

**PRESBYTERIAN HEALTHPLAN  
PRESBYTERIAN INSURANCE COMPANY**

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**UTILIZATION MANAGEMENT PROGRAM  
DESCRIPTION**

Effective: 6/93  
Reviewed: 3/96; 3/97; 2/10/98; 1/21/99; 1/20/00; 6/15/00; 9/12/00; 1/18/01; 12/18/01; 1/23/02; 2/25/03;  
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## **PURPOSE**

The Presbyterian Health Plan (PHP)/Presbyterian Insurance Company (PIC) Utilization Management (UM) Program is established to ensure that excellent services are provided in a coordinated fashion with neither over- nor underutilization.. PHP/PIC has a well structured UM program

The Utilization Management Plan serves as the blueprint for defining the overall program description and clarifying structure and function.

This document describes:

- (1) scope of utilization management activities;
- (2) procedures to evaluate clinical necessity, access, appropriateness, and efficiency of services;
- (3) mechanisms to detect underutilization and over-utilization;
- (4) clinical review criteria and protocols used in decision-making;
- (5) mechanisms to ensure consistent application of review criteria and uniform decisions;
- (6) development of outcome and process measures for evaluating the utilization management program; and

## **PROGRAM OBJECTIVES**

- To ensure that members receive timely, medically necessary health care in an appropriate setting for a positive health outcome including the incorporation of culturally competent approaches to care;
- To ensure that services are sufficient in amount, duration and cope to responsibly be expected to achieve the purpose for which the services are furnished;
- To promote fair and consistent UM decision making which addresses the needs of individual patients and characteristics of the local delivery system;
- To develop indicators and thresholds for monitoring and evaluating services for continuity of care and over- or under utilization of medical resources, identifying issues, and developing follow-up measures;
- To provide information for use in provider profiles (such as medical resource utilization and practice patterns);
- To coordinate referrals for post-hospital medical services to appropriate providers, Presbyterian departments, or community support services;
- To identify quality, risk, and utilization issues and refer potential issues appropriately;
- To improve health, wellness and management of chronic diseases and catastrophic conditions through coordination with PHP/PIC's Health Management Model;
- To identify and change administrative processes that represent barriers to care and implement interventions to remove or minimize these barriers;
- To ensure inter-rater reliability of all individual performing UM review;

- To ensure that Groups providing delegated UM meet PHP/PIC, State, Federal, Employer Group and NCQA standards;
- To ensure Member and Provider satisfaction with the UM process.

## **STRUCTURE AND ACCOUNTABILITY**

The Utilization Management (UM) program is under the direction of the Chief Medical Officer (CMO). The CMO delegates responsibility for day-to-day operation to the Commercial, Medicare Programs, Behavioral Health, and Medicaid Programs, Medical Directors, the Director of Pharmacy, the Director of Behavioral Health and the Executive Director of Health Services.

Utilization Management activities are guided and supported by Presbyterian Medical Directors, and the Clinical Quality Committee. The Quality Improvement Committee (QIC) assumes overall responsibility for all clinical/non-clinical PHP /PIC quality and UM Program accountabilities.

The CMO has a reporting relationship to the President and the PHP/PIC Board. The Health Services Executive Director, Pharmacy Director and Physical/Behavioral Health Medical Directors report to the CMO.

Health Services review staff consists of clinically qualified licensed professionals who report to team leads or managers. Behavioral Health review staff are all trained behavioral health professionals, who report to and are supervised by an independently licensed behavioral health clinician. Pharmacy staff consists of technicians and pharmacy assistants who report to clinical pharmacists.

The Behavioral Health Department does not have a centralized triage and referral function and supports an open access model of outpatient visits to network practitioners.

Support and ancillary staff is made up of experienced professionals who report to managers, team leads or supervisors.

Teams in the Health Services and Behavioral Health Departments are responsible for most UM activities. Pharmacists, Licensed Nurses and/or Behavioral Health Professionals with the support of non-clinical coordinators perform activities such as benefit certification, concurrent review, retrospective review and care coordination. Medical Directors oversee utilization management processes and participate in benefit certification reviews, hospital concurrent reviews and retrospective reviews. Medical Directors or clinical peer consultants must make determinations for any denials on the basis of medical appropriateness for all of the following categories:

The Pharmacy Department ensures that PHP/PIC's procedures for pharmaceutical management promote the clinically appropriate use of pharmaceuticals.

- Denials of requests for covered medical benefits as defined by PHP/PIC (e.g., listed in the Evidence of Coverage, Summary of Benefits, CMS and HSD documents).

- Denials of requests for non-covered benefits that are requested for medical reasons by the member or practitioner (e.g., services that could be considered cosmetic).
- Denials of experimental treatments.
- Formulary medical exceptions.

#### **INITIAL ADVERSE DETERMINATIONS/Notice of Action**

- A. Coverage.** Before denying coverage for a health care service requested by a practitioner, provider or covered person on grounds of lack of coverage, PHP/PIC determines that there is no provision of the health benefits plan under which the requested health care service could be covered.
- B. Medical necessity.** Before PHP/PIC denies a health care service requested by a practitioner, provider or covered person on grounds of a lack of medical necessity, a physician renders an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of review, or after application of uniform and scientifically valid review criteria established by the health plan in consultation with specialists who are experts in the area that is the subject of review based on national standards. The physician shall be under the clinical direction of the medical director responsible for health care services provided to covered persons.

**NOTICE OF INITIAL ADVERSE DETERMINATION:** PHP notifies a covered person and provider of an adverse determination by telephone or as required by regulation and the medical exigencies of the case, but in no case later than twenty-four (24) hours after making the adverse determination. Additionally, the health care insurer shall notify the covered person and provider of the adverse determination by written or electronic communication sent within one (1) working day of the telephone notice. The notice shall:

- A.** If the adverse determination is based on a lack of medical necessity, explain clearly and completely why the requested health care service is not medically necessary. A statement that the health care service is not medically necessary will not be sufficient;
- B.** If the adverse determination is based on a lack of coverage, identify all health benefits plan provisions relied on in making the adverse determination, and explain clearly and completely why the requested health care service is not covered by any provision of the health benefits plan. A statement that the requested health care service is not covered by the health benefits plan will not be sufficient;
- C.** Advise the member, or the person authorized to act on their behalf, that he or she may request internal review of the health plan's adverse determination; and
- D.** Describe the procedures and provide all necessary forms to the grievant for requesting internal review and external review, if applicable (Medicaid may request a Fair Hearing).

Should the decision require specialized clinical judgement, the Medical Director will consult with another practitioner or provider within the required medical specialty (Peer Consultation).

UM decision making is based only on appropriateness of care and service. PHP/PIC does not specifically reward practitioners or other individuals conducting UM for issuing denials of coverage of

service. Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization. Presbyterian does not prohibit providers from advocating on behalf of enrollees within the UM process.

## **PROGRAM INTERFACES**

Care Coordination Interface: Although care coordination is distinct from basic utilization review, Care Coordinators interface and communicate with benefit certification units and activities.

### Quality Management Department Interface

Monitoring of sentinel events provides the Quality Management Program with information regarding potential quality of care issues. Utilization and Quality indicators may be used by Quality Management (QM) for re-credentialing and peer review. UM works closely with QM on health management and quality improvement initiatives.

### Health Care Utilization/Expense Team (HCUET) Interface

It is the responsibility of HCUET to analyze cost and utilization data, identify areas of over/under utilization (for both use of services and cost) and contribute to the development and monitoring of action plans to address over/under utilization variances.

### Clinical Quality Committee (CQC)

It is the responsibility of CQC to review clinical review criteria and discuss potential over/underutilization issues, if applicable.

### Provider Interface

Utilization profiles will be shared with providers in order to identify variances, which represent over-utilization, under-utilization and “best” practices. Performance improvement plans may be requested as recommended by Clinical Quality Committee (CQC) and/or Credentialing/Peer Review Committee.

### Provider Services Department Interface

UM partners with Provider Services to enhance the support necessary for practitioners to practice without undue barriers. UM staff serves on cross-functional committees with Provider Services.

### Health Management Interface

Evaluation and collaboration among UR nurses, Behavioral Health and Physical Health Care Coordinators, Quality Management staff, Pharmacy staff, and Behavioral Health Referral Coordination contributes to PHP/PIC’s health management program.

### Claims Department Interface

A claims department link is essential to ensure prompt, accurate payment of claims.

### Member Service Interface

UM partners with members to measure and identify issues for quality improvement such as member appeals results, complaints, and denials.

### Marketing Department Interface

UM and Marketing collaborate on benefits interpretation, contracting and customer service issues to ensure that information given to customer is consistent and appropriate.

### Finance Department Interface

Collaboration with finance is essential in defining the success of the UM program and to set utilization targets.

### Government (Medicaid, Medicare, State of New Mexico Programs & State coverage Insurance (SCI))

Regular, ongoing communication with the government program operations provides opportunities for identifying areas where joint policies, procedures and committees may be used to enhance effectiveness and efficiency and to insure compliance with regulations. The Behavioral Health Liaison, a Master's prepared behavioral health clinician, resides in Behavioral Health to facilitate communication and coordinate care with the Behavioral Health Single Entity for Medicaid members.

The Nurse Advice Line provides 24-hour triage for members to answer questions regarding personal health related issues as well as serving as a "hot-line" to provide clinical assessment and triage to evaluate the acuity and severity of a member's symptoms and make the clinically appropriate referral and decision-assistance based on symptoms for prediagnostic and post-treatment health care.

UM staff is available 24 hours 7days a week for rendering UM determinations for providers.

## **PROGRAM REVIEW AND EVALUATION**

The Utilization Management Program is evaluated annually. This formal review ensures that processes continue to be current and appropriate and also measures the effectiveness of continuous improvement activities. Monitoring is designed to identify and pursue opportunities for improvement and extends to delegated and non-delegated functions. Member and provider satisfaction with the UM process is part of the annual evaluation.

The Utilization Management Program is approved by the Clinical Quality Committee. The evaluation and work plan are incorporated into the Quality Improvement Evaluation and Work Plan which is approved by the Board and Quality Improvement Committee. Additionally, separate HCUET workplans are also developed to serve as specific program management tools. PHP/PIC Physical and Behavioral Health Medical Directors have significant involvement in the development and implementation of the program.

## **DATA SOURCES**

- Member Satisfaction Survey
- Provider Satisfaction Survey
- Audits of Delegated Groups
- Productivity Reports
- Data Warehouse
- Facets
- Claims History
- CaseTrakker
- Committee Recommendations
- Case Sampling
- Results of Outside Audits
- Results of Member/Provider Services Focus Group
- Employer Surveys
- Inter-rater Reliability Cases
- PHP Advocate
- Grievance/Appeals Log
- Phone Logs
- Financial Reports
- Practitioner Profiles
- PBM online pharmacy data

## **CONFIDENTIALITY/SECURITY**

All information and medical records obtained during the course of review activities shall be treated as confidential in compliance with all applicable state and federal regulations including, but not limited to, those required by the HIPAA. Presbyterian uses all reasonable diligence to prevent disclosure and/or re-disclosure except to its necessary personnel. This obligation excludes material or information that is in the public domain.

There are several levels of computer system security beginning with user logon, user name/password security. The second level of security is provided in the menu system, again requiring user name/password type key/entry for access. Once users have logged onto the system, they will be given access to those functions required for their positions. This prevents inadvertent errors. All user accounts are maintained under the Director of security for Information Systems. The appropriate Director assigns specific security levels.

### HSD and DOI Access to PHP UM Documentation:

In accordance with New Mexico State Medicaid and the Department of Insurance Regulations, Human Services Division (HSD) and Department of Insurance (DOI) will have access to all PHP UM review Documentation. A copy of the UM Program Description is submitted to HSD and Division of Insurance (DOI) annually.

## APPLICATION OF UTILIZATION MANAGEMENT CRITERIA

Measurable, objective, decision-making criteria ensure that decisions are fair, impartial and consistent. Criteria do not serve as practice guidelines; rather they assist in first level screening for medical necessity. Presbyterian does not utilize criteria as the sole basis for rendering Utilization Review determinations. Individual patient situations, risk factors, service availability, and local resources must be considered as criteria often reflects guidelines relevant to the least complicated case and the most complete delivery system. They may not be appropriate for a delivery system with insufficient alternatives to inpatient care. Therefore, Presbyterian considers the following factors when applying criteria to a given case:

- Age
- Comorbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Availability of services including, but not limited to skilled nursing facilities, or home care, in PHP/PIC's service area to support the member after discharge.
- PHP/PIC's coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care.
- Ability of local hospitals to provide all recommended services within the estimated length of stay.

Benefits are always validated to determine coverage. Benefit sources include: HSD Managed Care/Medical Assistance Program documents; CMS guidelines; Member Group Subscriber Agreements/Evidence of Coverage; Presbyterian Benefit Interpretation Manual, SCI Member Handbook and Contract.

Review staff may deny requests for the following reasons only:

- Lack of timely notification
- Member not enrolled/eligible
- Exhaustion of benefits (e.g. # of patient visits, behavioral therapy, pharmacy cap)
- Request not a covered benefit (except as described below)

Staff may also refer to a care coordinator to assist with obtaining alternative resources.

A Presbyterian Medical Director must make the following denial decisions:

- Denials of covered medical benefits as defined by PHP/PIC (e.g., listed in the Certificate of Coverage, Summary of Benefits) which are not medically necessary

- Denials of non-covered benefits that are requested for medical reasons by the member or practitioner (e.g., services that could be considered cosmetic)
- Denials of experimental treatments

## UTILIZATION MANAGEMENT CRITERIA

PHP/PIC uses both nationally recognized and local criteria including:

### PHYSICAL HEALTH

Medical Inpatient Admissions:

Milliman Care Guidelines  
CMS Medical Policy  
Internal Criteria

Rehabilitation:

Milliman Care Guidelines  
Internal Criteria  
"Oregon Outpatient Therapy Guidelines for Children with Special Healthcare Needs"

Home Care:

CMS Medical Policies  
Internal criteria  
Milliman Care Guidelines

Elective Procedures and Diagnostics:

Milliman Care Guidelines  
CMS Medical Policy  
Internal Criteria

Durable Medical Equipment:

Internal Criteria  
CMS Medical Policy  
DMERC, Region C

Pharmacy Services:

Formulary/Preferred Drug List  
CMS Guidelines  
National Specialty Guidelines

New Technologies:

Hayes Medical Technology Directory  
Hayes Technology Newsletter  
Hayes Outlook  
CMS Medical Policy

Coding:

CMS Guidelines  
Coding Clinic  
HCPCS/ICD 9/DRG/CPT coding texts

Other Medical Management Guidelines are researched and developed based on specialty and professional organization guidelines and local practice.

BEHAVIORAL HEALTH:

Inpatient Admissions:

American Psychiatric Association Criteria  
American Academy of Child and Adolescent Psychiatry Criteria  
Presbyterian Behavioral Health Level of Care Guidelines

Diagnostic:

American Psychiatric Association Recommendations on Psychological Testing

Rehabilitation:

American Society of Addiction Medicine Patient Placement Criteria Second Edition-Revised  
Behavioral Health Level of Care Guidelines

Outpatient Treatment:

American Psychiatric Association Criteria  
American Academy of Child and Adolescent Psychiatry Criteria  
American Society of Addiction Medicine Patient Placement Criteria Second Edition-Revised  
Behavioral Health Level of Care Guidelines

Updates

PHP/PIC annually reviews and updates UM criteria and the procedures for applying these criteria. Both proprietary and internal criteria may be modified to meet local practice standards. The process includes review by Presbyterian Medical Directors, actively practicing local practitioners, and the Clinical Quality Committee.

Copies of criteria are provided to practitioners and providers as requested on specific cases and/or through direct requests or routine updates.

***Use of Criteria by entities delegated to perform utilization management activities.***

Delegated entities are not required to use the criteria previously listed, but must meet the following standards;

- Must be based on sound clinical evidence and specify procedures for applying those criteria in an appropriate manner.

- Must involve appropriately practicing practitioners in development, adoption and procedures for applying criteria.
- Must be reviewed at least annually and updated, as indicated.
- Must be evaluated at least annually to assess consistency of application (Inter-rater reliability may be conducted through PHP/PIC)

## **PROGRAM SCOPE**

Ongoing utilization review activities present an opportunity to identify outdated or unnecessary UM procedures, duplication of services and potential quality of care issues as well as over- and under-utilization. Most importantly, members will receive medically appropriate quality care through coordination of services provided by knowledgeable, competent providers. Domains of scope include medical, pharmacy, and behavioral health.

The Utilization Management Program consists of the following components:

### Prospective review

- Certification for medical specialty care
- Certification of elective surgeries
- Pre-admission review
- Certification for selected therapies and diagnostic testing
- Certification for provider under focused review
- Certification for non-formulary drug requests
- Certification for certain formulary drugs

### Retrospective Review

- Medical claims review for medical necessity
- Coding validation
- Focused review of providers with quality of care/UM patterns of concern
- Pattern analysis

### Care coordination and Concurrent Review for

- Members who are at high risk due to chronic disease, complicated treatment, or severe restrictions with activities of daily living
- Out-of-area coordination of care
- Continued hospital stays
- Discharge planning
- Home Health Care
- Members with catastrophic illnesses

### Coding Support

- Inservices to provider groups
- Assistance with appropriate billing

### Analysis and Education

- Coordination with Decision Support Team

- Identification of over/under-utilization
- Service quality monitoring
- Provider profiling
- Benefits interpretation
- New technology assessment
- Pharmacotherapeutic assessment

### Health Management

- Catastrophic care coordination
- Community-based care coordination
- Specialty or population-based care coordination
- Disease management
- Wellness promotion including primary and secondary prevention, and healthy lifestyles.

### Delegated Review Oversight

- Initial review for appropriateness for delegated status
- Ongoing monitoring
- Consistent extensive support
- Monitoring of corrective action plans
- Education

### Evaluation of New Technologies and the New Application of Existing Technologies

- Evaluation by Technology Assessment Committee
- Research

### ***Prospective Review***

#### Certification

Benefit Certification assists in ensuring that members have access to medically necessary services which are available in their benefit package as a covered benefit. Except for emergencies or exemptions through policies or contracts, Presbyterian requires providers to obtain certification for certain non-emergent outpatient services; inpatient services, referrals for certain specialist or ancillary services, and services by out-of-plan providers. Certification requirements are governed by Presbyterian policies and procedures and state and federal regulations.

PHP/PIC will *not* certify/approve/authorize retroactive requests for services which require certification/prior authorization. For inpatient admissions, notification within 24 hours of admission is required. Where notification and/or requests for certification are not provided within 24 hours, the admission will be denied administratively. This applies to all facilities and services including behavioral health and physical health admissions.

#### Open Access to Women's Health Care

Members are allowed to self refer to contracted women's health care providers.

#### Hemo-Dialysis

Members are allowed to receive routine dialysis by either contracted or non-contracted dialysis centers without certification.

Services/Referrals Requiring Benefit Certification Are Monitored at the Time of the Request for:

- Benefit coverage
- Member enrollment
- Provider status (contracted or non-contracted)
- Coverage by other payor(s)
- Medical necessity
- Appropriateness of setting
- History or medical condition and treatments
- Special circumstances, socioeconomic issues, support issues, complexity of health status and availability of local health resources.

Services and referrals requiring certification are evaluated on an ongoing basis, but at least yearly and are dependent, in part, on the benefit plan preferred by the employer.

Emergency/Urgent Care

Emergency services do not require certification before treatment is rendered. Reimbursement for emergency care and emergency transportation will not be denied by PHP/PIC. It is assumed that the member acted in good faith and possesses average knowledge of health and medicine, seeks medical care for what reasonably appears to the member to be an acute condition requiring medical attention, even if subsequently determined to be non-emergent. PHP/PIC considers all members to be a "reasonable layperson" with the following characteristics: (1) a reasonable person's belief that the circumstances required immediate medical care that could not wait until the next working day or next available appointment; (2) the time of day the care was provided (3); the presenting symptoms; and (4) any circumstances which precluded use of PHP/PIC's established procedures for obtaining emergency care.

Urgent Care

Urgent Care means medically necessary health care services provided out of area or after a primary care physician's normal business hours for unforeseen conditions due to illness or injury that are not life-threatening but require prompt medical attention. An Urgent Care episode does not require certification, however follow-up care requires certification if not provided by the member's PCP and must be requested by the PCP in consultation with the member.

Pre-Admission Review

Pre-admission review provides an opportunity to review, analyze and certify that a proposed hospital admission is medically necessary and appropriate and to assist the admitting physician with obtaining resources. It is a method of assuring appropriate hospitalization, preventing unnecessary utilization of hospital services, and identifying potential discharge and continuum of care needs. The review facilitates:

- determination of benefit coverage before any financial liability has occurred;

- assurance that appropriate and cost-effective alternatives to expensive inpatient treatment will be considered;
- modification of inappropriate patterns of care so that costs can be controlled without compromising access or quality;
- active physician participation in the use of their patients' health care benefits;
- early consideration of discharge planning
- identification and resolution of quality of care issues
- identification of cases appropriate for care coordination

The pre-admission review process provides an opportunity for Presbyterian to work directly with the physician, hospital and member to assure that inpatient criteria have been met or to suggest alternative appropriate settings for the delivery of covered health care services.

In order to minimize constraints upon the member and the physician, the staff will promote and maintain a cooperative environment by:

- making decisions on the basis of complete medical information;
- contacting the treating physician in a timely manner for more information;
- consulting with appropriate medical peers to evaluate questionable cases.
- taking into consideration individual patient situations which impact care decisions (socioeconomic, severity of illness, resources, service accessibility).

The pre-admission screening process will use medically acceptable screening criteria to serve as medical guidelines. The function of the criteria in pre-admission review is to identify:

- cases that can safely be treated in an ambulatory setting;
- cases that ordinarily would be treated on an ambulatory basis; but, due to other medical conditions and/or complicating factors, require care in the hospital; and
- cases that should be reviewed by the Medical Director or designee;
- opportunities to educate the hospitals/attending physician on optimum utilization practices.

The Behavioral Health certification process for Commercial, Senior programs, ASO and PIC plans is developed for ease of use by members and providers. Members may directly refer themselves to a participating behavioral health provider, may be referred by their primary care physician, or may call PHP/PIC behavioral health to obtain the names of several providers that are experienced in treating the member's presenting problem and are located in geographical proximity to the member. Not all outpatient behavioral health services require a benefit certification for participating practitioners. The benefit certification process for all other services has been developed to minimize paperwork. The Behavioral Health staff can authorize requested services and will give the provider an certification number verbally followed by a written certification letter. In some cases the Behavioral Health staff may request a written treatment plan, clinical summary or specific discharge plan. These cases include the failure of the provider to convey satisfactory information to allow certification, cases that seem to fall out of standard behavioral health practice patterns, or cases where it is not clear the request is a behavioral health issue.

Facility based services (i.e. acute inpatient and partial hospitalization, substance abuse rehabilitation centers and residential treatment), require certification. Acute inpatient hospitalization reviews are primarily done telephonically.

PHP/PIC will *not* certify/approve/authorize retroactive requests for services which require certification/prior authorization.

For inpatient admissions, notification within 24 hours of admission is required. Where notification and/or requests for certification are not provided within 24 hours, the admission will be denied administratively. This applies to all facilities and services including behavioral health and physical health admissions.

### Out-of-Network Services

Each contract, policy, or arrangement between PHP/PIC and an enrollee, subscriber, or contract holder must provide that in the event medically necessary covered services are not reasonably available through participating providers, Presbyterian and the PCP or other participating provider shall refer an enrollee to a non-participating physician or provider at the usual and customary rate or at an agreed upon rate. Before PHP/PIC may deny such a referral to a non-participating physician or provider, the request must be reviewed by a specialist similar to the type of specialist to whom a referral is requested.

Presbyterian ensures that enrollees who are paneled to a delegated entity are not precluded from obtaining a referral from the enrollee's primary care physician to a specialist or other health care provider within PHP/PIC's network, if the referral is reasonable.

### ***Concurrent Review***

#### Inpatient Continuing Care

Services provided in hospitals, skilled nursing units, partial hospital programs and other clinical facilities are monitored and evaluated concurrently for medical necessity and the appropriateness of the level of care. An Inpatient Care Coordinator conducts reviews either on-site or by telephone. Community Care Coordinators may also perform concurrent review for members in their caseload.

During concurrent review, the Care Coordinator:

- Determines the optimum length of stay (based on appropriate guidelines for the member's diagnosis) which serves only as an initial guide. Length of stay must be individualized to the patient's status and community resources, as described previously and the local delivery systems.
- Evaluates with facility staff the member's discharge needs (e.g., therapies, DME, home health, care coordination)
- Identifies other potential payers
- Screens for and refers potential quality, risk, and utilization management issues
- Coordinates the transition of individuals who are hospitalized on the date of enrollment or the date of transfer to another health plan
- Obtains and documents information for decisions of medical necessity
- Assists the attending physician with transitioning to various levels of care such as SNF

- Assesses whether adequate services are being provided by the facility, whether there is adequate treatment planning and whether the scope and duration of services are addressing the individual's needs.

Care Coordinators may authorize requested transfers to a lower level of care and referrals for post-discharge ancillary services (such as home health or rehabilitative therapies). Inpatient Care Coordinators coordinate care management with evaluations.

If an admission or continued stay does not appear to meet medical necessity guidelines, the Care Coordinator first discusses the case with the attending physician and hospital UR nurse. If certification is to be denied, the case is reviewed with a PHP/PIC Medical Director. The Medical Director, consults with the attending physician, the PCP, and/or the hospital utilization review department agrees with the denial/decision and may reconsider the decision if additional information is provided.

### Outpatient Continuous Care

Outpatient concurrent review includes services which represent ongoing, intensive ambulatory care such as home health care, and rehabilitation.

During concurrent review of continuous outpatient care, the Care Coordinator, certification nurse, and/or rehabilitation specialist:

- determines optimum frequency and duration
- evaluates the plan of treatment in collaboration with the practitioner/provider
- obtains and documents information for decisions of medical necessity

### Discharge Planning

The Joint Commission for Accreditation of Healthcare Organizations (JCAHO) requires hospitals to provide discharge planning. During concurrent reviews, Care Coordinators identify and evaluate the needs that a member may encounter after discharge and work with attending physicians and hospital staff to plan and coordinate covered services.

Care Coordinators assist facilities in meeting discharge planning requirements; however, Presbyterian does not duplicate discharge services that Medicare, Medicaid, and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) require hospitals to provide. During concurrent reviews, Care Coordinators identify and evaluate the needs that a member may encounter after discharge and work with attending physicians and hospital staff to plan and coordinate covered services.

To maintain continuity of care and prevent readmission, Care Coordinators may assist hospitals in preparing for a member's discharge by contacting health care providers and/or facilities to assure post-discharge care is available to the member.

All members admitted to an inpatient behavioral health facility, partial hospital program, or any facility-based program are assigned a Presbyterian Behavioral Health Care Coordinator.

PHP/PIC will *not* certify/approve/authorize retroactive requests for services which require certification/prior authorization. For inpatient admissions, notification within 24 hours of admission is required. Where notification and/or requests for certification are not provided within 24 hours, the admission will be denied administratively. This applies to all facilities and services including behavioral health and physical health admissions.

Requests for renewals of services include, but are not limited to:

- Home Health Hospice
- Therapies
- Specialty referrals
- Home IV services

### ***Retrospective Review***

#### Medical Claims Review

The Medical Claims Review Unit provides retrospective review of claims for select facility and professional charges including, but not limited to inpatient services, outpatient services, or focused review. Nurses may review claims for coverage, medical necessity, appropriateness of charges, and level of care and may identify a need for further documentation to substantiate charges submitted. Emergency or urgent care services are not denied retrospectively for medical necessity issues, but may be denied for billing or technical coding errors.

#### Coding Validation

The purpose of coding validation is to assure PHP/PIC that the codes submitted by a provider accurately reflect information which is contained in the medical record. Correct coding is essential to assure appropriate claims payment as well as appropriate data to perform statistical analysis. Presbyterian Behavioral Health uses restricted CPT codes. Only those CPT codes allowed by contract will be paid.

PHP/PIC may review a sample of inpatient and outpatient records for validation of correct coding. Providers have an opportunity to appeal changes in coding decisions through the claims appeal process.

#### Focused Review

If issues of over- or under-utilization, and/or quality of care have been identified, a focused provider review may be initiated. Level of care and quality of care are assessed through this review process. Findings are presented to the Medical Directors and may be reviewed by the Credentialing Committee, or other appropriate committee.

#### Coding Support

The Coding Manager is a registered coder who provides ongoing consultation to provider offices in addition to sponsoring formal educational workshops.

## ***Analysis and Education***

Analysis is performed routinely and ad hoc, and may include the following to monitor for over/underutilization:

- I. Monthly inpatient
  - A. Plan statistics
    - 1. Days/1000
    - 2. Admits/1000
    - 3. Average length of stay
    - 4. Average per admission cost
  - B. Hospital and Provider specific
    - 1. Days/1000
    - 2. Admits/1000
    - 3. Average length of stay
    - 4. Average per admission costs
  - C. Statistics by service type (same as above)  
(medicine, surgery, pediatrics, gynecological surgery, obstetric, mental health, chemical dependency, ICU, neonatal ICU, rehabilitation, outpatient surgery)
  - D. Statistics by line of business, as above
  - E. Retrospective certifications
  - F. Pended cases for review
  - G. In-network vs. out of network
  - H. Number and percentages of denied days
- II. Monthly/quarterly summary of outpatient utilization:
  - A. Primary/Specialist care encounter rates
  - B. Visits/ER/member per year (annualized) and cost
  - C. Percentage of new visits
  - D. Revisit interval rates (churning: seeing patient more than is medically necessary)
  - E. Laboratory/pathology utilization per visit
  - F. Radiology utilization per visit (total and focused)
  - G. Pharmacy utilization and drug profiling
- III. Referral Utilization
  - A. Referral rate per 100 primary care visits or per 1,000 members per year
  - B. Comparison of PCP referral rate with peer group referral rate
  - C. Initial referrals only compared with total referral visits
  - D. Cost per referral by PCP, plan average, and specialty
  - E. Number of visits and cost by specialty
    - 1. top specialty referrals for each PCP
    - 2. average cost per visit
    - 3. per member per month cost by specialty
  - F. Percentage Primary vs. Specialty Utilization
- IV. Out of network specialty care in point of service plans (% of total specialty care; cost; specialty and utilization categories)
- V. Ambulatory procedures by procedure, by patient groups, etc.

- VI. Ancillary care  
(Physical Therapy, Occupational Therapy, Speech Therapy, Podiatry, Oral Surgery, Chiropractic, Home Health, and Acupuncture, etc.)
- VII. Comparison to PHP/PIC Goals and Benchmarks
  - A. Referrals
  - B. Outpatient visits
  - C. Inpatient surgeries/1000
  - D. Ambulatory procedures/1000
  - E. Home Care
  - F. Emergency Room
  - G. Behavioral Health inpatient days per thousand
  - H. Behavioral Health average length of stay
  - I. Behavioral Health admissions per thousand
- VIII. Practitioner profiling
- IX. Readmission rates
- X. Drug utilization, e.g., Generic vs. brand usage relevant to disease management protocols
- XI. Scope of Utilization Monitoring
  - A. PHP/PIC as a whole
  - B. Each product line
  - C. Provider and practice sites
    - 1. PCP sites
    - 2. Provider sites who perform UM
    - 3. High volume specialty practice sites
  - D. Employer group specific

### ***Health Management***

Presbyterian Health Plan (PHP)/Presbyterian Insurance Company(PIC) firmly believes in and strongly supports the concept of health management. Presbyterian currently offers a comprehensive and well-coordinated complement of care management services. Health management at PHP/PIC is built around three core components: staying healthy, living with illness, and getting better.

Presbyterian recognizes that progressive, innovative, and cohesive health management strategies are critical success factors in its mission to improve the health of individuals, families, and communities. Such realized strategies have enormous potential to improve the health of populations when coupled with an informed member who is presented with choice and partnered with caring professionals who are evaluated on explicit quality-of-care standards. Tools include, but are not limited to, wellness, prevention, disease management, and demand management.

The following descriptions represent key components of PHP/PIC's plan to accomplish such service:

- Adoption and dissemination preventive health guidelines and promotion of healthy lifestyles.
- Periodic front-end assessment and evaluation of select populations, allowing for interventions to improve status.
- Programs that provide wellness/behavior modification for individuals at risk of health incidents due to lifestyle issues.
- A telephonic program for members with nurses who answer questions regarding disease and treatment, triage patients in need of care, interface with network physicians regarding patient issues, and refer for care coordination intervention.
- Focused programs that guide patients and providers through a particular episode such as prenatal wellness, asthma self-care, and depression.
- Chronic care management for individuals with conditions that can be improved or more effectively managed through appropriate physician intervention and self-care.
- Advice and assistance for patients and their physicians in determining how long a disability and subsequent recovery period should last.
- Development of web-based tools to support providers.
- Development of "Member Connections" tools (both electronically and hard-copy) to support members in evaluating their personal health needs through Health Risk and Health Needs assessments.
- Care coordination to provide complex case management.

Presbyterian offers very active care coordination programs for members with catastrophic, high-cost, high-risk, or complex illnesses, injuries, or conditions. This personalized, highly tailored care serves to manage and guide members through the health care continuum in a coordinated, caring, cost-effective, and quality-oriented manner. Both acute and chronic conditions are referred via multiple sources to this program through appropriate care coordination diagnostic "triggers." Such referral sources include members, family, providers, utilization management and discharge planning personnel, and customer service representatives. An awareness of appropriate care coordination categories is generated through internal postings and educational training of Utilization Management and Member Services personnel as well as through provider and member newsletters, publications, and educational training sessions. Health risk assessment, functional status questionnaires, and care coordination trigger reports keyed from claims and pharmacy data are utilized to maximize capture of members who would benefit from care coordination.

The Health Management Program may be amended to reflect contract requirements and/or population needs analysis.

### ***Delegation of Utilization Management Activities***

Presbyterian Health Plan retains accountability for all utilization management decisions. Responsibility is assigned to the Healthcare Improvement Division. A Contract or Memorandum of Agreement defines performance expectations for both Presbyterian Health Plan and delegated agencies. A Delegated Review Coordinator, who is a RN with experience performing utilization review, coordinates the pre-evaluation training, monitoring and oversight of delegated review entities. Delegated utilization review status is revoked if serious problems cannot be corrected and if recommended by the relevant committee. (Currently, PHP/PIC has one minor delegation program with home health delegation program only.)

PHP/PIC is accountable for all the utilization management activities conducted for Presbyterian plan members, and must assure that members are receiving equitable access to care and service. Presbyterian oversees the delegated entities as evidenced by the following activities:

- evaluating the delegated entity's capacity to perform the delegated activities to delegation;
- approving the delegated entity's UM program annually;
- evaluating regular reports;
- evaluating annually whether the delegated entity's activities are being conducted in accordance with PHP/PIC and regulatory accreditation standards.

PHP oversees the activities of subcontractors for the Medicaid Program, and ensures that all State, Federal, and Presbyterian requirements are met. The subcontractors include dental, vision, Presbyterian Behavioral Health does not delegate any utilization management activities.

### **DOCUMENTATION**

Requests for certification (with approval or denial decisions, actions taken, and notice of denials) and facility notifications are documented by review staff and become part of the member's health plan record. Rules of confidentiality apply.

### **CONTINUOUS QUALITY IMPROVEMENT**

As part of Presbyterian's system-wide continuous quality improvement program, the Healthcare Improvement Division uses the "PDSA" methodology. Data collected includes evaluation of member and practitioner satisfaction with the utilization management process, review consistency, continuity and coordination of care, and operational efficiencies.

### **COMMUNICATION SERVICES**

PHP/PIC provides access to staff for members and practitioners seeking information about the UM process and the authorization of care.

Members and practitioners can access staff to discuss UM issues.

### Access to Staff

PHP/PIC provides the following communication services for members and practitioners:

- Staff is available at least eight hours a day during normal business hours for inbound calls regarding UM issues.
- Staff can receive inbound communication regarding UM issues after normal business hours.
- Staff can send outbound communication regarding UM inquiries during normal business hours, unless otherwise agreed upon.
- Staff members identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- A toll-free number or staff who accept collect calls regarding UM issues.
- Access to staff for callers with questions about the UM process.

## **APPEALS**

All levels of appeals and grievances are handled through the Appeals and Grievances Department. Health Services, Behavioral Health, and Pharmacy comply with all State, Federal and/or Accreditation requirements for notification of denials and appeal rights. Policies and procedures for appeals and grievances are maintained and updated by the Appeals and Grievances Department.

## **QUALITY, RISK AND UTILIZATION MANAGEMENT SCREENING/REFERRAL**

The Health Services screening processes for quality, risk or utilization management concerns are integrated with the Quality Management (QM) Program through the quality/risk management referral process. Potential QM or Risk Management issues identified during review of patient records (during concurrent, retrospective or certification reviews) are documented on the standard form and referred to the QM Department. (Based on severity, certain issues are handled immediately after consultation with an administrator or medical director before being forwarded to the QM Department.)

Certification and care coordination personnel participate in the development of indicators used in the screening process and in review and revision of the screening tool.

## **STAFFING**

### Medical Directors

Medical Directors must be physicians with unrestricted licenses in the State of New Mexico. The Behavioral Health Medical Director(s) must be a board-certified Psychiatrist.

Under the direction of the Chief Medical Officer, Presbyterian Health Plan's medical directors actively participate in certifications, care coordination and medical claims review activities, including:

- Assisting nurses in evaluating requests for certification.
- Participating in concurrent reviews in consultation with nurse Care Coordinators, attending physicians, and representatives of clinical facilities.
- Assisting Care Coordinators in identifying members who may need care coordination services. Medical directors assist Care Coordinators in the development and implementation of treatment plans and work with providers, members, and their families to reduce and prevent inappropriate use of medical services such as emergency rooms or prescription medications.
- Reviewing potential and final denials in light of contractual and regulatory requirements, policies and other applicable criteria.
- Participating in the development of medical review criteria used in UM and QM activities.
- Identifying system or operations issues.
- Reviewing claims and medical documentation and making determinations regarding coverage, appropriateness, and medical necessity of services provided.
- Participating in peer review and in the evaluation of quality and utilization issues as members of the CQC, Credentialing, Pharmacy and Therapeutics, Benefits Development and Interpretation, and Technology Assessment Committees.

Medical directors confer and consult with participating and nonparticipating health professionals and providers on issues related to utilization, quality, and continuity of care. They assist in the education of providers with regard to regulatory guidelines, Presbyterian Health Plan policies and procedures, practice parameters, results or outcomes of quality and utilization management studies, and managed care concepts.

Practitioners and providers are given the opportunity to discuss individual cases with a Presbyterian Medical Director.

### Physical Health Services

*Executive Director of Health Services* is a Registered Nurse (RN) and has oversight of the medical review process; oversees UM criteria application consistency; monitors indicators to assess UM functional area efficiency; is a CQC and QIC Committee member; and has accountability for all UM audits.

*Care Coordinators* are RN's or LPN's licensed in the State of New Mexico with training and/or experience in care coordination, utilization review, home care, public health nursing, quality assurance, and/or discharge planning. Certification by a Care Coordination or Utilization Management Association is encouraged. At least 1 to 3 years of clinical nursing experience is required. Hiring practices are geared towards identifying a variety of clinical backgrounds, which will add to the base of clinical knowledge within the department.

*Referral Coordinators/Care Coordination Assistants* are intake technicians with experience in the healthcare and/or insurance industry. They perform intake and processing

*Coding Manager* must be an ART, RRA with demonstrated expertise in coding and records management.

*Health Services Managers/Supervisors* are RN's or other health professionals with experience in Management and Utilization Review.

*Hours of Operation* - Regular business hours are Monday through Friday 8:00 a.m. to 5:00 p.m. After hours coverage for UM is available through UM on-call staff.

*Emergency Coverage* -Although staffing ratios are designed to meet volume and service needs, there may be instances when staffing is inadequate for coverage due to illness, inclement weather or local competition for qualified personnel.

During periods of inclement weather, staff living closest to the PHP/PIC office site remain to service any provider offices which may remain open. Contingency plans for technical failures are in place.

### Pharmacy

*Director of Pharmacy Services*, a Pharmacist licensed in the State of New Mexico with oversight of the pharmacy exception review process. The Pharmacy Services Director participates on BDIC, CQC and Pharmacy and Therapeutics committees.

*Registered Pharmacists* are licensed in the State of New Mexico and oversee all potential denial decisions, including referrals to the Medical Director. Registered Pharmacists also participate on the Technology Assessment Committee and the Pharmacy and Therapeutics Committee.

*Pharmacy Technicians* perform intake to and referrals to clinical pharmacists.

### Behavioral Health Services

*Behavioral Health Care Managers* are RN's, Behavioral Health professionals or Behavioral Health therapists licensed in the State of New Mexico with training and/or experience in utilization review. BH Care Managers assist members and practitioners in assuring appropriate level of care. They are also responsible for the appropriate triage and referral of members. .

The *Behavioral Health Clinical Team Leader and Director* for Behavioral Health have a minimum of a Master's degree, five years of post-Master's clinical experience, and are licensed in the State of New Mexico.

*Hours of Operation* - Regular business hours for Behavioral Health are Monday through Friday 8:00 a.m. to 5:00 p.m. All other hours are covered through an on-call mechanism. Members, providers and practitioners who attempt to contact Presbyterian Behavioral Health during these "off-hours" times are transferred to the answering service which then contacts a designated on-call Behavioral Health staff member.

## COMMITTEES

### Clinical Quality Committee (CQC)

The Committee's responsibilities include recommending and reviewing medical review criteria; reviewing UM indicators; analyzing and evaluating information generated through utilization review; recommending studies to evaluate medical care; reviewing the results and outcomes of the studies; recommending and evaluating practice parameters; and, reviewing cases and assisting in other projects as requested.

The Committee also acts in an advisory capacity, assisting the Medical Directors and the Health Services Department in peer review and utilization issues. The Committee is made up of a Medical Director, the Health Services Director, and participating physicians representing varied specialties.

The Committee meets at least ten times a year (or more frequently if requested) and reports directly to the Clinical Quality Committee.

Regular members of the Clinical Quality Committee will serve a two-year term, but may serve longer if it is requested.

Only practitioners (Physicians; Nurse Practitioners; Physician Assistants) may vote on medical issues.

A quorum of fifty (50) percent plus one voting member will be established before any medical issues are voted on.

Minutes of the Clinical Quality Committee meetings are kept in the Quality Management office either in the original form, on microfilm, or on electronic or other media.

Reports and summaries of UM activities are kept for five years, either in the original form, on microfilm, or on electronic or other media.

A letter to a member must be kept for 10 years (or in the case of a minor until they turn 23 whichever is longer)—I know this section is specific to committee items but thought I would alert that this retention timeline would not be appropriate in all instances.

### Technology Assessment Committee (TAC)

Presbyterian Health Plan (should this include PIC now too? Is that in the charter for TAC or does it just say PHP which PIC will adopt?) has a process for evaluating new medical technologies or the application of existing technologies in the benefit package. This includes procedures, drugs, and devices. Experimental or investigational as related to drugs, devices, or Medicare treatments or procedures means:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given at the time the drug or device is furnished;
- Reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its

toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis;

- Reliable evidence shows that the consensus among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with the standard means of treatment or diagnosis; or
- The drug or device is used for a purpose that is not approved by the FDA (except as required by State or Federal Regulations).

“Reliable evidence” shall mean only published reports and articles in the authoritative medical and scientific literature listed in the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Evaluations are of two types:

1. General, based on new therapies as described in the medical literature and/or brought to the attention of PHP/PIC by providers, members or employers;
2. Case specific.

Refer to the UM policy regarding “New Technology Evaluation” for process detail. Presbyterian subscribes to a national, comprehensive technology assessment service to assist with evaluations.

#### Benefits Interpretation Committee (BIC)

The BIC is a multifunctional committee, which serves to ensure consistent and fair interpretation, clarity, and application of benefits.

#### Pharmacy and Therapeutics Committee (P&T)

The P&T Committee addresses pharmacy issues. Recommendations from the P&T Committee are sent to the Presbyterian Quality Improvement Committee (QIC) on programs and processes to enhance the quality of pharmacy services with optimal cost effectiveness.

## **PROGRAM SUMMARY**

An organized, efficient, and effective utilization management program is essential to ensure that members receive quality care that is appropriate and timely. Through the overarching strategy of developing and applying health management to radically improve the value of services through learning, relationships, and information, the *Healthcare Improvement Team* contributes to the purpose of “improving the health of individuals, families and communities.”