POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Clinical Decision Criteria and Application
PAGE: 1 of 6	**REPLACES:**
APPROVED DATE: 3/12	**RETIRED:**
EFFECTIVE DATE: 7/12	**REVIEWED/REVISED: 3/13, 3/14, 2/15, 1/16, 1/17, 2/18**
PRODUCT TYPE: ALL	**REFERENCE NUMBER:** WA.UM.02

SCOPE:
Coordinated Care (Plan) Medical Management Department

PURPOSE:
To ensure clinical decisions are made and documented using all relevant clinical information and are based on written, nationally recognized clinical decision support criteria.

POLICY:
Plan and delegated vendors (as applicable) use written clinical support criteria to evaluate medical necessity, level of care, and/or clinical appropriateness of select services including inpatient hospitalization and outpatient referrals. They will work collaboratively to ensure members have timely access to high quality healthcare and appropriate healthcare resources. The Utilization Management (UM) criteria and the procedures for applying them will be reviewed annually and updated as appropriate.

PROCEDURE:

I. <u>Clinical Criteria</u>

A. Evidence-based, nationally recognized clinical support tools:
Plan UM staff consult the following criteria sets when determining medical necessity, level of care, and appropriateness of physical health care: Refer to CP.MP.68 – *Medical Necessity Criteria* for appropriate hierarchy in selecting criteria.

- Most recently available written/electronic version of McKesson's *InterQual* Level of Care and Care Planning Criteria for Acute Adult, Acute Pediatric, Long-Term Acute Care, Rehabilitation, Subacute/SNF, Home Care, Molecular Diagnostics, Home Care, Durable Medical Equipment, Adult and Pediatric Procedures, and also available BH criteria including Geriatric Psychiatry, Adult Psychiatry, Adolescent Psychiatry, Child Psychiatry, Chemical Dependency & Dual Diagnosis, Residential & Community-Based Treatment.
- Health Technology Assessment (HTA)
- Plan's Medical Management Guidelines for therapies and rehabilitation
- Local state and/or regulatory guidelines, where applicable, may also be used in making UM decisions.
- While *clinical practice guidelines <u>are not</u>* used as criteria for medical necessity determinations, the Plan's Medical Director and UM staff

will ensure that UM decisions are consistent with guidelines distributed to network providers. Such guidelines will include, but not be limited to, Preventive Health (adult and child), Asthma, Prenatal Care, Diabetes, and Synagis.

- Other nationally recognized support and reference tools such as Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, Agency for Healthcare Research and Quality (AHRQ), etc., are available to Medical Director(s).
- Centene's Clinical Policy Committee will determine clinical policy related to new and emerging technologies and new uses for existing technologies. Clinical policies are available to all health plan staff and external providers on the provider portal or upon request. (See CP.CPC.01 *Clinical Policy Committee*). Clinical policies are reviewed and updated at least annually by the committee. These policies are also available within the McKesson InterQual Products under Specialty Referral.

B. Annual Review of Criteria:

Updates and revisions to McKesson's InterQual Level of Care and Care Planning Criteria are reviewed annually during the Plan's MMSC/QIC Committee meetings. All clinical policies created/updated by the Clinical Policy Committee are also presented for review and adoption at the Plan MMSC/QIC meetings. At this time, local practitioners with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on adoption of UM criteria and on instructions for applying the criteria.

C. Availability of Criteria:

Providers are notified via the comprehensive new provider orientation, the Provider Manual, and provider newsletters of the criteria utilized by Coordinated Care for medical necessity determinations. The Provider Manual, newsletters, and other provider information are also available on the Plan web site. These communications include notification that treating providers may, at any time, request UM criteria pertinent to a specific authorization by contacting the Medical Management Department or may discuss the UM decision with the Plan Medical Director.

II. Clinical Criteria Application

A. Levels of Clinical Review

Clinical criteria are applied to determine medical necessity and/or appropriate level of care for the service being requested. Two levels of

UM clinical review are available for all authorization requests (UM.02.01 - *Medical Necessity Review*)

A. Level I review is conducted by a clinical UM designee (Prior Authorization Nurse, Concurrent Review, etc.) who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. A Level I review is conducted utilizing McKesson's InterQual criteria **or applicable medical policy**, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care. Other factors that must be considered when applying criteria to a given individual situation includes the member's age, co-morbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable. At no time shall a Level I review result in a reduction, denial or termination of a service. Adverse determinations can only be made by a Medical Director, or qualified designee, during a Level II review.

B. Level II review is conducted by an appropriately licensed practitioner or other health care professional. If the request is for behavioral health service, a qualified behavioral health practitioner will be consulted during the review. If the request is for dental services, a qualified dental practitioner will conduct the Level II review. All Level II reviews shall be conducted utilizing McKesson's InterQual criteria or applicable clinical policy with consideration given to continuity of care, individual member needs at the time of the request and the local delivery system available for care. A board-certified consultant may also be used in making a medical necessity determination.

B. Consistency in Applying Criteria:

Annual Interrater Reliability (IRR) testing is performed on all staff involved in UM decision making to ensure consistency in determinations and documentation is being attained. (Refer to *UM.02.05 – Interrater Reliability.)*

- All current InterQual users will be tested at least yearly. This includes all Medical Directors, Registered Nurses, Licensed Practical Nurses, Behavioral Health Specialists and Licensed Clinical Social Workers who use InterQual.

- All new employees must be tested after training but before the end of the 90 day orientation regardless of any pre-employment test. If this testing coincides with the annual testing, it may be used for both. If there are more than 30 days separating the new employee and annual testing, it must be repeated.
- Temporary staff required to use InterQual must be tested prior to working in the live authorization system. Temporary employees who do not pass the applicable IRR testing are ineligible for assignment.
- Staff will be kept updated related to any changes of the InterQual system as needed based on when changes occur.
- Staff will be re-trained as needed based on annual testing results. When wide-spread issues are identified as a result of IRR testing, the corrective action plan can include, but is not limited to:
    a. In-service training for all staff
    b. Modifications to on-line documentation standards
    c. Modifications to the criteria set after approval by the Clinical Policy Committee or,
    d. Development of internal checklists/guides for staff use.

III. Oversight of delegated UM activities

A. Centene Plans may, at their discretion, delegate UM activities, including adoption or development of utilization decision criteria, to qualified subcontracted vendors. For example, Plans may delegate management of high tech outpatient radiology services to National Imaging Associates (NIA).

B. The Plan is accountable for delegated UM services and monitors performance of these services. Initial monitoring occurs through the approval of the delegate's UM program, policies and procedures (or the delegated portions of the program). Subsequent performance reviews are achieved through routine reporting and at least annual evaluation. The evaluation criteria are NCQA or Plan/State standards. The Plan also retains the right to reclaim the responsibility for performance of this function should standards not be maintained.

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REFERENCES:
UM.01 – *Utilization Management Program Description*
UM.02.01 – *Medical Necessity Review*
UM.02.05 – *Interrater Reliability*
CP.CPC.01 - *Clinical Policy Committee*
CP.MP.68 – *Medical Necessity Criteria*
UM.04 - *Appropriate UM Professionals*
WA Contract – Section: Authorization of Services
Current NCQA Health Plan Standards and Guidelines

ATTACHMENTS: N/A

DEFINITIONS:
Health Technology Assessment (HTA): a program that determines if health services used by Washington State government are safe and effective. The program examines scientific evidence for new technologies which is then reviewed by a committee of practicing clinicians. The purpose of the program is to ensure medical treatments and services paid for with state health care dollars are safe and proven to work. HTA contracts for scientific, evidence-based reports about whether certain medical devices, procedures and tests are safe and work as promoted.
Medical Director: As used in this policy, a collective term for the Vice President of Medical Affairs (VPMA), Medical Director or Associate Medical Director.
UM Designee: Member of the UM department who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. See UM.04 Appropriate UM Professionals for UM department staff titles, qualifications and reporting structure.

REVISION	**DATE**
Updated language	3/14
Updated language	2/15
Inserted new language from HCA contract amendment regarding need for annual report on HTA authorization decisions. First report due 1/15/2017	1/16

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Removed language regarding HTA report due to change in HCA contract. Updated InterQual product list. Updated policy list.	1/17
Removed reference to Cenpatico Behavioral Health and included Behavioral Health Staff under IRR testing section.	2/18

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Coordinated Care Vice President of Medical Management: signature on file