

MEDICAL MANAGEMENT

HealthSCOPE Benefits, Medical Management Department is licensed as a Utilization Review Agent with the Texas Department of Insurance. The HealthSCOPE Benefits, Inc. Utilization Management Program is a systematic evaluation of the entire scope of healthcare services that a member receives while enrolled in the health plan. The purpose of Utilization Management is to ensure that Members receive healthcare services that are medically necessary, appropriate to the patient's condition, provided in a cost-effective and quality manner, and rendered in the appropriate setting.

The Utilization Management Plan applies to all age categories and range of diagnoses. Utilization Review activities are focused on high volume, high risk and problem prone areas. The Utilization Management Plan will apply to all eligible membership in order to achieve equitable, optimal healthcare services. The Utilization Management Program goals and objectives will be accomplished utilizing a process of healthcare assessment through prospective, concurrent, retrospective review of services, and case management.

Personnel employed by or under contract with the Medical Management Department to perform utilization review are appropriately trained and qualified and if applicable, currently licensed. Any personnel obtaining information regarding a patient's specific medical condition, diagnosis and treatment options or protocols directly from the physician, healthcare provider, either orally or in writing, and who are not Physician are nurses, or healthcare providers qualified to provide the service requested by the provider.

All covered services authorized or approved by the Medical Management Department must be medically necessary. Medical necessity means that the covered services prescribed are known by the majority of licensed practitioners to be safe and effective for the diagnosis or treatment of that injury or illness. The Medical Management Department's Utilization Review Process, in regards to determining medical necessity, is guided by nationally recognized criteria, called Milliman Care Guidelines. Milliman Care Guidelines span the continuum of patient care and describe the best practices for treating common conditions in a variety of care settings. Milliman Care Guidelines are utilized as a screening guide and are not intended to be a substitute for practitioner judgment. Utilization review decisions are made in accordance with currently accepted medical or healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Criteria are used for the determination of medical necessity but not for the denial of services. The Medical Director reviews all potential denials.

Utilization Review Process

1. Prior Authorization Process

The prior authorization process requires the review of elective or impending hospitalization prior, (at least seven (7) days), to admission. The prior authorization process includes two levels of review, a Level I review and a Level II review. A Level I review is conducted by nurse reviewers with clinical knowledge and experience in utilization review. The nurse reviewers screen cases for appropriateness using Milliman Care Guidelines.

When the case meets screening criteria, the nurse authorizes the case and if it involves an inpatient stay assigns an initial or expected length of stay. The nurse enters all pertinent information into the claims payment system issues a prior authorization number. The provider is notified of the decision and given the prior authorization number for billing purposes.

Requests for elective medical and surgical admissions not meeting criteria are referred to the Medical Director for Level II review. The Medical Director reviews all documentation pertaining to the case. Telephonic consultation with the attending physician may be initiated when insufficient or conflicting information is obtained during Level I review. After a determination is made by the Medical Director, the case is processed appropriately.

For inpatient and outpatient prior authorization requirements, please refer to current Medical Management Guidelines. Each prior authorization request requires minimal information for consideration. Refer to the current prior authorization form for basic information needed to perform the review.

2. Concurrent Review

Concurrent review is initiated on those admissions that remain in the inpatient setting passed the initial or expected length of stay issued. In addition concurrent review is also initiated for those cases that involve unplanned and/or emergent admissions. Concurrent review verifies the need for continued hospitalization, determines the appropriateness of treatment rendered in the hospital setting, and monitors the quality of care to ensure professional standards of care are met. Information assessed during the review includes: additional days/service/procedures proposed; reasons for extensions; clinical information to support the appropriateness and level of service proposed; and whether the diagnosis is the same or changed.

Concurrent review is conducted throughout the inpatient stay, with each hospital day approved based on the patient's condition. Each day is evaluated for medical necessity. The need for Case Management or discharge planning services is assessed during each concurrent review, meeting the objective of planning for the most appropriate and cost-effective alternative to inpatient care.

If at any time, the patient's stay ceases to meet inpatient criteria or if discharge criteria are met, or alternative care options exist, the nurse contacts the provider and obtains additional information to justify the continuation of the hospitalization. When the medical necessity for the case cannot be determined, the case is referred to the Medical Director to review the continued stay request. After a determination is made by the Medical Director, the case is processed accordingly.

3. Retrospective Review

Retrospective Review is the initial review of any service that has already been received by a member. This may include weekend admissions, emergency care or out of network admissions. If a retrospective review is conducted, a determination will be made within 30 days of receiving all of the necessary information.

4. Discharge Planning

Discharge Planning is a method of controlling costs and directing the appropriate services upon discharge from the hospital.

For patients who have not fully recovered or do not require the highly specialized and expensive services of acute hospital care, discharge planning ensures that the patient receives the most timely appropriate, safe and cost-effective discharge through home healthcare or appropriate placement in a lower level of care setting. Discharge planning should occur as early as possible in a patient's hospital stay. The Medical Management Nurse reviews the post-hospital needs of the member.

When necessary, the Medical Management Nurse works with the UM/UR staff of the hospital to arrange for services needed before the member is discharged from the hospital.

5. Confidentiality of Medical Records

The Medical Management Department Personnel preserve the confidentiality of individual medical records to the extent required by law. Personnel do not disclose or publish individual medical records, personal information, or other confidential information about a patient obtained in the performance of utilization review without the prior written consent of the patient or as otherwise required by law. Personnel may provide confidential information to a third party under contract or affiliated with the Medical Management Department for the sole purpose of performing or assisting with utilization review. Information provided to third parties will remain confidential.

Information generated and obtained by employees in the course of utilization review is retained for at least two years if the information relates to a case for which an adverse decision was made at any point or if the information relates to a case that may be re-opened.

The Medical Management Department provides to the Texas Insurance Commissioner on request individual medical records or other confidential information for determination of compliance with the Texas Administrative Code, Title 28, § 19.1714.

Adverse Determination and Appeals Process

1. Adverse Determination

In the event of an adverse determination or denial issued, written notification is sent by the Medical Management Department to the provider and the member. If the member is hospitalized the written notification is sent only to the provider. This notification includes the following, the principal reason(s) for the adverse determination, the clinical basis for the adverse determination, a description of the source of the screening criteria that were utilized as guidelines in making the determination and a description of the procedure for the appeal process.

In any instance where the Medical Management Department Personnel questions the medical necessity or appropriateness of the healthcare services, the healthcare provider who ordered the services is afforded a reasonable opportunity to discuss the plan of treatment for the patient and the clinical basis for the decision with a physician prior to issuance of an adverse determination.

2. Post Stabilization Denial

Denial of post stabilization care subsequent to emergency treatment as requested by a treating physician or provider is provided within the time frame appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour of the request. Notification is made to the treating physician or healthcare provider.

3. Appeals for an Adverse Determination

Appeals may be made orally or by written communication. An enrollee, a person acting on behalf of the enrollee or the enrollee's physician or healthcare provider may appeal an adverse determination orally or in writing. Within five working days from receipt of the appeal, the Medical Management Department sends the appealing party a letter acknowledging the date of receipt of the appeal.

The letter includes a reasonable list of documents needed to be submitted by the appealing party for the appeal. If the appeal is made orally, the Medical Management Department sends a one page appeal form to the appealing party.

Appeals are forwarded to the Physician who was not involved in the previous determination. After review of the appeal, the Medical Management Department issues a response letter to the patient, a person acting on

behalf of the patient, or the patient's physician or healthcare provider explaining the resolution of the appeal.

The letter includes a statement of the specific medical and/or contractual reason for the resolution, the clinical basis for such decisions, and the specialization of any physician or other provider consulted. Written notification to the appealing party of the determination of the appeal is made as soon as practical, but in no case later than 30 days after the date the health plan receives the appeal.

4. Expedited Appeals

Expedited appeals are available for emergency care denials, denials of care for life threatening conditions, and denials of continued stay for hospitalized patients. Expedited appeals are reviewed by a healthcare provider who has not previously reviewed the case. Such appeals are completed within a time frame appropriate for the medical immediacy of the condition, procedure, or treatment, but in no event exceed one working day from the date all information necessary to complete the appeal is received. The Medical Management Department provides written confirmation of expedited appeal decisions within two working days of providing initial notification, if the initial notification was not in writing.