9 - Utilization Management

Health Plan of Nevada (HPN) defines Utilization Management as the process of evaluation and determination for appropriateness of health care services. Listed below are just a few of the functions performed by our Utilization Management System:

- Prior authorization (pre-service determinations)
- Admission, health care services and after-hours concerns (Access Center)
- 24/7 Advice Nurse
- Concurrent review
- Denials, and appeals process

9.1 Prior Authorization (Pre-service Determinations)

Definition: Pre-service determinations involve cases or services that must be approved, in whole or part, in advance to members obtaining medical care or services. Prior authorization and precertification are pre-service claim determinations.

Prior authorization is the assessment and screening of requests for health care services from providers. The screening determines if the treatment is compatible with the diagnosis, if the member has benefits for the services requested, and if the requested services are to be provided by a participating provider in an appropriate setting. This allows members' access to cost-effective, specialized care, necessary for their medical conditions, through their primary care physician.

The health plan's Prior Authorization Department is responsible for the processes of notification and prior authorization with clinical review for medical necessity and final determination of selected medical procedures, treatments, services, or equipment.

9.2 Notification

Specialty-specific procedures, treatments and services must be processed through the Prior Authorization Department. However, they do not require review by licensed personnel. The notification process includes checking eligibility, benefit coverage, and determination of appropriate site and provider. These requests are built into the computer system for provider payment purposes only. Services are to be done by designated providers and facilities. If not, prior authorization with clinical review by licensed personnel will be required.

9.3 Medical Necessity Determination

The prior authorization process includes checking member eligibility and benefit coverage, clinical review to determine medical necessity and determination of appropriate site and provider. Clinical review involves gathering all relevant clinical information that supports determinations of medical necessity of requests for medical treatment or services.

Nationally accepted guideline criteria, including, but not limited to; evidence based clinical criteria, locally and nationally developed health plan criteria, and CMS guidelines and regulations are applied based on the needs of individual members and the local delivery systems. The UM criteria utilized in rendering a decision is available to providers on our web site at

healthplanofnevada.com/provider, or upon request by contacting the Prior Authorization Department at **(702) 243-8499 or (888) 224-4036**.

HPN also utilizes consultants from appropriate specialty areas. Consultants representing the specialties of cardiology, gastroenterology, hematology, infectious disease, nephrology, neurology, orthopedics, pediatrics, urology, etc. are used for review of individual cases when appropriate. All consultants are either board certified by one of the American Boards of Medical Specialties or other specialty certification appropriate to the practitioner's discipline.

Prior authorization staff has the authority to approve all situations that meet criteria and to refer potential denials or questionable cases to a medical director for review. Only a medical director may issue a prior authorization denial for decisions involving medical necessity review. Notifications of denial with appeal rights are given to members in writing and to providers verbally (Expedited cases), via the Online Provider Center, and in writing.

The purpose of the prior authorization function is to ensure that every HPN member receives quality care delivered to promote wellness, through utilization of appropriate resources, in the most appropriate setting and in the most cost-effective manner. This is achieved through the evaluation and determination of the appropriateness of the member's and practitioner's use of medical resources prior to services being rendered and the provision of any needed assistance to health care providers and/or the member to ensure appropriate use of resources.

9.4 Services That Require Prior Authorization

Services that require prior authorization with clinical review include, but are not limited to:

- All out-of-area services and non-plan provider services
- Elective admissions or extensions of stay to an inpatient facility, skilled nursing facility, or acute rehabilitation facility
- Selected outpatient facility-based procedures
- Diagnostic and therapeutic services, including but not limited to: Complex radiology such as level II OB Ultrasounds, CT, CTA, MRI, MRA, PET and SPECT; intensity modulated radiotherapy (IMRT)
- Anesthesia services: anesthesia for dental procedures; select pain management procedures performed in the office setting
- Home health care services including IV therapy
- Elective mental health and substance use services
- Prosthetic and orthotic devices, $750 or over, or services outside of capitation agreements
- Durable medical equipment purchases or rentals, $750 or over (unless under capitation with HPN)
- Courses of treatment, which may include, but are not limited to: allergy testing or treatment, home health care, physiotherapy or manual manipulation, rehabilitation services (physical, speech or occupational therapies), cardiac rehabilitation and pulmonary rehabilitation
- Selected injectable and infused medications
- Transplants
- Sleep disorder studies performed in an office setting
- Bariatric surgery
- Gender affirming care
- Select genetic tests

- In-office services over $1500 billed charges (per line item)
- ABA therapy after max benefit reached

Note: Prior authorization of urgently/emergently needed care is NOT required. However, notification of such services is expected.

A prior authorization request may be initiated by a licensed facility, physician, or other ordering provider, patient or responsible patient representative including a family member. Patient prior authorization requests should be submitted by the provider using the appropriate prior authorization request form.

Step Therapy Exception Requests

Step therapy exception requests for members can be submitted on the Online Provider Center, or faxed to (800) 282-8845. Exception requests are to be submitted as **STAT** through phone, fax, or web portal. The request should include the **Exception Request Form** (section 23), along with the following required clinical information:

- Progress notes
- Laboratory results
- Radiology results
- Previous medications
- Other factors impacting the plan of care

Processing delays may occur if the requestor (e.g. rendering provider, ordering provider, or member) does not have the appropriate documentation of medical necessity.

Requests are reviewed by registered nurses, pharmacists, and board-certified oncologists, and will be processed in 24 hours for a STAT and 2 days for a routine request. Requests without a decision within the allotted timeframe will be considered automatically approved.

Biomarker Requests

Biomarker requests for members can be submitted on the Online Provider Center, faxed to (800) 282-8845 or (702) 304-7411 or phoned into (702) 240-8933. The requests can be submitted either STAT or routine and should include the following required clinical information:

- Progress notes
- Laboratory results
- Radiology results
- Previous medications
- Relevant medical personal / family history
- Other factors impacting the plan of care

Processing delays may occur if the requestor (e.g. rendering provider, ordering provider, or member) does not have the appropriate documentation of medical necessity.

Requests are reviewed by a registered nurse or Medical Director and will be processed in 24 hours for a STAT and 72 hours for a routine request for cases with a cancer related diagnosis.

9.5 Prior Authorization Timeframes

Routine Requests

Routine requests are reviewed with a determination rendered within the timeframes required by the Department of Labor, National Committee for Quality Assurance (NCQA), Centers for Medicare and Medicaid Services (CMS) and Nevada Division of Healthcare Financing and Policy-Managed Care Division**.** If additional clinical information is needed to render a decision, the provider will be contacted by phone and/or fax to supply the necessary information.

The UM criteria that is utilized to render a decision is available to providers on our web site www.healthplanofnevada.com/Provider or providers may request a copy by contacting the prior authorization department at **(702) 243-8499 or (888) 224-4036**.

Urgent (Expedited) Requests

Urgent (expedited) requests are for those services, which are related to urgent medical care conditions that have the potential to become an emergency in the absence of treatment.

Urgent (expedited) requests are reviewed, with a determination rendered, and provider notified within the requirements of the Department of Labor, NCQA, the Centers for Medicare and Medicaid Services (CMS) and Nevada Division of Healthcare Financing and Policy- Managed Care Division which is 72 hours, although we do strive to provide the determination within one calendar day.

9.6 How to Obtain Prior Authorization for Services

We are committed to providing exceptional service to our members and providers. Our Online Provider Center offers benefit and claim information, referral and prior authorization submissions, and more!

All Health Plan of Nevada Inc, and Sierra Health and Life Insurance Company providers are required to submit all routine prior authorization requests online using the *Online Provider Center*. Stat/urgent prior authorization request can be submitted through the online center as well. Stat/urgent requests can also be called or faxed to the UM Department at the numbers below.

- Website: Online Provider Center
- Fax:

Las Vegas area	**(702) 304-7411**
Toll free	**(800) 282-8845**

- Phone:

Las Vegas area	**(702) 243-8499**
Toll free	**(888) 224-4036**

Note: UM Representatives are available Monday – Friday from 8:00 a.m. - 5: 00 p.m. (PST) to assist you.

Note: If your group is not currently set up with an Online Provider Center Administrator account you may submit a request online via the Online Provider Center website by clicking on “Register” and following the on-screen instructions. Online Provider Center tutorials are available online

through the HPN website. Provider Services is available to answer any specific questions you may have regarding the application.

It is the responsibility of the requesting provider to provide pertinent case-specific clinical information to support the request for medical services or treatment.

Hospital Admit Notifications and Utilization Review

All hospital admissions (including elective and emergent) require notification within 24 hours of admission. This notification can be submitted using one of the methods listed below.

Telephone Numbers for Admission Notification:	
Admit Notification	**(702) 242-7770**
Toll Free	**(800) 365-9687**
Fax Numbers	**(702) 667-4623**
	(800) 645-6941

Telephone Numbers for Concurrent and Utilization Review:	
Concurrent review	**(702) 797-2100**
Toll free	**(877) 487-6659**
Utilization Review (out of area)	**(800) 216-7525**

Business Hours: Monday – Friday, 8:00 a.m. – 5:00 p.m. PST

For hospital admission notification and utilization review **after hours and weekends,** contact the Access Center at:

Telephone Numbers:	
Las Vegas area	**(702) 242-7330**
Outside Las Vegas area	**(800) 288-2264**
Fax	**(702) 242-7025**

Please check the Online Provider Center regularly for UM notes and decisions on your prior authorization requests and admission notifications. The UM team documents throughout the day. Requesting and servicing providers can access the Online Provider Center to view case notes related to requests prior to receiving formal written or verbal communication.

9.7 Patient and Provider Access Center (After hours admissions, health care services and 24/7 Advice Nurse)

Understanding the importance of quick and accurate information, the HPN admission, health care services and 24/7 Advice Nurse have joined together to develop a department specifically designed to assist members, physicians and all other providers with health care information and services.

This 24-hour information and care management system provides access to a “one-stop-shop” staffed with specially trained registered nurse professionals who work to meet the service and care needs of members and providers. As liaisons, registered nurse staff members are actively involved in coordinating care by assisting with admissions, healthcare services and health care triage advice to HPN members.

Staff assists with urgent/emergent hospital admissions and after-hours prior authorization for urgent outpatient services, patient transfers and referrals for other health care services such as home health, hospice, case management, durable medical equipment and infusion therapy.

The 24/7 Advice Nurse program provides quick, comprehensive solutions to member's health concerns no matter the time of day or night. Specially trained registered nurses are available 24 hours a day to offer simple, accurate advice regarding specific symptoms, illnesses or injuries or to simply answer members' questions about a particular health concern. If a member does need to see a physician or visit an urgent care clinic, the nurse will direct the member to an urgent care clinic or assist with scheduling an appointment.

For information and assistance from the Access Center or 24/7 Advice Nurse, call or fax:

Telephone Numbers:	
Las Vegas area	**(702) 242-7330**
Toll free	**(800) 288-2264**
Fax Numbers:	
Las Vegas area	**(702) 242 7025**

Note: Prior authorization is **NOT** required for emergency procedures or services for screening and stabilization in cases where a prudent layperson, acting reasonably, based on presenting symptoms, would have believed that an emergency existed.

9.8 Inpatient Concurrent Review

At HPN, the Continuity of Care Department provides initial and ongoing assessments of members receiving care in the inpatient setting to ensure that the member is receiving the appropriate level of care based on medical necessity. To accomplish this task HPN provides hospitalists, case managers and medical director leadership to perform daily case reviews telephonically and/or on-site for all members hospitalized in an acute care facility, a rehabilitation facility or a sub-acute or skilled facility. The functions of Continuity of Care include review of medical status for appropriate length of stay and level of care, discharge planning, case management, and referrals for ongoing post-hospital care. Nationally accepted guidelines and criteria are used to make medical necessity determinations.

Only a medical director issues denials for continued stay. Notifications of denial with appeal rights are given to members in writing and to providers verbally as well as in writing.

HPN's Continuity of Care Department is available 7 days a week from 8:00 a.m. – 5:00 p.m. (Pacific Standard Time) and can be reached at **(702) 797-2100**.

9.9 Transition of Care (TOC) / Continuity of Care (COC) Process

For information regarding the health plan's process for Transition of Care or Continuity of Care, please refer to the TOC / COC Form located in **Section 23 Frequently Used Forms**.

9.10 Denial and Appeal Process (Commercial Plans)

Denial

A denial, or adverse determination, is the determination by a plan medical director that the services requested are not medically necessary after review of the clinical information submitted with the request for services. Only a licensed physician can make utilization management denial decisions based on medical necessity. Prior authorization staff communicates the denial verbally and through written correspondence to the requesting provider. The provider is informed, at that time, of their right to physician-to-physician communication regarding the impending denial, as well as the appeal process. During the physician-to-physician communication, the requesting physician should provide NEW or ADDITIONAL clinical information.

No financial incentives or other types of compensation are given to UM decision-makers for the reduction or denial of services or care. Decision-making is based on appropriateness of care (medical necessity of the service, appropriateness of providers of care), eligibility of the member, benefit coverage for the service, the individual needs of the member and the availability of services within the local healthcare delivery network.

Appeal

A formal appeal process is set into action when requested by a member, his/her designee(s) or his/her provider(s). These requests are evaluated by a medical director or a physician peer reviewer. This physician will be in the same or similar specialty that usually provides the service being requested and will not have been involved in the initial decision to deny the requested service. On behalf of a member, a provider can appeal a denial for a specific procedure, treatment or service by contacting the Prior Authorization department either by phone, mail or fax. Member requests to appeal a denial for a specific procedure, treatment or service are received in the Member Services department.

For appeals, please call: **(702) 243-8499 or (888) 224-4036**. Additional directions will be outlined in the denial letter.

Members can request an expedited (immediate) appeal review by the health plan for continued stay denials, and denials for services that, if not received immediately, would threaten life or limb.

9.11 Medicaid Action, Notice of Action and Appeals

Please see Section 8.10 for Medicaid Guidelines

9.12 Retrospective (Post-Service) Review

Retrospective (post-service) review is the process of assessing the appropriateness of the medical care, services, treatments and procedures, and the providers of that care, after the care has been rendered. A review is conducted of the members' medical record(s), including admitting diagnosis and presenting symptoms, as applicable.

Retrospective (post-service) review is required for:

- Emergency admissions to out-of-area or out-of-plan facilities
- Outpatient and emergency room care received in non-contracted facilities

- Other care and services received by members when the provider of care will not cooperate with health plan review procedures
- Other unauthorized care

Medical Adjudication Department nurses, who are a part of the Claims Department, conduct all reviews using nationally recognized evidence based clinical criteria or health plan medical policies. This process can take up to 30 days. Only a medical director can issue denial decisions based on medical necessity of services.