

WORK PROCESS

DEPARTMENT: Medical Management	DOCUMENT NAME: Medical Necessity Review (TruCare)
PAGE: 1 of 9	REPLACES: CC.UM.02.01
APPROVED DATE: 8/01/2011	RETIRED:
EFFECTIVE DATE: 7/1/2012	REVIEWED/REVISED: 8/12; 07/13; 5/14; 1/15; 10/15; 1/16; 3/16; 7/16; 9/16; 4/17; 6/17; 7/17,3/18, 4/18
PRODUCT TYPE: All	REFERENCE NUMBER: WA.UM.02.01

SCOPE: Coordinated Care Medical Management Department

PURPOSE:

To ensure utilization management (UM) decisions are conducted by appropriate professionals and all relevant information is used in making medical necessity determinations in the TruCare medical documentation system.

WORK PROCESS:

Level I Review

The UM designee for Coordinated Care reviews all relevant information to determine if a Level I or Level II review is indicated.

1. Automatically referred for Level II review - services or procedures that:
 - Require benefit interpretation
 - Are not addressed in InterQual/ASAM criteria and no local criteria or policy exists
 - Are potentially experimental or are new technology/procedures
 - Inpatient Stay less than 24 hours requesting Acute Care and refusing offer of OBS conversion.

If *any* of the above applies, the UM designee informs the requesting party of the necessity for further review, enters the request in the authorization system, and forwards the request to a Medical Director for a Level II Review.

2. If a Level I review is indicated, the UM designee reviews all relevant clinical information about the member's condition, (including factors that may require special consideration such as age, co-morbidities, complications, progress of treatment, psychosocial issues, home environment, support structure, acute vs. chronic condition and/or life-threatening illness), against InterQual Criteria, ASAM, internal medical/clinical policies or other applicable guidelines. Determinations and provider notifications are made according to the expediency of the case as described in the *Timeliness of UM Decisions and Notifications* (UM.05) policy.
3. Clinical information meets criteria: when the request meets the associated InterQual screening criteria or other predetermined criteria, the UM designee approves the request, enters an approved authorization into the TruCare® authorization system and issues an authorization number. Note: *Some services*

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will be reviewed using InterQual/Policies with a variance table. These variances describe additional criteria that must be met, allow for approval when some InterQual criteria points are not met or when differences in local policy exist. See Table 1.

4. **Clinical information is insufficient:** see *Timeliness of UM Decisions and Notifications* (UM.05) policy.

5. **Clinical information does not meet criteria:** when the information does not meet the screening criteria or guideline, the UM designee verbally informs the requesting party of the need for Level II review and documents all information in the TruCare authorization system, including the managing physician and his/her contact information. Immediately following verbal notification to the provider, the UM designee creates an *Advisor Review* in the TruCare authorization system, notifying the Medical Director of the need for a Level II Review.
 - o Only a Medical Director (or other appropriate healthcare practitioner) can make an adverse determination decision.
 - o When referring for Level II Review, UM designee for Coordinated Care creates an *Advisor Review* in TruCare, which generates a date and time stamped *Task* in TruCare to the Medical Director. The *Review Notes* should outline the clinical information and reason for the referral to the Medical Director, including why the request is not meeting the standard medical necessity review criteria. The Medical Director replies back by completing the *Advisor Review* in TruCare. For documentation purposes, the *Advisor Review* needs to be completed by the Medical Director within the TruCare authorization system, even if the discussion with the Medical Director and the decision takes place face-to-face or telephonically.

6. **Limitation extensions (LE)** can be requested when a provider is exceeding the stated limits for nondurable medical equipment/medical supplies or other services with stated limits. The UM designee may review a request for a Limitation extension as a Level 1 review. Limitation extensions are considered based on the following criteria.
 - o The member has shown a level of improvement related to the requested health care service and there's a reasonable probability of continued improvement if the requested health care service is extended; **and/or**
 - o There's a reasonable probability the client's condition will worsen if the requested health care service is not extended

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- For AHFC, the UM Nurse would coordinate with the Coordinated Care FC Health Care Coordinator on any requests for LE. The Health Care Coordinator will coordinate this information with Children’s Administration (CA) and Foster Well-Being (FWB) units.

Level II Review

1. The Medical Director, or other designated qualified practitioner, reviews the UM designee’s TruCare *Authorization Detail*, *Line Item Detail*, and UM designee’s InterQual criteria *Clinical Review* (if applicable). The Medical Director will also review the associated medical/clinical policy as applicable.
2. The Medical Director, or designee, takes into consideration all documentation pertaining to the case, including any factors that may require special consideration such as:
 - Age, co-morbidities, complications, progress of treatment, psychosocial issues, home environment, support structure, acute vs. chronic condition, and/or life-threatening illness.
 - Local delivery system including availability and coverage of benefits for skilled nursing facilities, sub-acute care facilities, or home care in the local service area and/or the local hospitals’ ability to provide all recommended services within the estimated length of stay
3. If additional and/or clarifying information is needed due to insufficient or conflicting information obtained during the Level I review, the Coordinated Cares’ Medical Director may discuss the case with the managing physician. Only the treating physician/provider may participate in this peer-to-peer discussion.
4. The Medical Director may also consult with a board-certified participating physician from the appropriate specialty, if needed for additional or clarifying information. When there is no contracted specialist available, the Medical Director may contact a specialist in the community for input. For Behavioral Health determinations the request must be reviewed by a physician board-certified or board eligible in General Psychiatry or Child Psychiatry, a licensed doctoral level psychologist, a physician board certified or board eligible in Addiction Medicine/subspecialty in Addiction Psychiatry by ASAM or a pharmacist as appropriate. Specifically for inpatient psychiatric treatment the request must be reviewed by a physician board certified or board eligible in General Psychiatry and Inpatient SUD treatment requests must be reviewed by a physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry or by ASAM.

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5. The Medical Director makes the determination to approve, reduce, or deny the service or level of care requested.

6. The Medical Director and/or Coordinated Care UM designee enters all information and rationale related to the determination in the TruCare authorization system *Advisor Review* and *Notification* sections, to include:
 - *Date of Review*
 - *Reviewed By*
 - *Reviewer Specialty*
 - *Review Reason*
 - *Peer to Peer* contact (PST date/time) by the Medical Director
 - How Received Information
 - *Criteria Source*
 - *Clinical Review Notes*
 - *Rationale* for Medical Director Determination
 - Date and time of oral notification to requesting provider/servicing facility
 - Date and time of written notification to requesting provider/servicing facility/member

7. If the Medical Director *approves* the authorization, he/she completes the *Advisor Review* determination and the TruCare workflow task assigns the UM designee with completing the authorization *Determination* and *Notification*.

8. The Medical Director may reduce the level of care or service requested as outlined in policy CC.UM.02.02, *Leveling of Care*.

9. If after review of all required information, the Medical Director decides to *deny* the request, a standard letter is sent from the clinical authorization system which includes a detailed paragraph explaining the Medical Director's reason(s) for the denial and the process for an appeal (see UM.07, *Adverse Determination (Denial) Letters*).
 - Only the Medical Director or other designated qualified practitioner can make a denial decision.
 - The Medical Director may work with Coordinated Care UM designee to draft the denial letter.
 - The letter will include the name of the Medical Director and indicate their unique electronic signature is on file.
 - The UM designee orally notifies the managing physician and facility of the Medical Director's decision and sends out the denial letter

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within the timeframes as noted in the *Timeliness of UM Decisions and Notifications* policy, UM.05.

10. **Exception to the Rule:** In cases involving a request for a non-covered health care service the Medical Director will review the request under the exception to rule process (ETR). All ETR requests are reviewed first by the Supervisor for Prior Authorization as the designee of the Medical Director. The Medical Director has final authority to approve or deny a request for exception to rule. The Medical Director may approve the request for an ETR if the following criteria are met.

- The item or service(s) for which an exception is requested falls within accepted standards and precepts of good medical practice;
- The member's clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s).
- The client's health care professional certifies that medical treatment or items of service which are covered under the client's medical assistance program and which, under accepted standards of medical practice, are indicated as appropriate for the treatment of the illness or condition, have been found to be:
 - i. Medically ineffective in the treatment of the client's condition; or
 - ii. Inappropriate for that specific client.
- The request service or item is not excluded under State statute.
- The request for the services or item is made no more than 90 days from the administrative denial for the non-covered code.
 - i. A member may request an appeal and an exception to rule simultaneously. The request for appeal does not change the timeframe for the request for ETR. The ETR request must be made no later than 90 days from the date of denial.
- The requested clinical information is provided within 30 days from the date of request.
- For AHFC, the UM Nurse would coordinate with the Coordinated Care FC Health Care Coordinator on any requests for ETR. The Health Care Coordinator will coordinate this information with Children's Administration (CA) and Foster Well-Being (FWB) units.

11. Medical Director documents the Advisor Review and completes the *Advisor Decision* field in TruCare to indicate reason for approval or denial.

The Medical Director may also approve services or settings that are in lieu of services that are not covered by the State Plan under the following circumstances:

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- The alternative service or setting is medically appropriate and cost effective substitute for the service or setting
- The member is not required to use the alternative service or setting
- The services are authorized

Timeliness for determinations follow the requirements in WAC 182-501-0160; all standard timeframes for notifications apply. Members do not have a right to a fair hearing on exception to rule decisions.

Table 1: InterQual/Corporate Policy Variances

Interqual Subset/Policy	Variance
Negative Pressure Wound Therapy Pump	For initial application the following additional diagnosis may be used to approve the equipment provided all other InterQual criteria are met: <ul style="list-style-type: none"> • Seroma • Wound dehiscence
NIPPV	A home sleep study will qualify in lieu of a facility attended study CPAP tolerance during the sleep study does not need to be assessed
Acute Coronary Syndrome	Under Intervention, Antiplatelet (includes PO), administered or contraindicated. ASA can be used in lieu of specified Antiplatelet medication.
C-Diff	Under Failed OP anti-infective treatment, you can select one of the criteria and document that many of our members do not seek OP care.
Laboring > 2 days	Induction of Labor <= to 2 days OR Term Labor with contractions <= to 2 days can be used for <= 3 days instead.
Colony-Stimulating Factors - CP.PHAR.26 - Neulasta	If members meets all other criteria may approve even if criteria point; Neulasta will not be given between 14 days before an 24 hours after chemo, is not met
All Acute Subsets	If IV fluids are running at 100ml/hr or more weight does not need to be documented and the review can be approved if all other criteria are met.
All Acute Subsets- Critical/Intermediate Level of care	If member meets all criteria points but respiratory interventions q1-2 hours while on NIPPV or mechanical intervention at the critical/intermediate level of care the review can

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	be approved
Elective Inpatient Surgical Prior Authorizations	If a requested surgery is on the inpatient list in InterQual no other criteria need to be met when <i>prior</i> authorizing an elective surgery unless the procedure requires a separate clinical review.
All Acute Subsets- Critical/Intermediate Level of care	If member in critical/intermediate level of care on continuous IV drip and meets all other criteria points “administration continuous and monitoring q1-q2hr” does not have been documented and the review can be approved
Elective Cardiac Stenting	% of vessel occlusion does not need to be documented if the provider is requesting a potential stent at the same time as the angiogram/cardiac cath provided all other criteria are met
Palliative Care	If member meets subacute care pre-admission review based on palliative care/hospice criteria, we will automatically approve one week of care. This will allow time for transition, clarification of care needs, and decision making about hospice enrollment. Subsequently review and approval will be based on subacute criteria.
Psychological Testing	If member meets InterQual Criteria for psychological testing the review can be approved for up to 8 units.
Program Assertive Community Treatment (PACT)	Upon notification of PACT services authorization will be built and approved for one year of services.

Predetermination Request

A request from a member, provider or facility to determine if a service is a benefit for the plan. A pre-determination request is processed within 5 calendar days from the date of request. Information included in the Predetermination notice is as follows:

- If the service is a covered benefit
- If a prior authorization is required
- If any pre-service requirements apply
- If a medical necessity review will be performed after the service has been delivered
 - The clinical review criteria used to evaluate the request
 - Any required documentation

The notice advises that the pre-determination request is not a prior authorization and does not guarantee services will be covered.

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<p>REFERENCES / ASSOCIATED PROCESSES</p> <p>WA.UM.01 - Utilization Management Program Description WA.UM.02 - Clinical Decision Criteria and Application WA.UM.04 - Appropriate UM Professionals WA.UM.05 - Timeliness of UM Decisions and Notifications WA.UM.07 - Adverse Determination (Denial) Letters NCQA Health Plan Standards and Guidelines</p>

<p>ATTACHMENTS</p>

<p>DEFINITIONS:</p> <p>Medical Director: As used in this policy is a collective term for the Chief Medical Officer, Chief Medical Director or Medical Director.</p> <p>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 CC.UM.04 Appropriate UM Professionals for UM department staff titles, qualifications and reporting structure.</p> <p>Exception to Rule: Request for a health care service that is not covered under Medicaid Benefits.</p> <p>Limitation Extension: A request to exceed the stated limits for nondurable medical equipment or medical supplies.</p>

REVISION LOG	DATE
Removed network steerage language, addressed in another policy. Added in language for ETR process for clarity around timeframes and process.	1/5/2015
Added InterQual variance table	10/14/2015
Add additional InterQual variances	1/21/2016
Added Neulasta variance to variance table per clinical policy committee update	3/30/2016
Added additional IQ variances for surgery, elective cardiac stenting, and post-surgical wound per CMD	7/6/2016
Added additional Variance for palliative care	9/29/2016
Updated ETR section to remove reference to previous CM process, added in ASAM criteria.	4/3/2017
Updated to remove IQ variance for Wound Vacs for Post-Surgical wounds due to InterQual update to include this criteria.	4/12/2017
Update Variance Table to include increase in units for Psychological Testing	6/16/2017
Added BH reviewer language from FIMC contract	7/13/2017
Added additional language to reflect coverage of services in lieu of per AHMC contract amendment	7/25/2017
Added verbiage for completion of Advisor Decision and requirement for Level II review for >24 hour inpatient stay for OBS conversion appropriateness	3/17/18
Added variance for prior authorizations of elective inpatient surgical admissions	4/2/2018
Added language for pre-determination request notices and processes.	4/17/2018

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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 Medical Management: Approval on File