POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Monitoring Utilization
PAGE: 1 of 4	**REPLACES DOCUMENT:**
APPROVED DATE: 9/11	**RETIRED:**
EFFECTIVE DATE: 1/12, 2/1/2015	**REVIEWED/REVISED: 09/13, 6/14, 11/14, 4/15; 5/16, 5/17, 5/18, 4/19, 2/20**
PRODUCT TYPE: Medicaid	**REFERENCE NUMBER:** LA.UM.01.03

SCOPE:
Louisiana Healthcare Connections (Plan) Medical Management Department

PURPOSE:
The Plan monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under-or overutilization which may impact health care services, coordination of care and/or appropriate use of services and resources.

POLICY:
The Plan monitors, reviews, and analyzes utilization data at least annually. Corrective action is taken when outliers are identified, and the results of the corrective action are re-evaluated within six months of implementation. Issues not resolved in the time frame determined are forwarded to the Medical Management Committee (MMC), or Credentialing or Peer Review Committee for individual provider issues, as appropriate for investigation and resolution.

All clinical documentation including care plans, ICT notes, assessments and communications is housed in TruCare, our medical management documentation system.

PROCEDURE:
1. The Plan chooses a minimum of five (5) data types to be used for analysis. Data can include contracted or non-contracted providers. Data indicators may include, but are not limited to:
   - Length of stay (LOS) data
   - Inpatient acute care days or discharges
   - Unplanned readmissions
   - Rates of selected procedures including but not limited to: non-obstetric dilatation and curretage, hysterectomy, cholecystectomy, laminectomy/diskectomy, angioplasty, cardiac catheterization, coronary artery bypass graft, prostatectomy, reduction of fracture of femur, total hip replacement, totat knee replacement, partial excision of large intestine, carotid endarterectomy, electroconvulsive therapy. (Any number of selected procedures qualifies as only one of the five data types necessary for analysis.)
   - Member survey or CAHPS results

- Ambulatory visit rates
- Rates for referral to specialists
- Rates of use of pharmaceuticals (data provided by Envolve Pharmacy Solutions)
- Rates of referral to ancillary providers such as laboratory and radiology service providers
- Member complaints and appeals related to medical service denials
- Rates of early and periodic screening diagnosis and treatment (EPSDT) services.

2. Thresholds are set and/or trends are evaluated by the MMC or Quality Assurance and Performance Improvement Committee (QAPIC) to identify under-and overutilization for the chosen data types.

3. The Medical Director or his/her designee reviews the data at least annually, **including behaviroal health data**, against the established threshold for signs of under- **and** ~~or~~ overutilization **for the chosen data types**.

4. When under-or overutilization is identified, further qualitative analysis is conducted, including analysis by product and provider or practice site, to determine potential reasons for the results and to formulate effective interventions addressing the specific circumstances indicated in the analysis.

5. If analysis identifies an issue which requires intervention, a corrective action plan (CAP) is developed within thirty (30) days, for approval at the next scheduled MMC meeting. It is the responsibility of the Medical Director to ensure the CAP is initiated within thirty (30) days of MMC approval.

6. Six (6) months after implementation of the CAP, the data is analyzed to determine the impact.

7. If the issue is unresolved, the CAP is reassessed and revised and a date for re-evaluation is determined. Dependent on the issue and the need for meaningful improvement/data, the MMC may decide that the CAP should be extended.

8. For issues involving specific providers, if at the end of a time extension the issue remains unresolved, the Medical Director will prepare a written summary for review by the Peer Review Committee.

9. The Peer Review Committee will consider the issue and make its recommendation at the next scheduled meeting or within fifteen (15) days of receipt of the Medical Director's summary if there is evidence of under-or over-utilization that could seriously affect care received by members.

REFERENCES:
Code of Federal Regulation - CFR 422.152(b)(2)
LA MCO RFP Amendment 11– Section 8 Utilization Management
Current NCQA Health Plan Standards and Guideline

ATTACHMENTS:

DEFINITIONS:

REVISION LOG:	**DATE**
US Script added as pharmacy vendor	8/13
Changed UM to MM to recognize the name change of the committee	6/14
LA Procurement 2015 Policy Update, changed QIC to QAPIC	11/2014
Updated NCQA date to current	4/15
Corrected "MM Committee" to "MMC" as referenced	5/16
No changes	5/17
Removed Attachment named List of UM Policies	5/18
Grammatical Changes. Changed US Script to Envolve Pharmacy Solutions. Revised MCO Contract to LA MCO RFP Amendment 11 in References.	4/19
Changed date of revision, **Added verbiage: All clinical documentation including care plans, ICT notes, assessments and communications is housed in TruCare, our medical management documentation system.** **Edited: including behaviroal health data, against the established threshold for signs of under- and overutilization for the chosen data types.**	**2/2020**

POLICY AND PROCEDURE APPROVAL

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

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~~VP Medical Management: _____Electronic Signature on File_____~~
~~Sr. VP Medical Affairs: _____Electronic Signature on File_____~~

Sr. VP, Population Health: Electronic Signature on File
Chief Medical Officer: Electronic Signature on File