Piedmont WellStar HEALTHPLANS

Medical Management

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At a Glance

The Medical Management Department at Piedmont WellStar HealthPlans is responsible for managing health care resources. The Medical Management Department performs the following functions:

- Review and authorize certain procedures when deemed medically necessary. A list of these procedures can be found on the Quick Reference Guide at pwplans.org under resources and forms
- Review and authorize appropriate out-of-network and out-of-area care, including transition of care and member transfers from out-of-network facilities
- Offer Care Advising services through the Piedmont WellStar HealthPlans Personal Approach to Health (PATH) programs
- Administer member and provider surveys and assessments

For questions and additional information, call **Medical Management Prior Authorization** at **855-514-3680** from 8 a.m. to 5 p.m., Eastern Standard Time, Monday through Friday.

Procedures Requiring Prior Authorization

Prior authorization is the process that Piedmont WellStar HealthPlans uses to determine the medical necessity and coverage of certain procedures, treatments and devices.

For a complete list of procedures that require prior authorization, please visit the Medical Quick Reference Guide, available online at www.pwplans.org under Resources and Forms. If you would like a hard copy of the quick reference guide mailed to you, please email provider relations at ProviderRelations@pwplans.org.

Medical policies outlining items, services, and procedures utilized for review for prior authorization can be found at pwplans.org in the provider section, under Policies and Guidelines. InterQual® Criteria for a case specific review is available upon request.

To initiate a prior authorization, the provider is asked to complete a prior authorization form and submit this (to the fax number at the top of the form) with any pertinent medical records to support the request. This could include any pertinent medical records, lab results or other diagnostic studies.

If coverage is not approved, the provider may appeal the decision by filing an appeal. The appeal process is outlined in the Provider Standard and Procedures section of this Provider Manual.

How and When to Contact Medical Management

Providers can contact the Medical Management Department for questions, or to request a review for prior authorization by calling **855-514-3680** from 8 a.m. to 5 p.m., Monday through Friday.

Piedmont WellStar HealthPlans providers must contact the Medical Management Department to:

- Obtain coverage for services requiring prior authorization (as noted in the medical quick reference guide)
- Notify the plan of an admission to acute care hospitals, skilled nursing facilities, rehabilitation facilities, and long-term acute care centers. This enables Piedmont WellStar HealthPlans to identify members' special needs and coordinate their care. In some cases, clinical staff may work with the Provider to facilitate care at an alternate setting which can most appropriately meet the needs of the member

Utilization Management

The Piedmont WellStar HealthPlans Utilization Implementation Team develops and oversees the design and implementation of the utilization management program. The success of the program relies on the support by providers in our network.

Program Goals

The following are goals of the Utilization Management Program:

- To provide high quality, medically necessary and affordable health care services to our members through a qualified network of providers who are systematically selected and retained through the credentialing and performance appraisal process
- To maintain a Health Plan model that empowers the provider to make medical decisions, supports a medical home model, and enables the provider to proactively manage the care of the members
- To coordinate preventive care, wellness efforts and chronic care management, ensuring efforts are focused on the member;
- To respect and value the confidentiality, safety, and dignity of all members
- To verify that the Utilization Management Program is in compliance with any and all applicable requirements of federal and state regulators and accrediting bodies
- To meet the guiding principles of the Triple Aim:
    - OUTCOME: improve the health of our members
    - SERVICE: enhance the member experience
    - EFFICIENCY: control the cost of healthcare

Qualification and Training

Appropriately licensed, qualified health professionals supervise the utilization management process and are involved in all medical necessity decisions. All medical necessity denials of healthcare services are made by a provider who is clinically qualified and appropriately licensed per regulatory guidelines.

Medical Directors

The Medical Director oversees every aspect of the UM Program, including medical necessity review. Any requests that do not meet medical necessity are forwarded to the Medical Director for review and determination is made based on medical necessity.

Utilization Management Review Staff

The Utilization Management (UM) staff and their activities are an integral component of the Utilization Management Department. This work supports activities across the continuum of care, including optimal outcomes, continuity of care, and strives to manage care within the benefits of our members.

The primary function of the UM staff is to review and verify medical necessity for requests in the following categories:

- Prior authorization of services
- Out -of-network services
- Transition of care
- Concurrent review of continued stay or ongoing services

- Discharge planning
- Case management referrals
- Retrospective (post service) review of services

The Utilization Management Department reports UM activity and uses this data to fine tune the utilization program.

All utilization review decisions are based only on appropriateness of care, service, existence of coverage, and setting of the covered service. Please note:

- We do not use financial incentives in conjunction with our Utilization Management Program.
- We do not reward doctors who conduct utilization review for issuing denials of coverage or service.
- We do not offer financial incentives to utilization management decision makers that encourage decisions resulting in underutilization.

Inter-rater Reliability

At least annually, our clinical leadership assesses the consistency with which providers and UM Managers apply UM criteria in decision-making. The assessment is performed as a periodic review using InterQual® assessment sets to ensure consistent use of criteria in clinical decision-making and ensure consistency.

Provider Access to Criteria and Other Pertinent Policies

Each contracted provider will have access to this Provider Manual, a quick reference guide, a comprehensive orientation to the health plan programs, and information about how, and when, to interact with the health plan. This information has been posted online at pwplans.org.

Program Methods/Utilization Management Process

The utilization management process includes the following: After hours service, referrals, prior authorization, pre-determination, concurrent review, ambulatory care, post service review, discharge planning, case management/complex case management and care coordination. All services must be medically necessary to be approved. The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, skilled/rehab services, outpatient services, ancillary services, scheduled inpatient services, and/or notification of emergent/urgent inpatient services. The process is complete when the requesting provider has been notified of the determination in writing.

Concurrent Review

Concurrent Review is the review of the medical necessity of an inpatient stay, including extended stays or additional health care services required in the course of treatment. Concurrent Review is performed by an Inpatient Care Advisor (ICA) during the same time frame that care is provided to the member.

The inpatient concurrent review process begins with the utilization management staff, who will work with the clinical team to:

- Assess the clinical status of the member
- Verify the need for continued hospitalization
- Facilitate the implementation of the provider's plan of care
- Consider the need for referral to care management
- Promote timeliness of care
- Determine the appropriateness of treatment rendered
- Determine the appropriateness of the level of care
- Monitor the quality of care to verify that professional standards of care are met

Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed
- Whether the diagnosis is the same or changed
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures proposed
- Reasons for extension

If, at any time, services cease to meet criteria, discharge criteria are met, and/or, alternative safe level of care options exist, the Utilization Manager will notify the facility to see if additional information is available to justify the continuation of services. If the medical necessity for the case cannot be determined, or if there are potential quality issues, the case is referred to the Medical Director for review. The need for care advising or discharge planning services is assessed early after admission. Each concurrent review thereafter, will meet the objective of planning for the most appropriate, and cost-effective alternative, to inpatient care. Potential quality of care issues will be promptly referred to Complaints and Grievances Department for investigation and resolution.

Inpatient Discharge Planning

Discharge Planning facilitates coordinated, cost effective care that minimizes the chance of readmission by arranging for the appropriate services upon discharge from the hospital. For members who have not fully recovered, or do not require the highly specialized services of acute hospital care, discharge planning can facilitate a safe discharge with additional health care services, such as home health care or appropriate placement in an extended care facility.

Discharge planning should occur as early as possible in a member's hospital stay. Prior to discharge, the Inpatient Care Advisor reviews the post-hospital needs of the member with the UM/UR staff of the hospital and arranges for follow up/outpatient services.

Referral to Care Advising: The Inpatient Care Advisor should assess the need for care advisor intervention by considering the criteria outlined in the Personal Approach to Health (PATH) programs.

Post Service (Retrospective) Reviews

A retrospective review is offered on a case-by-case basis to determine the medical necessity of services that have already been provided.

- **Identification of Post Service Review:**
  The medical review process begins by reviewing clinical data/medical records, and/ or contacting the appropriate nurse and/or provider. Instances in which a post-service decision may be required:
    - Out of area utilization
    - Unplanned discharge
    - Late notification of a member hospitalization remains hospitalized

- **Obtaining Pertinent Information:**
  The medical review process begins when the review staff reviews clinical information from the medical record, hospital/utilization review nurse, and referring/attending provider. The Utilization Review staff obtains relevant information to:
    - Verify that the proposed service is a covered benefit under that member's policy
    - Assess the Medical Necessity of care provided
    - Assess the appropriate level of care

Adverse Decision/Determination
A denial of authorization for payment of services is also called an adverse determination. An adverse determination means that that an admission, extension of stay, or other health care service, upon review, is determined to be not medically necessary. Adverse decisions that are not medically necessary or appropriate may result in reduced or non-payment of a benefit.

Adverse determinations will be communicated in writing to the member and/or treating/attending provider. The notification shall be easily understandable and will include the specific reason/rationale for the determination, and specific language outlining the criteria used to make this determination. Furthermore, the denial letter will inform the member of his/her ability to request this criteria as well as instructions on how to file an appeal.

Verbal notification of adverse determination is provided to the treating provider (attending provider or Primary Care Physician if attending provider is unknown), and the facility. The Inpatient Care Advisor advises that the admission did not meet medical necessity.

Peer to Peer/Reconsiderations
The Medical Director applies medical necessity, medical policy and his/her clinical expertise to make a determination in each case. This decision will take into account the specific needs of that member and benefit design. If the case involves a procedure or service that is not within the scope of the Medical Directors' education and training, a provider with the appropriate expertise is consulted.

In cases involving a pre-service or concurrent review determination of a health care service, the provider has the opportunity to request a peer to peer discussion with an identified health care provider representing Piedmont WellStar Health Plans (which may be an outside private review agent). This reconsideration will occur within three business days of the provider's request. Based on the member's condition, the provider can request an

expedited reconsideration. If the provider is not satisfied with the outcome of the peer to peer/reconsideration, they have the right to request an appeal within sixty (60) business days. Please note that the peer to peer/reconsideration process is not a prerequisite to filing an appeal.

Please note: The resubmission of a corrected claim due to a minor error or omission is not an appeal. Corrections or resubmissions of claims due to minor errors or omissions should be sent to the customary claim address. See Administrative Appeal section below.

Appeal of Utilization Management Decisions
See the Provider Standards and Procedures Section of this Provider Manual for more information regarding appeals.

Program Evaluation

- **Regulatory Compliance and Process**
  The Utilization Management Program is evaluated on a minimum annual basis, and modifications are made as necessary. The program is evaluated by using:
  - The results of Member Satisfaction Surveys and/or Member complaint, grievance and appeal data
  - Provider complaint and Provider Satisfaction Surveys
  - Relevant UM data
  - Provider profiling
  - Over and under-utilization

- **Over and Under Utilization**

  Poor quality of care can be the result of either under- or over- utilization of services. Monitoring of under-utilization is integral to the health management programs and specifically relative to services that assess the current state of the member's clinical condition such as medication refills and routine testing. Over-utilization is assessed in the ambulatory setting through a review and analysis of diagnostic, laboratory, and pharmacy services, and in the inpatient setting through review of compliance with guidelines for admission and appropriateness of discharge planning. Occurrences of "never events" and hospital acquired conditions are monitored and managed as a potential quality of care case. Results are trended for improvement opportunities.

  The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UM Committee for review, action and follow-up. The final document is then submitted to the governing body for approval.

- **Satisfaction with Utilization Management**
  Annually, Piedmont WellStar HealthPlans will evaluate both member and provider satisfaction with the UM process through the following; Provider satisfaction survey results, member/provider complaints, appeals and feedback from members/providers. If the results indicate that there are areas of dissatisfaction,

Piedmont WellStar HealthPlans will develop action plans to improve the areas of concern which may include staff retraining and member/provider education.

Personal Approach To Health (PATH)

The PATH model aims to improve people's lives through a collaborative, multi- disciplinary care advising approach. The goals of the PATH approach are to improve the quality of care, enhance the member's experience, and reduce the total cost of care by appropriately utilizing scarce medical resources. The care advising team consists of personnel including Medical Director Leadership along with nurses, trained medical assistants, social workers, clinical nutritionists and pharmacists. The care advising team works with PCPs, specialists, and home care agencies among others to coordinate follow-up care and support adherence to provider developed care and treatment plans.

Here is a list of some programs available for Piedmont WellStar HealthPlans members, though specific programs may only be applicable to certain members depending on plan choice:

- Complex Care Management Program
- Chronic Condition Management Program
- Unplanned Care Management Program
- Hospital Transitions Program
- Maternity Program

Clinical and Preventive Health Care Guidelines

Piedmont WellStar HealthPlans strongly endorses the value of clinical practice guidelines. The Piedmont WellStar HealthPlans Quality Improvement Committee (QIC) is responsible for the development and ongoing review of these guidelines. The QIC also assists Piedmont WellStar HealthPlans with monitoring adherence to practice guidelines and identifying opportunities for improvement when non-adherence is found.

Piedmont WellStar HealthPlans reviews all practice guidelines annually and updates them as needed to reflect changes in recent scientific evidence or technology.

These guidelines may include:

- Adult cholesterol management
- Attention deficit/hyperactivity disorder
- Depression
- Diabetes mellitus health management guidelines
- Evaluation and management of heart failure—outpatient
- Management of asthma in infants, young children, and adults
- Management of hypertension
- Prenatal care guidelines

If applicable, Piedmont WellStar HealthPlans annually reviews and updates a schedule of pediatric (birth to age 19) and adult (ages 19 and older) preventive health guidelines. Piedmont WellStar HealthPlans encourages its providers to follow these guidelines to reduce variation in care, prevent illness, and improve members' health.

Piedmont WellStar HealthPlans continues to add and revise guidelines. To see the most current clinical and preventive health care guidelines, go to **www.pwplans.org** or call **Provider Services** at **855-869-7225** for a hard copy. Provider Services representatives are available from 8 a.m. - 5 p.m., Monday through Friday.

Member and Provider Surveys and Assessments

Member and Provider Satisfaction Surveys

Piedmont WellStar HealthPlans conducts annual surveys of both member and provider satisfaction. Participation by members and providers enables Piedmont WellStar HealthPlans to develop quality improvement plans.

The surveys assess:

- Access to care and/or services
- Overall satisfaction with the Health Plan
- Provider availability
- Quality of care received
- Responsiveness to administrative processes
- Responsiveness to inquiries

Provider Performance Tracking

Piedmont WellStar HealthPlans is continuously analyzing and identifying best practices and areas of improvement regarding quality of care and cost-effectiveness. Only providers with a predetermined minimum number of Piedmont WellStar HealthPlans members may have clinical profiles developed. These individual profiles compare providers to the performance of all other providers within their specialty and against national benchmarks. The profiles may be distributed to providers on a semiannual basis.

Quality Improvement Program

The goal of the Quality Improvement Program is to continually examine clinical and administrative operations in an effort to improve Piedmont WellStar HealthPlans ability to deliver high-quality, timely, safe, and cost-effective health care services.

The Quality Improvement Program operates in accordance with the guidelines established by the National Committee for Quality Assurance (NCQA), and the Centers for Medicare & Medicaid Services (CMS).

The program critically assesses Piedmont WellStar HealthPlans' performance regarding customer service, provider satisfaction, credentialing, pharmacy, preventive services, utilization of resources, and various health care initiatives.

At the center of the program are the providers who serve on the Quality Improvement Committee (QIC). The QIC, representing providers and administrative leadership, operates directly under the auspices of the board of directors. The QIC is vital to Piedmont WellStar HealthPlans because it develops and evaluates clinical and operational standards for providers.

The Provider Agreement requires providers to comply with Piedmont WellStar HealthPlans Quality Improvement Program. To obtain additional information, providers may go online at www.pwplans.org or call **Provider Services at 855-869-7225**, 8 to 5 p.m., Monday through Friday.

Health Plan Definitions

Medical Necessity
Services or supplies are determined to be medically necessary if they are:
- appropriate and consistent with the diagnosis and the omission which could adversely affect or fail to improve the member's condition;
- not primarily custodial care, unless custodial care is a Covered Service under the benefit plan;
- compatible with the standards of acceptable medical practice in the United States;
- provided in a safe and appropriate setting given the nature of the diagnosis and severity of symptoms; and
- not provided solely for your convenience or the convenience of the provider.

PWHP reserves the right to determine in its sole judgment whether a service meets these criteria and will be authorized for payment. Authorization for payment decisions shall be made by PWHP with input from the member's PCP or other provider performing the service.

Independent consultation with a provider other than the PCP or attending provider may be obtained at the discretion of PWHP. The fact that a health care provider may order, prescribe, recommend, or approve a service, supply, or therapeutic regimen does not, of itself, determine medical necessity and appropriateness or make such a service, supply, or treatment a covered service.

Other Pertinent Definitions

Assigning Lengths of Stay – A process for assigning approved days for an acute care inpatient admission based on relevant clinical information.

Business Day - means Monday through Friday, except for Federal holidays.

CMU-Case Manager Utilization

CSR- Clinical Services Representative

Covered Service - means a health care service that is a covered benefit under an employer's self-insured health plan.

Concurrent Review – A review during a course of treatment to determine whether the amount, duration and scope of the prescribed services (including extended stays or additional health care services) continue to be medically necessary or whether a different service or lesser level of service is medically necessary.

Emergency Medical Condition – A medical condition that reveals itself by acute symptoms of sufficient severity or pain such that a prudent layperson could reasonably expect the lack of immediate medical attention to result in: (a) Placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious

jeopardy; (b) Serious damage to bodily functions; (c) Serious dysfunction of any bodily organ or part.

Identifi™ – An integrated health management system for documentation of information related to the Member's health, hospital confinements, ongoing monitoring, care, or case management, etc.

InterQual® Criteria – A set of regularly updated, rules-based, member specific evidence-based medicine decision support system that ensures medical necessity reviews that are based on established clinical guidelines and criteria. InterQual® criteria can also be used to help determine initial length of hospital stay.

Length of Stay – (LOS) The number of days between hospital admission and hospital discharge. The day of admission is counted; the day of discharge is not.

LTAC – Long Term Acute Care facility.

MDS – (Minimal Data Set) – Clinical information needed for pre-authorization services.
Ongoing Ambulatory Care – Ambulatory care of symptomatic conditions, usually requiring regular or frequent visits or encounters (e.g., allergy injections or therapy visits).

PATH – Personal Approach to Health. Piedmont WellStar HealthPlans holistic Care Management approach.

Participating or Network Provider – A facility, hospital, doctor, or other health care professional that has been credentialed by and contracts with the self-insured employer sponsored health plans that Piedmont WellStar HealthPlans serves as a Private Review Agent.

Prior Authorization (Pre-service Decisions) – A determination made by Piedmont WellStar HealthPlans to approve or deny coverage for a provider's request to provide a service or course of treatment of a specific duration and scope to a member prior to the provider's initiation or continuation of the requested service. (May also be referred to as prospective review, pre-certification or organization determination.)

Rehabilitation (Rehab)–for the purposes of this document, facility based care that includes a wide array of services, including evaluation and treatment to help members recover from an illness or injury, or therapy for those with disabilities. Treatment teams evaluate individual needs; develop a rehabilitation plan to meet those needs, with the focus being to help the member gain independence.

Skilled Nursing Facility (SNF) - A type of health care facility recognized by the Medicare and Medicaid systems as meeting long term health care needs for individuals who have the potential to function independently after a limited period of care. A multidisciplinary team guides health care and rehabilitative services, including skilled nursing care. Skilled nursing care includes rehabilitation and various medical and nursing procedures.

Urgent Medical Condition – Any illness, injury or severe condition which under reasonable

standards of medical practice would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or Emergency Medical Condition. The terms also include situations where a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.

Utilization Management (UM) – An objective and systematic process for planning, organizing, directing and coordinating health care resources to provide medically necessary, timely and quality health care services in the most cost-effective manner.