

**CHILDREN'S MERCY
FAMILY HEALTH PARTNERS**

TITLE: Utilization Management Plan
NUMBER: CMFHP # 5401K
SCOPE: Kansas

EFFECTIVE: January 1, 2007
REVISION DATE: March 22, 2007; July 25, 2007; December 21, 2007
REVIEWED WITH NO CHANGES:
APPROVED BY STATE: February 26, 2008
RETIRED:

POLICY:

It will be the policy of Children's Mercy Family Health Partners (CMFHP) that the health care services provided to all members will be monitored under the Utilization Management Plan. The Utilization Management Program will oversee the process by which each member receives appropriate healthcare services with effective and efficient coordination of care to promote an assurance against under-utilization or over-utilization.

PURPOSE:

The purpose and philosophy of Children's Mercy Family Health Partner's 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, Children's Mercy Family Health Partners 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:

- A. 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; the failure of the health plan to provide services in a timely manner as defined in the appointment standards described herein or the failure of the health plan to act within timeframes for the health plan's Prior Authorization review process specified herein.
- B. Administrative Denial means denial by CMFHP for Medical Services and Hospital Services on the grounds that administrative procedures, explained in the CMFHP Provider Administration Manual, provider updates and bulletins, or during provider education were not followed by the provider. An Administrative Denial is subject to appeal.
- C. Adverse Determination means a determination by CMFHP, or its designee utilization review organization, that an admission, availability of care, continued stay or other Hospital Service or Medical Service has been reviewed and, based upon the information provided, does not meet CMFHP'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.
- D. Ambulatory Review means utilization review by CMFHP of Medical Services and Hospital Services performed or provided in an outpatient setting.
- E. Care Coordination means a method of coordinating the provision of health care so as to improve its continuity and quality.
- F. Case Management is a clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by patients/families with complex issues; promoting the achievement of quality, clinical, and cost outcomes; intervening at key points for individual patients; addressing and resolving patterns of issues that have a negative quality or cost impact; and creating opportunities and systems to enhance 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.

- G. Certification, Pre-Certification or Prior Authorization means a determination by CMFHP, or its designee utilization review organization, that an admission, availability of care, continued stay, or other Medical Service and Hospital Service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.
- H. Clinical Peer means a physician or other Health Care Professional, engaged or approved by CMFHP, 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.
- I. Clinical Review Criteria mean the screening procedures, decision abstracts, clinical protocols, practice guidelines, and Medical Director decision processes used by CMFHP to determine the necessity and appropriateness of Medical Services and Hospital Services.
- J. Concurrent Review means utilization review conducted by CMFHP during the member's hospital stay or course of treatment.
- K. 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 CMFHP's Health Services department to ensure compliance with Clinical Review Criteria, Medical Necessity, and the Covered Services provided under the member's Contract.
- L. Disease Management is the process of intensively managing a particular disease or syndrome. Disease management encompasses all settings of care and places a heavy 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.
- M. Emergency Medical/Mental Health 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 medical condition means a medical or mental health 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 the following:
- 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
 - Serious impairment to bodily functions
 - Serious dysfunction of any bodily organ or part
 - Serious harm to self or others due to an alcohol or drug abuse emergency
 - Injury to self or bodily harm to others
 - 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
- N. 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.
- O. Peer Review means an evaluation by a group of unbiased practicing physicians: (a) of the effectiveness and efficiency of care rendered by a health plan, 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 managed care organization's network.

- P. Prospective Review means utilization review conducted by CMFHP prior to authorization for Medical Services and/or Hospital Services.
- Q. Retrospective Review means utilization review of Medical Necessity for Medical Services and/or Hospital Services that is conducted by CMFHP 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.
- R. Second Opinion means an opportunity or requirement for a member, authorized by CMFHP, to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed Hospital Service or Medical Service to assess the Medical Necessity and appropriateness of the initial proposed Hospital Service or Medical Service.
- S. Utilization Management Program means a set of formal techniques designed and/or approved by CMFHP to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Medical Services and 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.
- T. Utilization Review Organization means a utilization review agent who has been engaged or approved by CMFHP to perform utilization review functions on behalf of CMFHP.

PROCEDURE:

I. Utilization Management Program Objectives

Fulfillment of the following program objectives will be a continuous process, to be undertaken consistent with the requirements of federally mandated peer review organizations, state regulatory bodies, plan requirements, and other required review entities. 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 health care services to members.
- 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 health care 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 application of quality indicators to identify 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. Provide timelines for correction/corrective action plans and assign specific health plan staff to monitor compliance and follow up.
- I. Assessing, coordinating and monitoring appropriate discharge planning needs, and assuring that Case Management is aware of members who have ongoing significant or special needs.
- J. Establish protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective review of claims to comply with federal and state laws and regulations.
- K. Consistent application of policies and procedures, which are clearly specified in provider contracts and/or manuals.
- L. Monitor use of emergency services.
- M. Identification of over and under utilization for inpatient and outpatient services and develop appropriate actions to correct issues and provide ongoing monitoring.
- N. Coordination of services for both covered and non-covered benefits.
- O. Coordination of school based clinic services when benefits are provided by the Plan
- P. Ensuring that provider and subcontractor compensation is not structured to provide direct financial incentives for the provider or subcontracted vendor to deny, limit, or discontinue medically necessary services to any member.
- Q. Provide regular utilization management and quality assessment reporting to the health plan management and health plan providers, including profiling of provider utilization patterns.
 - 1) Requests for services and care are assessed for coverage and provision within the CMFHP network. If services are medically necessary and a covered benefit, but not available within the CMFHP network, CMFHP will assist in the coordination of services to an appropriate qualified provider.
 - 2) Coordinates with other areas in the Health Plan to determine which services require prior authorization, for both coverage issues and medical necessity.
 - 3) When services are determined not to be covered under the Plan's benefit provision, whether the services are carved out to another vendor or not covered by state coverage guidelines, CMFHP will assist the member in coordination of services,

II. Scope of Utilization Management Program.

The following covered services will be monitored under the Utilization Management Program:

- A. Case Management Services
- B. Comprehensive Day Rehabilitative Services
- C. Core services provided by Local Public Health Departments
- D. Corneal Transplants
- E. Durable Medical Equipment
- F. Emergency Room Services
- G. Emergent and Non-Emergent Transportation
- H. Hearing Aides and related Services
- I. Home Health Services

- J. Hospice Services
- K. Inpatient Services
- L. Kidney Transplants
- M. Laboratory, Radiology, and other diagnostic Services
- N. Nurse Advice Utilization and Outcomes
- O. Pharmacy Utilization
- P. Physician and Advanced Practice Nursing Services
- Q. Podiatry Services
- R. Transplant Services (other than Corneal or Kidney): before and after admission for transplant, including evaluation (in-network and out-of-network)

III. Program Organization

A. Authority and Responsibility.

1. Children's Mercy Family Health Partners' Board of Directors is ultimately responsible for Utilization Management activities. Utilization Management activities are reported to the Board of Directors by the Chair of the Medical Oversight Committee at least annually.
2. The Director of Health Services is responsible for implementation of the Utilization Management Plan, under the supervision of the Chief Executive Officer and the Medical Director(s).
3. The Chief Executive Officer, or his/her designee, ensures that the departments and Medical Directors fully support and participate in the Utilization Management Plan. In addition, the Chief Executive Officer will ensure that the Utilization Management Program will be developed and implemented by professionals with adequate and appropriate experience in quality assessment and improvement, utilization management, and continuous improvement processes.
4. The Medical Oversight Committee evaluates the program activities on at least an annual basis through the Annual Appraisal process.
5. The Medical Directors are responsible for oversight of the Utilization Management Program and annual approval of the Utilization Management Program and related policies. The Medical Directors responsibilities for Utilization Management include:
 - a. Assure compliance with applicable state, federal, or RFP Utilization Management Standards as described in applicable statute or contract.
 - b. Participate in implementation, monitoring, evaluation and developing improvement of the Utilization Management Program.
 - c. Serve as liaisons between the health plan and the network providers.
 - d. Participate with the Health Services staff in the various level of reviews, providing timely, written determinations with reference to national standards when available, as well as rationale for decision-making.
 - e. Be proficient with the variety of resources used within the Health Plan for Utilization Review and recommend any changes through the Utilization Management Program review.

B. Medical Management Committee Requirements.

The Medical Management Committee (MMC) will be responsible for oversight for the Utilization Management Program to ensure that members receive quality care in the most appropriate setting.

1. Responsibilities:
 - Oversee UM program, and ensure compliance with any federal and state laws and regulations
 - Annually review UM plan and audit results
 - Annually adopt review criteria, including purchased and internally developed materials
 - Review UM trends
 - Review any UM outlier practices, specifically over/under utilization reports.
 - Review any corrective action plans that relate to UM trends and reviews.
 - Review pharmacy profile reports
 - Annual review of discharge planning procedures
 - Report to the Medical Oversight Committee
 - Receives reports from the committees for Pharmacy and Therapeutics; Nurse Advice; and Health Services Review

2. Membership: Medical Director(s) - chair
 - i. Director of Operations
 - ii. Director of Health Services
 - iii. Manager Clinical Services
 - iv. Manager of Pharmacy Services
 - v. CMFHP network physicians

3. Requirements: The committee will meet quarterly. Written minutes of each meeting will be maintained.

C. Committees reporting to the Medical Management Committee:

1. Pharmacy and Therapeutics Committee:
 - a. Responsibilities:
 - i. Develop, maintain and adopt formulary changes, both additions and deletions
 - ii. Review pharmacy profiles
 - iii. Recommend programs to address issues of over or under utilization

Reports to MMC
Receives reports from Psychiatric Drug Committee
 - b. Membership:
 - i. Manager of Pharmacy Services – chair
 - ii. Medical Director(s)
 - iii. Director, Health Services
 - iv. CMFHP network physicians
 - c. Requirements: The Committee will meet quarterly. Written minutes of each meeting will be maintained.

2. Nurse Advice Committee:
 - a. Responsibilities:
 - i. Oversight of the activities of the Nurse Advice Program
 - ii. Quarterly reporting of phone triage activities,
 - iii. Quarterly review of call center statistics, including call volume, dropped calls, and disposition.
 - iv. Annual review of member satisfaction surveys
 - v. Quarterly review of member or provider complaints
 - vi. Initiate and monitor response to any performance improvement action based on either statistical variation from expectation or member or provider concerns

- vii. Perform annual return on investment analysis
 - b. Membership:
 - i. Manager of Clinical Services - chair
 - ii. Director of Customer Relations
 - iii. Director of Health Services
 - iv. Manager Quality Management
 - v. CMH Nurse Advice Representative
 - vi. McKesson Nurse Advice Representative
 - c. Requirements: The Committee will meet quarterly. Written minutes of each meeting will be maintained.
- 3. Health Services Review Committee:
 - a. Responsibilities:
 - i. Internal forum to review and approve decisions that impact multiple departments but are primarily based on clinical operations of the Health Plan, such as proposed changes to policies, criteria, benefit structure, and network
 - ii. Fraud and abuse oversight
 - iii. Receives reports from Clinical Criteria Committee
 - b. Membership:
 - i. Director of Health Services – chair
 - ii. CEO
 - iii. All Directors
 - iv. Various supervisory and staff positions
 - c. Requirements: The committee will meet biweekly. Written minutes of each meeting will be maintained.

D. Qualifications of Health Services Staff.

The Medical Directors are licensed to practice in the State of Kansas. They are board-certified, board-eligible or have sufficient experience in their field or specialty to be determined qualified. Staffing for the Health Services Department will consist of Registered Nurses and Social Workers, who are also licensed in the State of Kansas.

E. Telephone Access to Utilization Management Department. The Health Services Department can be accessed through an ACD line as follows:

Prior Authorization/Utilization Review	1-888-691-4874
FAX Machine	1-877-347-9366

24 hour/7 day a week access to clinical nursing staff is provided to all CMFHP members for information on how to access emergency, urgent, or routine care, and/or home advice regarding medical conditions. The availability of Nurse Advice services is communicated to members and providers through CMFHP Customer Service staff, CMFHP Health Services staff, member newsletters, provider newsletters, the CMFHP website, and various targeted mailings to members throughout the year. In addition, members are given instructions on how to access care both in the network and outside of the network through Customer Service and Health Services staff, as well as written communications (i.e. member newsletters). For members with language or hearing barriers, a TDD line and translation service is available for communication with CMFHP.

IV. Utilization Management Program Description

The Utilization Management Program shall be primarily concerned with ensuring medical necessity of services and the appropriate level of care when medically necessary services are provided. Children's Mercy Family Health Partners uses the following definition for medical necessity.

Medical necessity means that a health intervention is a covered category of service (meaning it is not specifically excluded from coverage) and is medically necessary, according to all of the following criteria:

- a) "Authority." The health intervention is recommended by the treating physician and is determined to be necessary.

- b) "Purpose." The health intervention has the purpose of treating a medical condition.
- c) "Scope." The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
- d) "Evidence." The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness will be determined by scientific evidence as provided in section 5.7.3.c. of the Kansas RFP. For existing interventions, effectiveness will be determined as provided in section 5.7.3.d. of the Kansas RFP.
- e) "Value." The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" does not mean the lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet CMFHPs definition of medical necessity.
- f) Interventions that do not meet CMFHPs definition of medical necessity may be covered at the choice of CMFHP. An intervention will be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient will be the overriding determining factor.

CMFHP recognizes the value provided by thoughtfully designed and implemented medical studies and the evidence based approach that results. However, the rapidly changing field of medical care can make the highest standard of randomized controlled studies unavailable for all conditions. Each intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or newly described diseases or orphan populations, will be evaluated on the basis of professional standards of care or expert opinion as described below:

- The scientific evidence for each proposed intervention will be considered first and, to the greatest extent possible, will be the basis for determinations of medical necessity. This includes the recommendations for various recognized specialty organizations. If limited or no published scientific evidence is available, professional standards of care will be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about coverage for proposed interventions will be based on expert opinion. The fact a treatment is recommended by the treating physician does not, by itself, constitute expert opinion. Coverage of an intervention will not be denied solely on the basis of an absence of conclusive scientific evidence. Interventions may be deemed to meet CMFHP's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion. Professional standards of care and expert opinion are used when scientific information is limited; when evidence based medical standards are available, they will be used as the first step in determining coverage.

CMFHP will provide all services that meet the criteria described and will apply that criteria in a manner that provides members:

- The prevention, diagnosis, and treatment of health impairments;
- The ability to achieve age-appropriate growth and development; and
- The ability to attain, maintain, or regain functional capacity.

The Utilization Management Program processes for Medically Necessary and Medical Necessity shall describe:

1. Criteria used in the determination of medical necessity and appropriateness
 - a. The method by which the criteria are developed or chosen
 - b. The involvement of the provider, as appropriate, in providing references to assist in the development or enhancement of criteria
 - c. The method by which criteria are reviewed, updated, and modified
2. The process by which the medical necessity of health services is determined, including those staff that have the authority to deny payment or coverage

3. The data and information that are used in making medical necessity determinations (e.g., member's records, communication with Primary Care Providers (PCPs), etc.)
4. The procedures by which a member or contracting provider can appeal a denial determination
5. The role of utilization management in ensuring the quality of care for members

A. Delegation of Utilization Management. Children's Mercy Family Health Partners, at its sole discretion, may delegate the Utilization Management function in whole or in part. Delegation of the Utilization Management function will require approval of the Medical Director(s) and the Chief Executive Officer. The circumstances under which Children's Mercy Family Health Partners may delegate the Utilization Management function are:

1. Within an Integrated Delivery System (IDS) where the physicians and facilities are contracted under a single or joint agreement.
2. Carve-out services where an entire element of the benefit structure of the plan is being carved out to a single vendor who provides, usually on an at-risk basis, the full complement of services entailed within the applicable benefit.
3. Other situations approved on a case-by-case basis and subject to the approval of the Chief Executive Officer and Medical Director(s).

Where delegation of the Utilization Management function exists, Children's Mercy Family Health Partners retains the right and the obligation of oversight of the contracted party by the Medical Director, Director of Health Services or his/her designees. This oversight shall include, but may not be limited to:

1. Review of periodic utilization data by the Medical Management Committee.
2. Periodic review to monitor adherence to a written Utilization Management Plan which has been reviewed and approved by Children's Mercy Family Health Partners.
3. Coordinate with Children's Mercy Family Health Partners staff regarding identified topics for focus in Utilization Management or Case Management areas.
4. Provide copies of Physician Reviewer decisions upon request.
5. Provide copies of Adverse Determination letters, appeals, and Adverse Determination overturns resulting from appeals.
6. Comply with all federal, state, and local applicable laws regarding Utilization Management activities, including program certification if required by applicable law or competent jurisdiction.
7. Report to Children's Mercy Family Health Partners' Medical Management Committee as appropriate, but at least quarterly.
8. Report to the Medical Oversight Committee (MOC) as necessary (determined by the MMC).
8. Adopt Children's Mercy Family Health Partners' clinical guidelines or protocols as mutually agreed upon.
9. Comply with applicable aspects of the payer contract under which the delegated member is eligible for benefits with Children's Mercy Family Health Partners.
10. Review of an annual Utilization Management appraisal with regard to all activities performed by the sub-contractor.

The sub-contracted Utilization Management entity shall issue utilization review letters, denial letters or letters of Adverse Determination of appeal decisions using language consistent with the utilization review letters of Children's Mercy Family Health Partners and applicable state or federal laws, rules, or regulations.

- B. Prior Authorizations Children's Mercy Family Health Partners 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 Provider Quick Reference Guide, the CMFHP internet website, and by calling the Health Services Department.

CMFHP maintains written criteria sets used in the review of services that are based on sound medical evidence, updated regularly, and consistently applied. When appropriate, a consultation is sought with the requesting provider. In addition, the process of review and clinical criteria used are available to either a provider or a member upon request, as well as publicized through provider newsletters and orientations.

All denials and appeals are reviewed by a Medical Director or Physician Advisor with experience or expertise comparable to the provider requesting the service(s). Reasons for decisions are documented in the online computer system and assigned a reference number.

Timeframes for Prior Authorizations:

1. Approval or denial of emergency services as determined by emergency room staff will be provided within thirty (30) minutes of request
2. Approval or denial of request for services determined to be urgent by the treating provider will be provided within twenty-four (24) hours
3. Approval or denial of routine services will be provided within two (2) business days of obtaining all necessary information needed. If additional information is needed, CMFHP will notify the requesting provider within two (2) business days. In no case will CMFHP exceed fourteen (14) calendar days following the receipt of a request for service to make a determination
4. Involuntary detentions (96 hour detentions or court ordered detentions) do not require prior authorization

Documentation shall be maintained in the computer system on any alternative service(s) approved in lieu of the original request. In addition, Children's Mercy Family Health Partners 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 services will be authorized while a determination of the medical necessity of ongoing services or supplies is being made. Children's Mercy Family Health Partners will assist the member to 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 services will be approved.

If Children's Mercy Family Health Partners approves purchase of a custom or power wheelchair, eyeglasses, hearing aids, dentures (excluding orthodontic services), custom HCY/EPSTD equipment, augmentative communication devices placed within six months of approval etc. which is delivered or placed after enrollment in the health plan ends, Children's Mercy Family Health Partners will be responsible for payment

Prior authorization is accomplished by calling the Health Services staff, Monday through Friday from 8:00am to 5:00pm, except holidays. Prior authorization requests may also be submitted by fax. Prior authorization requests left on voice-mail after hours will be responded to within the guidelines below.

1. Inpatient prior authorizations are made pursuant to industry standard criteria (e.g. Milliman Care Guidelines). Initial authorizations will be assigned an authorized length of stay based on the applied criteria. Re-certification is required when the hospital determines that an additional period of confinement will be required, but not later than the day on which the prior certificate has expired. Hospital utilization review staff should

make requests for re-certification during normal business hours. Failure to perform certification or re-certification may result in administrative denial of the admission or continued stay. CMFHP provides coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital.

2. Newborns: Pre-certification of newborn care is not required. Newborns will be deemed certified if they are discharged with the mother. If a newborn is going to remain an inpatient after the discharge of the mother, notification to CMFHP is required. CMFHP provides post-discharge care for newborns and their mothers. The post-discharge care consists of a minimum of two visits by a registered nurse when ordered by a physician. At least one of those visits will be provided in the home upon a physicians order. Services provided by the registered professional nurse or physician shall include, but not be 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 the performance of any necessary and appropriate clinical tests.
3. Referral to a non-participating provider: Referral to a non-participating provider requires prior authorization. Children's Mercy Family Health Partners will approve such referrals if:
 - a. A network provider(s) is unavailable or unable to provide the medically necessary covered service which is required for the member within a medically acceptable time frame, and/or
 - b. The non-participating provider agrees to accept the negotiated payment rate and hold the member harmless for the amount in excess of Children's Mercy Family Health Partners' allowable payment.

Member rights are communicated in writing to all non-participating providers at the time services are authorized.

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 the Plan deems necessary (i.e. third trimester pregnancy, ongoing cancer treatment).

4. Member Self Referral: Members may self refer for the following in-network services:
 - a. Eye Examination, Routine
 - b. Family Planning Services (In-network or Out-of-Network)
 - c. Obstetrical Care
 - d. Public Health Services (Immunizations, TB, STD, HIV Testing, etc.) (In-network or Out-of-Network)
 - e. Well Woman Exams, (Breast Exams, Pelvic Exams, Mammograms, and PAP Smears)
 - f. 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

C. Process of Utilization Review.

All initial, concurrent, and retrospective reviews for inpatient admissions will follow the below procedures and timeframes. In addition, all reviews will at a minimum:

- i. Require review of any appeals or denials by a professional with experience or expertise comparable to the provider requesting the authorization
- ii. Utilize sound medical evidence that is updated regularly and consistently applied, allowing for discussion with the requesting provider when appropriate.
- iii. Document all reasons for decisions clearly and assign certification numbers for reference on all approvals and denials
- iv. Document any alternative service approved in lieu of the original request
- v. Maintain fair and unbiased practices for reconsideration requests when the

communication of avoidable days.

4. Retrospective Review Determinations. Children's Mercy Family Health Partners may perform retrospective utilization reviews in some situations. These situations will include, but may not be limited to:
 - a. Claims identified as having a potential for fraud and abuse,
 - b. Hospital not notifying CMFHP of an admission until after discharge has occurred,
 - c. Random claim selections for the purposes of quality monitoring, or
 - c. Targeted reviews of specific procedures or services in an effort to substantiate services were performed.
 - d. Retrospective reviews will be performed within one (1) year of the date of service. Retrospective reviews will be completed within thirty (30) working days after receiving all necessary information required to perform the review. If a retrospective review results in an adverse determination, the provider and Member will be notified in writing at the time of the determination.

5. Reconsideration of an Adverse Determination for Initial or Concurrent Review.
 - a. In a case involving an initial determination or a concurrent review determination, the health plan will give the provider rendering the service an opportunity to request on behalf of the member a re-consideration by the reviewer making the adverse determination.
 - b. A re-consideration is permitted if the provider has additional clinical information available that was not available during the review process that resulted in the adverse determination.
 - c. The reconsideration will occur within one (1) business day of the receipt of the request and will be conducted between the provider rendering the service and the Medical Director who made the adverse determination or a clinical peer designated by the Medical Director. If the Medical Director who made the adverse determination is not able to approve the service(s) based on the discussion, the case will automatically be referred for review to a physician reviewer who was not involved in any previous levels of review on the case.
 - d. In all cases, the provider must provide the additional clinical within 5 business days of the initial determination to be considered a reconsideration. Information received beyond this time frame will constitute an appeal.
 - e. If the reconsideration process does not resolve the difference of opinion, the adverse determination may be appealed by the member, or the provider on behalf of the member. Reconsideration is not a prerequisite to a standard appeal or an expedited appeal of an adverse determination.

6. Expedited Pre-certification Reviews - Expedited Review is used if the standard of time for review would seriously jeopardize the member's life, physical or mental health, or the member's ability to regain maximum function, as determined solely by CMFHP's Medical Director.
 - a. To initiate an expedited utilization review, the member or provider may call or send a letter to:

Health Services Department
Children's Mercy Family Health Partners, Inc.
215 W. Pershing Road, Suite 600
Kansas City, MO 64141-1806
1-888-691-4874

 - b. Label all Mailings- CONFIDENTIAL- DO NOT OPEN IN MAIL ROOM
The Health Services department will notify the member by phone within one business day after receiving the expedited review of the plan's determination.

- c. A written confirmation of the plan's decision will be mailed to the member and provider upon completion of the determination.
7. Administrative Denials. An administrative denial is subject to member and provider appeal procedures. The provider and/or member may file an appeal regarding the administrative denial by phone or in writing. The appropriate provider and member will be notified of an administrative denial in writing at the time of the determination. See policies 2501K and 2503K for specific provider and member appeal rights.
 8. Ambulatory Review. Children's Mercy Family Health Partners will perform review of ambulatory services. These reviews will consist of, but may not be limited to:
 - a. prior authorization of specific outpatient services;
 - b. concurrent review of various services such as ongoing home health or physical therapy;
 - c. retrospective review of selected services; and
 - d. concurrent review of pharmacy utilization.
 9. Discharge Planning. The Health Services staff, in cooperation with members' attending physicians and the hospital discharge planning personnel, will work to facilitate appropriate and timely discharge from inpatient care and other alternative levels of care. Health Services staff will assist hospital staff to identify, based on members' medical needs, an in-network community resource for members ready for discharge. Children's Mercy Family Health Partners expects all network hospitals to have effective discharge planning teams that ensure medically appropriate and timely discharge of members. Discharge planning is initiated through communication between the hospital, member, family, and Health Services staff at the time of admission to ensure continuity of care and to provide the appropriate level of support to the member. The Health Services staff members participate in the discharge planning process to assess the needs of the member and refer appropriate cases for case management when ongoing coordination of care and services is necessary.

The Health Services staff will review hospital admissions for appropriate length of stay, appropriate management and discharge services, and appropriate and timely follow-up of the member with the provider, or the referring extended care services.

- D. Emergency Medical Conditions and Nurse Advice. It will be the policy of Children's Mercy Family Health Partners to ensure appropriate access to Emergency Services and post stabilization services for all members. CMFHP has a network of hospital-based emergency rooms and urgent care centers throughout its geographical service area. CMFHP encourages appropriate emergency room utilization through various procedures and programs.

A prior authorization is not required for Emergency Medical Services.

1. Access to Emergency Room Services. Members are instructed, through their Member Handbook and educational materials such as brochures and member newsletters, to present directly to the nearest emergency room or to call 9-1-1 in case of life-threatening emergency situations.

When a member receives emergency room services that require immediate post-evaluation or post-stabilization services, the plan will provide an authorization decision within thirty minutes of receiving a request; if the authorization decision is not made within thirty (30) minutes, services will be covered. CMFHP will not limit what constitutes an emergency medical condition on the basis of a list of diagnoses or symptoms.

Children's Mercy Family Health Partners 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. .

Children's Mercy Family Health Partners will cover and pay for emergency services from any provider, regardless of whether the provider that furnishes the services has a contract with CMFHP.

2. Payment for Emergency Services and Post-stabilization Care. Children's Mercy Family Health Partners will pay out-of-network providers for emergency services at the current Kansas Medicaid program rates in effect at the time of service unless the provider of service and CMFHP have negotiated another mutually acceptable rate.
All post-stabilization care services obtained within or outside of CMFHP's provider network that are pre-approved by a CMFHP provider or CMFHP staff will be the financial responsibility of CMFHP.
All post-stabilization care services obtained within or outside of CMFHP's provider network that are not approved by a CMFHP provider or CMFHP staff within thirty (30) minutes of a request for approval, but are administered to maintain the member's stabilized condition, will be the financial responsibility of CMFHP.
Post-stabilization care will be approved if the treating provider cannot contact CMFHP. Post-stabilization care will also be considered the financial responsibility of CMFHP if the CMFHP staff is contacted by the treating physician and the staff is unable to contact a CMFHP physician for consultation or treatment review within 30 minutes.
For out-of-network services, if there is a member financial responsibility, CMFHP will limit the member responsibility for post-stabilization care services to an amount no greater than what CMFHP would charge the member if he or she had obtained the services through a CMFHP provider.

CMFHP will negotiate mutually acceptable payment rates and payment timeframes with out-of-network providers for post-stabilization services for which CMFHP is financially responsible.

3. Nurse Advice. Children's Mercy Family Health Partners contracts for nurse telephone triage services to members 24 hours/day, 7 days a week.

Based on the clinical information given, the Nurse Advice staff will advise the member to seek services at the nearest in-network emergency room for an urgent care need, or to the nearest emergency room without regard to its network status when emergency services are needed. Nurse Advice will further:

- a. assess the member's need for transportation and make arrangement for transport if needed, and
- b. contact the appropriate emergency room notifying the staff of the member's imminent arrival, provide the member's name and medical complaint.

If the member presents to an emergency room without having first contacted Nurse Advice, providers are instructed to perform an appropriate COBRA/EMTALA screening to assess what level of treatment is required. If the needed treatment is for an Emergency Medical Condition, services should proceed without contacting the plan. If the needed services are not for an Emergency Medical Condition, the emergency room should: (a) discharge the member with instructions to contact his/her PCP as needed or (b) direct the member to an urgent care facility.

If a member is unsure if he/she needs to go to an emergency room, the member is encouraged to contact the Children's Mercy Family Health Partners' NURSE ADVICE line prior to presenting to the emergency room. The nurse uses the verbal information from the member and applies clinical protocols, approved by the Medical Director(s) to triage the situation and determine the appropriateness of emergency services. Based on the clinical protocols, Nurse Advice may advise the member on urgent care, home care and/or give the member home-care instructions and/or instruct the member to contact his/her PCP within a specified timeframe. Nurse Advice will also advise the member of

his/her right to seek emergency medical services under the Prudent Lay Person standard.

4. Retrospective Emergency Room Reviews. Children's Mercy Family Health Partners reserves the right to perform retrospective review of emergency room utilization.
 - a. The Health Services staff may periodically review random emergency room visit records on a retrospective basis to ensure appropriateness of the emergency room services.
 - b. The Health Services staff will review reports of members who have had more than two (2) emergency room visits in any sixty (60) day period. When appropriate, members will receive education on how to access care in both emergent and non-emergent settings as well as how to utilize transportation services.
 - c. CMFHP Care Managers will attempt to provide member education regarding the use of the phone triage services by contacting members who utilized the emergency room for non-emergent services without first contacting the Nurse Advice line.
5. Out-of-Area or Out-of-Network Emergency Services. Children's Mercy Family Health Partners will pay out-of-area or out-of-network emergency room service to providers for services related to an Emergency Medical Condition.

E. Complaints, Grievances and Appeals: CMFHP provides a comprehensive process for filing of complaints, grievances and appeals. Refer to policies 2501 and 2503 for detailed explanation of CMFHP's provider complaint, grievance, and appeal process and the member grievance and appeal process.

F. Reviews and Updates of Utilization Management Program.

1. Annual Review. The Utilization Management Program shall be reviewed and evaluated at least annually by the Medical Management Committee, the Medical Directors, and the Medical Oversight Committee. Annual reviews shall include the following:
 - a. Review, revision as deemed appropriate, and approval of Utilization Management Plan by the Medical Management Committee and the Medical Oversight Committee. Subsequent approval by the Board will be sought for substantive changes.
 - b. Review of an annual appraisal of the Utilization Management Program, which includes all activities of the Health Services Department within the past year, including significant findings, recommendations, actions taken, and utilization issues forwarded to the Quality Management or Credentialing Committees, and overall effectiveness and efficiency of the Utilization Management Program. Preparation of the annual appraisal will be the responsibility of the Director of Health Services and his/her designees.
 - c. Review of delegated Utilization Management activities in similar format and content to (b), above.
 - d. Review for consistent application of clinical review criteria by both Health Services staff and physician reviewers.
2. Reports of Utilization Issues to Other Committees or Departments.
 - a. Medical Management Committee (MMC). The Medical Management Committee (MMC) will report any issues discovered as part of the utilization review processes which may affect the quality of care provided to members. The chair of the Medical Management Committee or his/her designee will present a report to the Medical Oversight Committee quarterly.
 - b. Credentialing Committee. The MMC will report any issues discovered as part of the utilization review process which may need to be taken into consideration during subsequent credentialing or re-credentialing processes, e.g. identification of a provider who does not cooperate with Children's Mercy Family Health Partners' Utilization Management procedures.

- c. Provider Relations Department. The Health Services department will report any issues discovered as part of the utilization review process:
 - 1. which indicate a need for provider counseling or education, e.g. providers who do not understand the plan's procedures or inquire about operations issues, such as claims procedures;
 - 2. provider complaints concerning administrative aspects of the health plan;
 - 3. non-participating provider requests for plan participation; or
 - 4. authorizations or rates negotiated for services to be performed by non-participating providers;
 - d. Customer Services Department. The Health Services staff will report any issues discovered as part of the utilization review process that indicate the need for member education regarding specific benefit(s);
 - e. Quality Management Appeal Nurse. The Health Services staff will report any issues discovered as part of the utilization review process, including:
 - 1. Member grievances or appeals regarding any aspect of the health plan;
 - 2. Provider complaints regarding the behavior of a member or any aspect of the health plan;
 - 3. Concerns about the level and/or quality of care provided;
 - 3. Receipt of appeals concerning adverse determination, claims denials, complaints or other situations as deemed appropriate.
3. Clinical Guidelines or Protocols. The Health Services Department will collaborate with other departments and clinicians to identify services, procedures, or processes that require the development of clinical guidelines or protocols. Development of protocols or guidelines will be the responsibility of the Clinical Criteria Committee. Internally developed protocols or guidelines will be approved by the Health Services Review Committee, with oversight from the Medical Management Committee, and communicated to the Health Services staff by the Director of Health Services or designee. The protocol and guideline review process is publicized in the member and provider newsletters.
4. Criteria to Evaluate Medical Necessity and Appropriateness of Medical Services.
- a. Children's Mercy Family Health Partners will adopt standard industry review criteria to assist in the processes of Utilization Management. The Medical Director(s) will approve:
 - 1. all criteria or changes to criteria, and
 - 2. adoption of new, updated, or replacement criteria.
 - b. Criteria identified for modification, replacement, or newly adopted may be identified by various persons and committees during the performance of their responsibilities. When criteria are identified, the person or committee who/which identifies the issue should advise the Director of Health Services who will be responsible to collaboratively investigate the issue and facilitate a review for change by:
 - 1. identifying the appropriate committee for discussion and decision;
 - 2. coordinating with Medical Directors and other departments as required in the development of criteria;
 - 3. developing a policy and procedure concerning the issue and seeking appropriate approval to implement such policy or procedure; or
 - 4. developing a corrective action plan for recommending to the appropriate committee for discussion and decision
 - 5. coordinating corrective action plans with the Compliance Officer
 - c. Industry standard criteria for determining medical necessity and appropriate lengths of stay or levels of alternative care may include, but not be limited to: Milliman Care Guidelines.

G. Medical Director Review Time Frames and Availability Consistent with the requirements of

Section C, "Process of Utilization Review", of this policy and procedure and applicable Kansas law, Children's Mercy Family Health Partners has developed criteria for Medical Director availability and response regarding utilization review decisions.

1. Medical Director Availability. A Medical Director will be available to the Health Services staff during all regular business hours, which are Monday through Friday, 8:00am to 5:00pm, excluding holidays. In the event a Medical Director will not be available for an extended period of time, he/she will arrange for a Health Plan credentialed physician, licensed in the State of Kansas, to accept calls on his/her behalf. Such arrangements shall be communicated in advance, preferably in writing, to the Director of Health Services.
 2. Initial Review Determinations. If contacted to perform an initial review determination, the Medical Director will render his/her decision verbally or in writing to Health Services within the specified timeframes for urgent or routine reviews. . The written utilization review worksheet will contain sufficient information to support the particular determination and then forwarded to the appropriate Health Services department.
 3. Concurrent Review Determinations. Concurrent review determinations will be rendered by the Medical Director verbally or in writing the same business day.
 4. Reconsideration Reviews of Adverse Determinations of Initial and Concurrent Review Decisions Reconsideration review regarding an adverse determination of an initial or concurrent review decision will be rendered by the Medical Director verbally or in writing the same business day.
 5. Expedited Reviews Following Adverse Determinations Expedited review following a reconsideration of an adverse determination will be rendered by the Medical Director verbally or in writing within 24 hours. The health plan will notify the member and/or provider at the time of the decision.
 6. Appeal of Adverse Determinations. A member or provider appeal of an adverse determination will receive a decision by the independent review organization, clinical peers and/or Medical Director in writing within (30)thirty calendar days of receiving the request. The health plan will resolve all member and provider appeals within the state-mandated timeframes (See policies 2501K and 2503K).
 7. Retrospective Review Determinations If contacted to perform a retrospective review, it will be completed by the Medical Director or his/her designee in writing within thirty (30) calendar days of receiving the request.
 8. All verbal decisions by the Medical Director will be documented in the CMFHP system by the involved Health Services staff, including time and date of the verbal decision.
- H. Children's Mercy Family Health Partners Notifications to Kansas DOI Children's Mercy Family Health Partners will comply with the Kansas Department of Insurance requirements to file annual reports of utilization review activities.
- I. Information Collection and Retention. The plan will collect information used in making medical necessity determinations, including member's medical records, documented conversations between the physician reviewer and the provider, and other information available in the decision making process.
1. Children's Mercy Family Health Partners will make every effort to obtain the necessary information to determine if health care services are medically necessary and appropriate. When additional information cannot be obtained, whether the provider is unable or unwilling to provide further information, the available information will be used to make the initial determination. The refusal or inability to provide any medical information necessary to determine medical necessity could result in administrative denial.

2. Utilization Management documentation, including criteria used for reviews, will be maintained in the Children's Mercy Family Health Partners' computer system and hardcopy files, if applicable. Files will be maintained for a minimum of seven (7) years.

J. Confidentiality of Information.

1. All information and records collected in the process of performing utilization review or case management activities will be maintained in a confidential manner that complies with all applicable federal, state, and local laws, rules, and regulations regarding such information and records.
2. Utilization Management data and reports are provided as required to:
 - a. Medical Management Committee
 - b. Medical Oversight Committee
 - c. Credentialing Committee
 - d. Provider Relations/Contracting
 - e. Customer Service
 - f. State and Federal Entities
 - g. Compliance Officer
3. Information is also compiled, aggregated, and used to evaluate the performance or practice of health care professionals. Profiling data and analysis are provided periodically to the network health care professionals. Such information is reported in aggregate, does not identify individual members, and reported in such a manner as to protect the identity of individual members.

K. Second and Third 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 benefit and the second opinion provider must either be a network provider, or meet the credentialing criteria of Children's Mercy Family Health Partners.

1. In-Plan Second Opinions

- a. The member or provider may request a second opinion from his/her PCP or a specialist to whom the member was referred by his/her PCP.
- b. The physician will:
 1. contact Children's Mercy Family Health Partners' Health Services staff;
 2. provide pertinent information; and
 3. suggest, if possible, an appropriate network provider to provide the second opinion.
- c. Health Services staff will consult with the Medical Directors and provide options for a second opinion provider, if not already requested.
- d. Children's Mercy Family Health Partners' staff will offer to make the appointment with the second opinion physician unless it is agreed at the time of the call that the member or provider will handle this function.

2. Out-of-Plan Second Opinion

Where there is not a network physician available who can provide the second opinion, Children's Mercy Family Health Partners will authorize an out-of-network provider to provide the second opinion. The physician who has contacted Children's Mercy Family Health Partners about the request for the second opinion may indicate his/her preference for the out-of-network provider, subject to plan approval.

3. Out-of-Area Second Opinion

- a. Requested by Member or Provider: In some cases, members may request a specific provider outside the Children's Mercy Family Health Partners' network area. Children's Mercy Family Health Partners will review the request and

consult with the member's physician(s) and the Medical Directors. If authorized, the plan will be financially responsible only for the professional medical services provided in the second opinion. All travel costs and incidental costs associated with the member getting to the second opinion provider visit will be the financial responsibility of the member.

- b. Requested by Children's Mercy Family Health Partners: Children's Mercy Family Health Partners may request that the second opinion be performed by a provider outside of the plan's network area. If the request is approved by the Medical Director, the plan will accept financial responsibility for both the professional second opinion, and the travel and incidental costs associated with obtaining the second opinion provider.

4. Third Opinions

Children's Mercy Family Health Partners, 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 allowed 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 a course of action.

- 5. Adverse Determinations Regarding Requests for Second or Third Opinions. The procedures set forth in Section IV, subsection C shall apply to any adverse determination issued regarding a request for a second or third opinion.

RELATED POLICIES:

CMFHP Policy, QM Plan 5101;
CMFHP Policy, Member Grievances System 2501K
CMFHP Policy, Provider Grievance System 2503K

REFERENCES:

RFP #09222: Sections 5.6.21, 5.8.3, and 5.8.4 and
RFP #09222: Attachment D; Grievance System

WRITTEN BY:

Ma'ata Touslee, R.N., Director of Health Services

REVIEWED BY:

Lisa Gabel, Manager of Clinical Services
Jenny Hainey, Manager of Quality Management
Chad Moore, Compliance Officer
Elizabeth S. Peterson, MD, Medical Director

REVIEW PERIOD:

Annual Review

APPROVED:

Health Services Review Committee

January 15, 2008

Chief Executive Officer

Date