (UM) Department applies nationally recognized utilization criteria, regionally developed medical policy, and standards of care for utilization management reviews. As available, Centers for Medicare & Medicaid Services (CMS) National and Local Coverage Determination Criteria are applied to Medicare Advantage service requests. NHP/NHIC/NHAS uses the following nationally recognized criteria:

   A. NHP/NHIC/NHAS developed medical policies located at https://policy.networkhealth.com/

   B. CMS National Coverage Decisions, Local Coverage Determinations (WI Carrier criteria), Medicare Part B

      1. The Medicare Coverage homepage, located at http://www.cms.gov provides a listing of all National Coverage Determinations, National Coverage Analyses, Local Coverage Determinations as well as a searchable database.
      2. The Medicare National Coverage Determinations Manual, Pub. 100-3, is the primary record of Medicare national coverage policies, and includes a discussion of the circumstances under which items and services are covered. This manual may be accessed at www.cms.gov/manuals
      3. Program Transmittals and Program Memoranda: CMS transmits new policies and procedures on new coverage determinations and benefits Program Transmittals are located at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals
      4. Medicare Internet-Only Manuals: These manuals present information on Medicare coverage of items and services. (e.g. Medicare Benefit Policy Manual; Chapter 8 - Coverage of Extended Care (SNF) Services _Section 30) Under Hospital Insurance Located at https://www.cms.gov/Regulations-and-

Medicare & You Handbook located at https://www.medicare.gove/pub/medicare-you-handbook

C. MCG - Recovery Facility Care Guidelines
D. MCG - Ambulatory Care Guidelines
E. MCG - Home Care Guidelines
F. MCG - Inpatient and Surgical Care Guidelines
G. MCG - General Recovery Care Guidelines
H. MCG - Behavioral Health Care Guidelines

II. NHP/NHIC/NHAS follows UM delegated entities' evidence-based criteria for those services that are delegated.
   A. NHP/NHIC/NHAS follows UM delegated entities' evidence-based criteria for those services that are reviewed internally, when applicable.
      1. Medicare out-of-network predeterminations for major joint procedures, esophagogastroduodenoscopy (EGD), diagnostic colonoscopy, physical and occupational therapy services, interventional pain, spine procedures, diagnosis and treatment of peripheral vascular disease, molecular-genetic testing, medical oncology, radiation therapy and certain medical drugs.

III. General Facts:
   A. NHIC applies CMS National and Local Coverage Determination (applicable to Wisconsin), Part A and B criteria and benefits to Medicare Advantage requests.
   B. NHP/NHIC/NHAS purchases MCG clinical care guidelines and receives updates as they become available. These nationally recognized, standardized Utilization Criteria (UM) criteria are reviewed at least annually and recommended to the Utilization Management Committee (UMC) for approval and use.
   C. NHP/NHIC/NHAS Medical Policies are developed in collaboration with participating network physicians, often when local practice differs from the national norm. These policies are reviewed and updated annually, or when a significant change in standard of care is identified, by the Utilization Management Committee (UMC) for approval and use.
   D. NHP/NHIC/NHAS developed Medical Policy and care standards are used in conjunction with or in lieu of the commercial standardized criteria when the parameters of a request for service are not clearly addressed by the standard criteria, or when local practice differs.
   E. All criteria used for utilization decisions are based on clinically sound evidence and allow for decision-making options that are responsive to the individual patient's needs and characteristics of the local delivery system.
   F. The Chief Medical Officer, Medical Director(s) and the Vice President of Care Services, retain the authority to authorize care that is in the best interest of the member. All Medicare Advantage utilization determinations are made within the benefit limitations of Original Medicare unless specifically expanded under the MA member's applicable Evidence of Coverage (EOC).
   G. The Chief Medical Officer and/or Medical Director make all determinations not meeting established medical necessity criteria based upon their clinical knowledge and experience, taking into consideration the patient's age, co-morbidities, complications, and other individual circumstances. (The Chief Medical Officer and/or Medical Director(s) consult with board certified practitioners when additional expertise is required.)
      1. The Chief Medical Office and/or Medical Director(s) consult with board certified practitioners when additional expertise is required. See desk procedure - Use of Board-Certified Practitioners for Consultation on

Medical Necessity Decisions.

H. Criteria are applied consistently to medical necessity decisions. At least annually, the Utilization Management (UM) Department evaluates the consistency with which reviewers use criteria, and corrective action plans are developed if excessive variation is found. (See NHP/NHIC/NHAS desk procedures Inter-Reviewer Reliability for UM Coordinators, CM Specialists and Medical Directors Inter-Rater Reliability.)

I. Criteria are available to providers, practitioners and/or members upon request, at no cost. Criteria is publicly available at https://networkhealth.com/provider-resources/policies-and-forms. Providers, practitioners or members may also submit requests via telephone, fax, electronically, or USPS directly to the NH staff. Providers are notified of the availability of the criteria and how to request the criteria through the provider resources website, denial letters and/or newsletters. Members are notified of the availability of the criteria and how to request criteria through denial letters and/or member newsletters. Once the request is received, UM staff send the requested criteria to the requestor via fax, electronically or USPS.

J. The NHP/NHIC/NHAS pharmacy guidelines are reviewed and/or revised by the NHP/NHIC/NHAS Pharmacy & Therapeutics Committee and approved by the QMC.

Procedure:

I. CMS and Published Commercial UM Criteria

A. Manager of Utilization Management or delegate:

1. Receives standardized UM criteria and/or updates to criteria.
2. Reviews the criteria for significant change.
3. Consults with Chief Medical Officer, Medical Director(s) and Vice President of Pharmacy Benefits as needed.
4. Summarizes changes and requests review by participating practitioners with appropriate clinical expertise.
5. Receives feedback and prepares presentation for the UMC in collaboration with the Chief Medical Officer and Medical Directors.
6. Presents updated UM Criteria to the UMC for review and recommendation for approval.
7. Communicates significant changes to the participating network physicians.

II. NHP/NHIC/NHAS Developed Medical Policy and Care Standards

A. Utilization Management Staff or Chief Medical Officer/Medical Director staff:

1. Identifies the need for a new Medical Policy, additional specific care standards, or annual updates to existing internally developed medical policies.
2. Refer to the desk procedure - Medical Policy Development for information on the development of new medical policies.
3. Develops a draft of the document in collaboration with the appropriate participating network practitioners and the Vice President of Care Services
4. Presents updated UM Criteria to the UMC for review and recommendation for approval.
5. Communicates significant changes to the participating network physicians.

III. UM Staff Application of Medical Criteria

A. Population Health Specialist

1. Receives request for medical service requiring prior authorization or

advance coverage determination/predetermination.

2. The electronic UM system date stamps request and forwards to appropriate UM Coordinator if necessary or enters request into UM information system.
3. Assists with entering additional authorization data as directed once decision has been made.

B. UM Triage Coordinator and or UM Coordinator:

1. Receives request for medical service requiring prior authorization or advance coverage determination.
2. Gathers adequate medical information to facilitate decision making. Clinical information includes, but is not limited to, the following:
    a. Office and hospital records
    b. A history of the presenting problem
    c. A clinical exam
    d. Diagnostic testing results
    e. Treatment plans and progress notes
    f. Patient psychosocial history
    g. Information on consultations with the treating practitioner
    h. Evaluations from other health care practitioners and providers
    i. Photographs
    j. Operative and pathological reports
    k. Rehabilitation evaluations
    l. A printed copy of criteria related to the request
    m. Information regarding benefits for services or procedure.
    n. Information regarding the local delivery system
    o. Patient characteristics and information
    p. Information from responsible family members in accordance with HIPPA regulations.
3. The UM Coordinator considers at least the following individual characteristics when applying criteria:
    a. Age
    b. Comorbidities
    c. Complications
    d. Progress of treatment
    e. Psychosocial situation
    f. Home environment, when applicable
4. Clinical decision-making for Medicare Advantage requests includes the consideration of the member's Evidence of Coverage, Explanation of Benefits, drug formulary, appropriate CMS regulations and guidance, required drug compendia, previous claims history and all submitted clinical information.
5. Clinical decision-making for Commercial and Marketplace requests includes the consideration of the member’s Certificate of Coverage, Explanation of Benefits, drug formulary, required drug compendia, previous claims history and all submitted clinical information.
6. Makes reasonable and sufficient attempts to obtain additional information if essential information is incomplete by contracting ordering or rendering practitioners and providers and/or member if necessary. (See desk procedure UM Decisions Timeframes, Notice Content and Process)
7. UM Coordinator reviews request based upon clinical review criteria applicable to the type of service requested in conjunction with the local delivery system and the ability to meet the member/participants specific

health care needs:

a. Commercial Membership
    i. Review request against NHP/NHIC/NHAS internally developed medical policies, MCG, and UM delegated medical policies if applicable, if not available then nationally published criteria, if not available then CMS criteria, if not available, then technology assessments and other medical information and published evidence provided by the practitioner requesting service.
b. Medicare Advantage:
    i. Review request against CMS NCD and LCD criteria, then NHP/NHIC/NHAS internally developed medical policies, MCG, and UM delegated entity policies if applicable medical policies and then commercially published criteria.
    ii. If specific criteria not available for requested service review the request based on the experimental process and the MA member's benefit limitations (provide an objective-evidence based rationale based on authoritative evidence for the determination)
    iii. Approves medical service when criteria met and enters authorization or delegates authorization entry to CM Specialist. UMC refers requests for medical service requiring authorization or advance coverage determination not meeting CMS, commercial and regionally developed medical criteria to Medical Director for denial determination or approval with exception.

Regulatory Reason:

- UM 2
- Code of Federal Regulations:
    - Sec 422.101 (b)(1)-(5)
    - Sec 422.112(a)(6)(ii)
    - Sec 422.152 (b)(1),(4)
    - Sec 422.202(b) and (c)
    - Sec 422.504 (a)(3)(iii)
- Medicare Managed Care Manual:
    - Chapter 4, Benefits and Beneficiary Protections, Section 10.16 Medical Necessity, Section 90.1 National and Local Coverage Determinations Overview, 90.3 General Rules for NCDs, Section 90.5 Creating New Guidance, 90.6 Sources for Obtaining Information, Section 110.1.1 Provider Network Standards
    - Chapter 6, Relationships with Providers, Section 20.1 Physician Consultation in Medical Policies

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