WORK PROCESS

DEPARTMENT: Medical Management	**DOCUMENT NAME**: Medical Necessity Review
PAGE: 1 of 7	**REPLACES:**
APPROVED DATE: 9/11	**RETIRED:**
EFFECTIVE DATE: 1/12, 2/15, 12/15	**REVIEWED/REVISED:** 09/13, 4/14, 2/15, 6/15, 9/15, 4/17, 5/17, 5/18, 5/19, 4/20**, 02/21**
PRODUCT TYPE: All	**REFERENCE NUMBER:** LA.UM.02.01

SCOPE:
Louisiana Healthcare Connections (Plan) 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.

WORK PROCESS:

Level I Review
The appropriate Plan UM Clinical Reviewer (CR) reviews all relevant information including the member's current condition, pertinent medical history, psychosocial findings, and social determinants of health against appropriate medical necessity criteria 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® or American Society of Addiction Medicine (ASAM) criteria and no local criteria or policy exists
    - Are potentially experimental or are new technology/procedures

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

2. If a Level I review is indicated, the UM CR 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® or ASAM Criteria, 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 *LA.UM.05 Timeliness of UM Decisions and Notifications* policy.
    - Clinical information *meets criteria*: when the request meets the appropriate clinical criteria set or other predetermined criteria, the UM CR approves the request, enters an approved authorization into the

clinical documentation system and provides notification to the appropriate provider. ~~***Note:***~~

- Some services will be reviewed using Interqual®/Policy 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 Advisor Variance attachment.
- **Determinations and provider notifications are made according to the expediency of the case as described in the LA.UM.05 policy Timeliness of UM Decisions and Notifications**

- Clinical information is *insufficient* ***to make a decision*****:** see *LA.UM.05 Timeliness of UM Decisions and Notifications* policy **for information on requesting additional clinical information.**
- Clinical information *does not meet* criteria*:* when the information does not meet the appropriate clinical criteria or guideline, the UM CR informs the requesting party of the need for additional information to support medical necessity. If the requesting provider is unable to provide any additional information or if the additional information provided does not meet the appropriate clinical criteria the UM CR will document in the rationale section the reason for the referral including why the request is not meeting medical necessity. The UM CR will then submit for a Level II Review by creating a *UM Advisor Review* Task in the clinical documentation system, notifying the Medical Advisor of the need for a Level II Review.
  - When referring for Level II Review, the Plan UM CR creates a *UM Advisor Review* Task in the clinical documentation system and assigns it to the appropriate queue in TruCare. The *Rationale* should outline the reason for the referral to the Medical Advisor, including why the request is not meeting the standard medical necessity review criteria.
  - **The Review note section should contain sufficient information for the advisor to complete the review efficiently. Such information includes the following:**
    - **Service being requested, dates of service, level of care, etc.**
    - **Provider name, specialty, and contact information**
    - **Criteria, subset, or guidelines/policy used, or statement that none exists**
    - **Specific criteria met or not met and information used for each criteria**

- **Information missing from the record**
- **Attempts at gathering additional information including who was contacted and how many contacts were made**

Level II Review

Only a Medical Advisor (or other appropriate health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease) can determine service authorization request denials or authorize a service in an amount, duration or scope that is less than requested. (Emergency RFP 8.1.15)

The Plan shall not deny continuation of higher level services (e.g., inpatient hospital) for failure to meet medical necessity unless the plan can provide the service through an in-network or out-of-network provider for a lower level of care. (Emergency RFP 8.4.3)

1. The Medical Advisor, or other appropriate health care professional, reviews the UM CR's case/event notes and/or the UM CR's InterQual® or ASAM criteria review (if applicable). The Medical Advisor will also review the associated or medical/clinical policy as applicable.
2. The Medical Advisor, or CR, 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 Plan Medical Advisor may discuss the case with the managing physician. Only the treating physician/provider may participate in this peer-to-peer discussion.
4. The Medical Advisor may also consult with a board-certified participating physician from the appropriate specialty, if needed for additional or clarifying information. When there is no network specialist available, the Medical Advisor may contact a non-participating specialist in the community for input

or refer the case to the Corporate Medical Management department to facilitate review through external review group.

5. The Medical Advisor makes the determination to approve, reduce, or deny the service or level of care requested.
6. The Medical Advisor enters all information and rationale related to the determination in the clinical documentation system as an *Advisor Review* to include:
    - Date of Review
    - Reviewed By
    - Reviewer Specialty
    - Review Reason
    - Peer to Peer contact by the Medical Advisor (if applicable)
    - Criteria Source
    - Clinical Review Notes **to support review summary** and include any consultants contacted by the Medical Advisor
    - Rationale for Medical Advisor Determination
    - Date and time of oral notification to requesting provider (if applicable)
    - Date and time of written notification to requesting provider (if applicable)
7. **~~If t~~**The Medical Advisor **~~approves the authorization, he/she returns the case via~~then selects Next Task to send a ~~the system's U~~ *UM Evaluate Advisor Review*** Task to the **~~UM CR~~Correspondence Unit (CU)** to complete the **~~authorization~~determination**.
8. The Medical Advisor may reduce the level of care or service requested as outlined in policy *LA.UM.02.02, Leveling of Care*.
9. If after review of all required information, the Medical Advisor decides to *deny* the request, a standard notice of action/denial letter is sent which includes a detailed explanation of the Medical Advisor's reason(s) for the denial and the process for an appeal (see *LA.UM.07, Adverse Determination (Denial) Notices*).
    - Only the Medical Advisor or other designated qualified practitioner can make a denial decision.
    - The Medical Advisor may work with the Plan UM CR to draft the denial letter.
    - The letter will have the signature of the Plan Medical Advisor making the adverse determination.
    - The Plan **~~UM CR~~CU nurse** orally notifies the requesting provider and/or facility of the Medical Advisor's decision and sends out the denial letter within the timeframes as noted in the *LA.UM.05 Timeliness of UM Decisions and Notifications* policy.

10. In cases ~~**involving**~~**involving** a request for service by an out-of-network provider or facility, the Plan will not only determine medical necessity of the service but must also authorize use of the out-of-network provider.

The decision to authorize use of an out-of-network provider will be based on continuity of care, availability and location of an in-network provider of the same specialty and expertise, and complexity of the case. The Plan may use pre-approved protocols to direct staff on the use of out-of-network providers**.** ~~**The decision to authorize use of an out-of-network provider will be based on continuity of care, availability and location of an in-network provider of the same specialty and expertise, and complexity of the case. The Plan may use pre-approved protocols to direct staff on the use of out-of-network providers.**~~

- If use of an out-of-network provider is *approved*, the Plan UM CR will inform the provider that they will be paid at an agreed upon amount based on the Louisiana Medicaid Program Fee Schedule.
- If the Medical Advisor does *not approve* the use of the out-of-network provider, the ~~**UM CR**~~**CU nurse** notifies the requesting party of the denial for out-of-network services and **the UM CR** works with them to facilitate transfer of the patient's care to an in-network provider and/or facility. The Plan Medical Advisor may also be involved in the coordination of the transfer. If the managing physician does not transfer the patient, the denial process is initiated as stated in section 9 above.

REFERENCES / ASSOCIATED PROCESSES
MCO Contract –Section 8 Utilization Management
Current NCQA Health Plan Standards and Guidelines
CC.UM.02.01
LA.UM.01 - Utilization Management Program Description
LA.UM.02 - Clinical Decision Criteria and Application
LA.UM.04 - Appropriate UM Professionals
LA.UM.05 - Timeliness of UM Decisions and Notifications
LA.UM.07 - Adverse Determination (Denial) Letters
CDS Training Manual

ATTACHMENTS

DEFINITIONS:
Medical Advisor: As used in this policy is a collective term for the Vice President of Medical Affairs (VPMA), Medical Director or Associate Medical Director.
UM CR: 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

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Appropriate UM Professionals for UM department staff titles, qualifications and reporting structure.

REVISION LOG	**DATE**
WORK PROCESS: **Level I Review**	09/12
Removed from document: • For Medicare Advantage, are not included in the National Coverage Decision (NCD) database/manual and no previous Local Coverage Decision (LCD) has been made • Requested by an out-of-network or out-of-state provider office or facility ***Level II Review*** **Removed from document:** 10. In cases involving a request for service by an out-of-network provider or facility, the Medical Director will not only determine medical necessity of the service but must also authorize use of the out-of-network provider. The decision to authorize use of an out-of-network provider will be based on continuity of care, availability and location of an in-network provider of the same specialty and expertise, and complexity of the case. The Plan may use pre-approved protocols to direct staff on the use of out-of-network providers. • If use of an out-of-network provider is *approved*, the Plan UM designee will inform the provider that they will be paid at 100% of the Louisiana Medicaid Program Fee Schedule. • If the Medical Director does *not approve* the use of the out-of-network provider, the UM designee notifies the requesting party of the denial for out-of-network services and works with them to facilitate transfer of the patient's care to an in-network provider and/or facility. The Plan Medical Director may also be involved in the coordination of the transfer. If the managing physician does not transfer the patient, the denial process is initiated as stated in section 9 above.	09/12 09/12

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Removed NCD, LCD from level 1 and 2. Updated NCQA date.	4/2014
Changed verbiage for TruCare notes and LA P&P references. Added ® mark to any InterQual references LA Procurement 2015 Policy Update	11/2014
Corrected policy reference numbers. Updated NCQA reference	6/2015
Added CCL.240 to references and purpose	9/2015
Grammatical changes only	4/2017
Added Advisor Variance attachment Updated Advisor Review and Notification section	5/2017
No Revisions	5/2018
Removed information no longer relevant to the process. Changed UM Designee to UM Clinical Reviewer (CR). Changed Medical Director to Medical Advisor for consistency. Removed definitions that were no longer relevant. Updated RFP references.	5/2019
Updated relevant clinical information Added ASAM criteria Changed MCO to plan Removed duplicate statement Grammatical changes Changed RFP to Emergency RFP	4/2020
Format changes **Added the reference to determination and notification timeliness** **Added requesting additional information if the criteria does not meet** **Added what should be included in the Review Note section** **Updated the Advisor documentation and processing the advisor determination** **Grammatical changes** **Added Corporate policy reference**	**02/2021**

POLICY AND PROCEDURE APPROVAL

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

~~Sr. Director, Population Health Electronic Signature on File~~

~~Chief Medical Officer Electronic Signature on File~~