UTILIZATION MANAGEMENT

An overview

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UniCare Health Plan of West Virginia, Inc.
Mountain Health Trust

Objectives

- Share key information about the utilization management (UM) process.
- Provide solutions to common issues that cause delays.
- Answer questions and hear concerns from the UniCare Health Plan of West Virginia, Inc. (UniCare) provider community.

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UniCare facts

- UniCare has been in operation since November 2003.
- We started in four counties with 700 members.
- Today, we have a statewide membership.
- We service Expansion, Temporary Assistance for Needy Families (TANF) and Social Security Income (SSI) members.
- With a membership of about 145,000, we're currently the largest MCO in West Virginia.

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Departments

Health Care Management	Behavioral Health	Network Education	Marketing
Claims and Operations	Quality	Finance	Human Resources
Government Relations	Compliance	Legal	Regulatory

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Health Care Management

Utilization Management and Case Management

Our primary goal

To ensure members receive the quality care they need while effectively managing Medicaid dollars.

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Health Care Management

- All programs are structured to ensure our members receive the highest quality services indicated for their medical condition in a timely manner.

- UniCare uses approved medical review criteria to ensure members are provided the right services at the right level of care and by the right health care provider. These programs work in a collaborative manner throughout the care continuum.

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Case management

- UM staff works closely with our case managers to ensure member needs are met.
- Case management staff helps with transportation, complex care needs, disease management, coordination of care and postdischarge management, as well as reducing avoidable readmissions and ER utilization.
- Case management referrals are based on the needs identified in the clinical information submitted to UM.
- Providers or members can also request case management by calling our Customer Care Center at **1-800-782-0095**.

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UM policies

- UM staff reviews the available medical records against our *Medical Policies*, AIM Specialty Health® (AIM)* guidelines, *Clinical UM Guidelines* and *MCG Care Guidelines*, which are developed using evidence-based criteria. This decision-making process is in place to prevent the overutilization or underutilization of resources based on the member's coverage.
- We do not reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.
- Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.

UM staff background

Our nurses have backgrounds in the following specialties:

- Trauma
- Oncology
- Rehabilitation
- Long-term care
- Neonatal intensive care unit
- Women's health
- Medical/surgical
- Critical care (cardiovascular, neurology and medical)
- Surgery
- Transplant
- Pediatrics

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Large geographical area

- Our UM staff comes from various locations, but as we fill positions, we make every effort to hire in-state. Our UM staff is currently in the following areas:
- West Virginia
  - Morgantown
  - Charleston
  - Parkersburg
  - Summersville
- Indiana
- South Carolina

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Which services require prior authorization (PA)?

- All inpatient hospitalizations (including transfers that are nonemergent or not to a higher level of care)
- Advanced imaging
- Outpatient therapy
- Certain outpatient surgeries
- Sleep studies
- Genetic testing
- Durable medical equipment
- Home health services
- All out-of-network requests

When deciding which services are subject to review, we look at utilization, potential for abuse, local and national trends, cost, and our state contract.

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PA vs. Continued Stay Review (CSR)

PA is for planned admissions or procedures, such as:

- Hysterectomy.
- Knee replacement.
- Advanced imaging.

CSR is for emergency admissions and inpatient extensions such as:

- Myocardial infarction.
- Chronic obstructive pulmonary disease exacerbation.
- Acute withdrawal.
- Any case where the member stays longer than the approved days.

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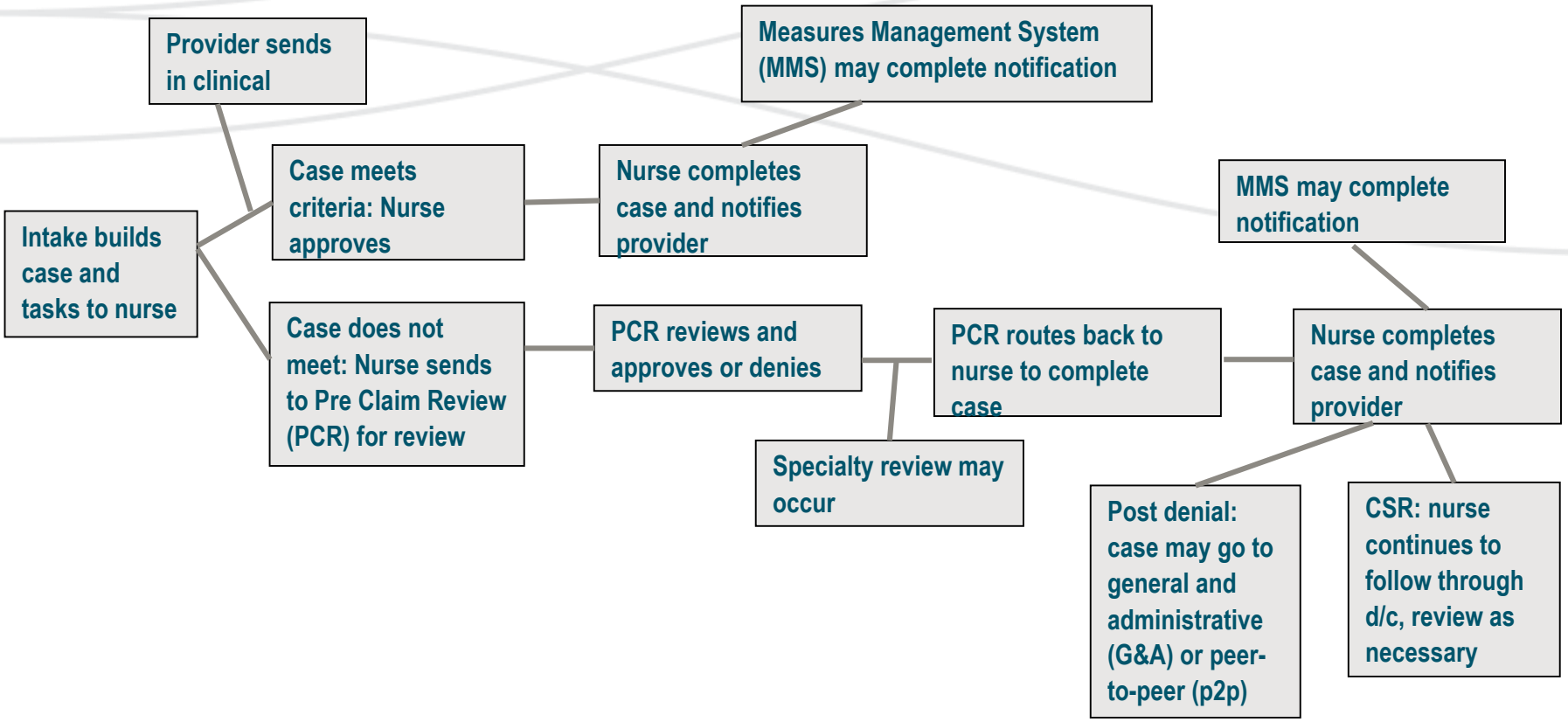
UM process

High-level overview



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How to start a request

- Fax: The *PA Request Form* is available on the provider website at **https://provider.unicare.com**.
- Availity Portal:* Online requests will be covered in a separate webinar.
- Phone:

PA phone:	1-866-655-7423
PA fax:	1-855-402-6983
CSR fax:	1-855-402-6985

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Precertification Look-Up Tool (PLUTO)

- PLUTO is located on the UniCare provider website at **https://provider.unicare.com**.
- It allows providers to look up specific codes to see if they're covered and if PA is required.
- You must enter each service you're requesting.

Tips:

- Capitalize letters in HCPCS codes.
- Select **Find Code** rather than using the *Enter* key on your keyboard.

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Required information

- Member name, ID and DOB
- ICD-10 code(s)
- CPT/HCPCS code(s)
- Number of units
- Referring/ordering provider
- Servicing provider
- Servicing facility (if applicable)
- Provider contact information
- TIN and NPI (for all providers/facilities)
- Date(s) of service (including the number of days requested for inpatient stays)
- Clinical information to support the request

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Turnaround times

Type	Time frame
Routine pre-service	7 calendar days
Urgent pre-service (including urgent discharge needs)	2 business days
Current inpatient requests	3 calendar days

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Urgent criteria

A request is considered urgent when waiting the normal time frame for review could do one of the following:

- Seriously jeopardize the life or health of a member or the member's ability to regain maximum function based on a prudent layperson's judgment.
- Subject the member to severe pain that cannot adequately be managed without treatment.
- Delay a member's discharge from an inpatient hospital.

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Examples: urgent vs. nonurgent

Urgent	Nonurgent
Abdominal CT scan for new hematuria	Sleep study
MRI L-spine with signs of compression	Tonsillectomy and adenoidectomy (T&A)
CT scan of the chest for suspected pulmonary embolism	MRI L-spine for a history of chronic, stable low-back pain
Member is currently inpatient and needs wound vac for discharge	Forgetting to request PA for a service scheduled for the next day

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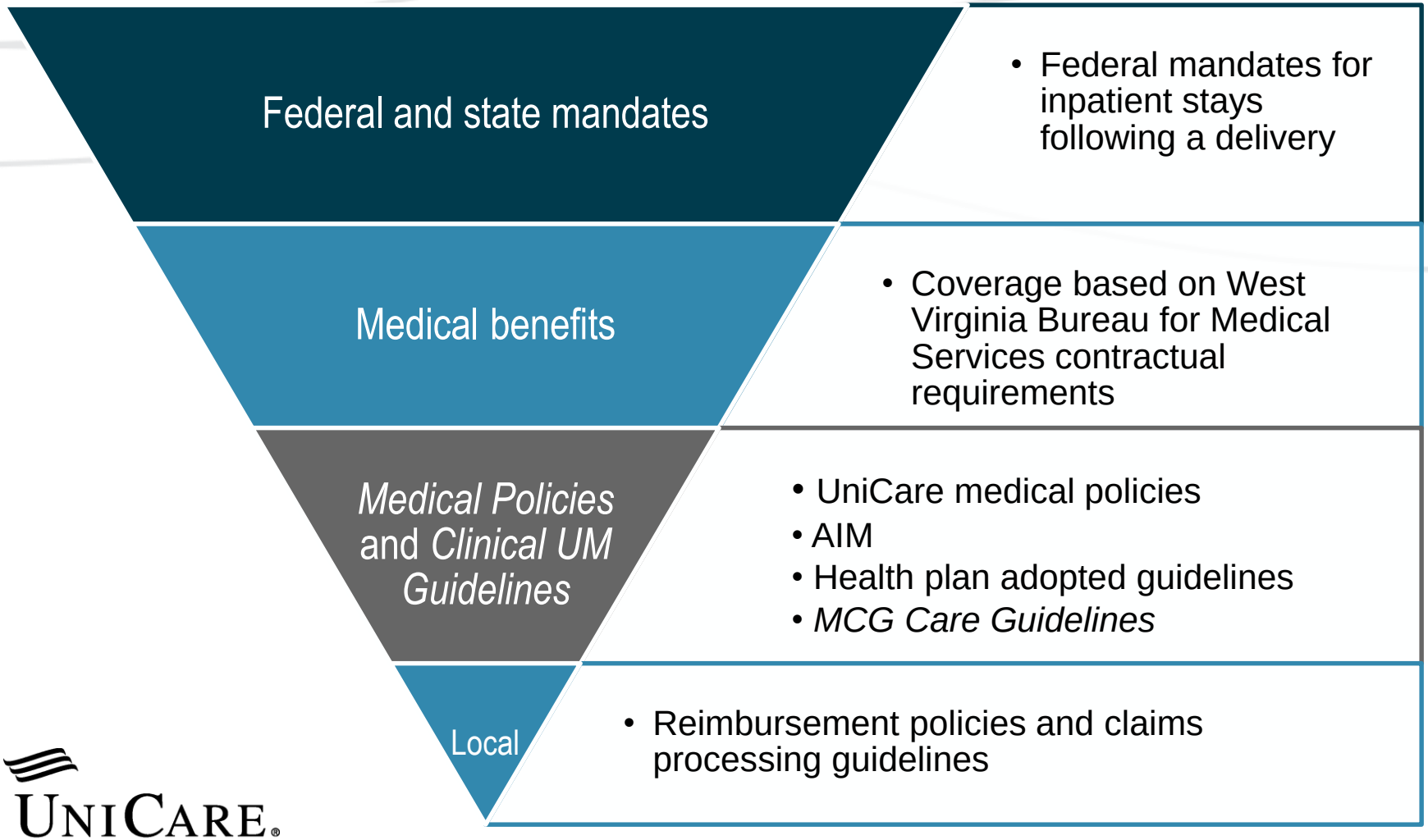
UM criteria

Hierarchy



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Criteria procedures

- We use evidence-based criteria to review all requests.
- The medical policy and technology assessment committee meets quarterly.
- All *Medical Policies* and *Clinical UM Guidelines* are reviewed annually.
- New technology is reviewed as it becomes available.
- When no policy is available, we refer to national standards (CMS, CDC, Agency for Healthcare Research and Quality [AHRQ], National Comprehensive Cancer Network [NCCN]) or the appropriate physician specialty society (American Academy of Family Physicians [AAFP], American Academy of Pediatrics [AAP], American Psychological Association [APA], American Society of Hematology [ASH], Infectious Diseases Society of America [ISDA]) to make a determination.
- All medical necessity denials are reviewed by a physician.

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Medical Policies and *Clinical UM Guidelines*

- Outpatient procedures:
  - T&A
  - Genetic testing
  - Spinal fusion and other spine procedures
- Durable medical equipment:
  - Custom wheelchairs
  - Life vests
  - Insulin pumps
- Other services:
  - Home Health
  - Physical/occupational/speech therapy

All policies are available on the provider website at **www.unicare.com.**

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AIM guidelines

- Our nurses review requests for advanced imaging, radiation therapy, musculoskeletal services and sleep management services using AIM criteria.
- Both pediatric and adult guidelines are available.
- All policies are available at **www.aimspecialtyhealth.com/marketing/guidelines/185/index.html**.

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MCG Care Guidelines

- Used for inpatient requests and certain outpatient procedures.
- Provides indications for admission and recommended length of stay.
- Helps differentiate observation from inpatient necessity.
- Includes pediatric and adult guidelines for certain diagnoses as well as common complications, extended stay criteria and discharge planning information.

Please note, there are some custom edits to the *MCG Care Guidelines* criteria. Individual guidelines are available upon request; due to licensing restrictions, we cannot publish them.

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Clinical information

- The amount of clinical information you submit depends on the request, but there must be enough information to support the request.

- Examples are on the following slides.

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Requesting MRI of the lumbar spine: criteria

Nonspecific low back pain:

- In a patient where focused history and physical exam suggest nonspecific lumbar pain and/or referred buttock or lower extremity pain and all of the following are met:
  - Patient is a potential candidate for surgery or epidural steroid injection.
  - Patient has, following clinical examination, completed a minimum of six consecutive weeks of physician supervised conservative therapy for the current episode of pain, including but not limited to any of the following:
    - Nonsteroidal anti-inflammatory drugs (NSAID)
    - Muscle relaxants
    - Steroids
    - Physical therapy; **AND**
  - After trial of conservative therapy as listed above, patient fails to show substantial improvement on clinical re-evaluation.

Requesting MRI of the lumbar spine: clinical to submit

- Document whether the patient is a candidate for surgery or epidural steroid injections.
- Detail any conservative treatment the patient has undergone.
- Complete and document the re-evaluation.
  - This can be copies of records, a note or entry in Availity, and/or actual patient and office visit notes. As long as we receive enough information to make a decision, you are free to use whichever format works best for you.

Requesting T&A: criteria

Tonsillectomy is considered medically necessary for individuals less than 18 years of age who meet one or more of the criteria below:

- A history of recurrent throat infection with a frequency of at least one of the following:
  - 7 episodes in the past year
  - 5 episodes per year for 2 years
  - 3 episodes per year for 3 years
- Additionally, documentation in the medical record for each episode of sore throat indicates at least one of the following:
  - Temperature greater than 38.3 degrees Celsius (100.8 degrees Fahrenheit)
  - Cervical adenopathy
  - Tonsillar exudates or erythema
  - Positive test for Group A β-hemolytic streptococcus (GABHS).

Requesting T&A: clinical to submit

- Submit documentation of recurrent throat infections meeting the criteria in the previous slide. Include documentation of fever, cervical adenopathy, tonsillar exudate/erythema and strep.
- The PCP tracking tool and forms are located on the provider website at **https://provider.unicare.com**.

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Minimum necessary

- We attempt to obtain and use the minimum necessary information we need in order to do our jobs appropriately.
- Please do not send the entire medical record. We do not need it.
- Becoming familiar with the criteria will help you decide what to send.

UM denials

Denial letters

- UniCare sends a denial letter each time a denial is issued.
- Denial letters:
- Are member-specific.
- Cite the criteria used for the denial.
- Include the reason the denial was issued, such as:
  - Insufficient information.
  - No conservative treatment documented.
  - Inappropriate level of care.
  - Service is non covered or limits exceeded
- Include information on appeals and how to file them.

Make sure to read the letter in its entirety to determine next steps.

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Example: member denial

We cannot approve surgery (tonsillectomy and adenoidectomy) for your child. This is because it is not medically necessary. Your child is having problems (throat infections). She breathes through her mouth. Records do not show that her tonsils are enlarged. Records do not show certain things (documentation in the medical record for each episode of sore throat which includes at least one of the following: Temperature greater than 38.3 C; or cervical adenopathy; or tonsillar exudates or erythema; or Positive test for Group A hemolytic streptococcus). We used *Health Plan Clinical UM Guideline CG-SURG-30 Tonsillectomy for Children with or without Adenoidectomy* (Publish date: June 6, 2018) to decide this.

Example: member denial (cont.)

We cannot approve the surgery to remove your womb (hysterectomy). This is because it is not medically necessary. You have pain. We do not know how long you have had this pain. We do not know what else you have tried. Records do not show you had surgery (laparoscopy) to look for a cause. We used *MCG Care Guideline*, 22nd Edition, modified by the health plan, for *Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted, W0010* to decide this.

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Options after a denial is issued

Peer-to-peer reviews

- Discuss your case with the physician who made the decision.
- You can receive an immediate decision during the discussion.
- Peer-to-peer reviews must be requested within 24 hours of the denial notice.
- Call the peer-to-peer line at **1-866-902-4628, option 3** and leave the following information:
  - Name, title and contact information.
  - Availability to return your call.
  - Member name, DOB and reference number.
  - Clinical information to help with the decision (if available).

New requests

- Submit a new request when there is new information that was not provided during the initial review.
- This option is only available for outpatient, pre-service requests.
- Follow the normal process to start a new case.
- We will make a decision within the standard turnaround time.

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Appeals

- The appeals process is outlined in the denial notice. Appeals may be requested up to 60 days after a denial notice. Please send the appeal request via either of these methods:
  - Fax: **1-866-387-2968**
  - Mail: UniCare Health Plan of West Virginia, Inc.
    Attn: Grievance and Appeals Department
    P.O. Box 91
    Charleston, WV 25321-0091
- You must provide all relevant clinical information.
- Standard appeals are completed within 30 days of your request.
- Expedited appeals are completed within 72 hours of your request.
  - We will use the same criteria we use for urgent PA requests.
- Appeals are reviewed by a different physician than the one who issued the initial denial.

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State fair hearing

- If UniCare appeals are exhausted, the next step is a state fair hearing.
- Request within 90 days of appeal letter.

  Bureau for Medical Services
  Office of Medicaid Managed Care
  350 Capitol Street, Room 251
  Charleston, WV 25301-3708

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Common issues

Not enough information

Examples:

- There is no documentation of conservative therapy for advanced imaging or spinal injections.
- There is no documentation of recurrent throat infections for T&A requests.
- There were less than 48 hours of clinical for inpatient admissions.
  - Most *MCG Care Guidelines* require that the member fails the observation setting before approving an inpatient admission.

Out-of-network requests

- Please make every effort to refer members to an in-network provider. You may use the provider finder at **https://provider.unicare.com** or call our Customer Care Center at **1-800-782-0095**.
  - For complicated care and coordination, call our Customer Care Center and request a case management referral.
- Out-of-network requests will be approved if no in-network provider is available or to ensure continuity of care for new members.
- For genetic testing:
  - We see frequent requests for genetic testing to be done at specialty laboratories.
  - LabCorp* provides comprehensive genetic testing services, including BRCA gene tests.

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Changes in requests

Claims must match what was entered in the PA request. To request a change, call or fax your UM intake to make sure it is processed appropriately. Examples of items you may need to change include:

- An MRI without contrast to an MRI with contrast.
- The date(s) of service.
- The facility.

You can make changes on the Availity Portal as long as the service hasn't been rendered. If it has been rendered, please contact UM to make the change.

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New UM system

UniCare care management platform

- Updated UM system
- More customizable for our market
- Better insight and reporting
- Integration with member and provider data

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What does this mean for you?

- Improved efficiency
- Information gathered in a different sequence during calls
- Letters will look different
- Authorization numbers will have a different format
- Place of service will match CMS approved POS
- No claims impact — Continue to submit with the authorization number you receive

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Provider resources

We're here to support you

- Provider workshops
- Provider newsletters
- Network representatives
- UniCare provider website
  - Important contact information
  - PLUTO
  - *Medical Policies* and *Clinical UM Guidelines*
  - Provider manuals
  - Benefit matrices
  - Reimbursement policies

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Questions or concerns?

Thank you

* AIM Specialty Health is an independent company providing some utilization review services on behalf of UniCare Health Plan of West Virginia, Inc. Availity, LLC is an independent company providing administrative support services on behalf of UniCare Health Plan of West Virginia, Inc. LabCorp is an independent company providing laboratory services on behalf of UniCare HealthPlan of West Virginia, Inc. UniCare Health Plan of West Virginia, Inc. uses AIM Specialty Health clinical criteria when performing utilization reviews; AIM Specialty Health is a separate company.

https://provider.unicare.com

UniCare Health Plan of West Virginia, Inc.

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