Policy Title: Utilization Review Criteria

Department: Utilization Management (UM)

Policy Number: UM 102

Rev. Date(s): 08/02/2019, 05/04/2022

Effective Date: 05/01/2015

Product Lines:	☑ All/Other	☑ Gold Coast Medi-Cal	☐ FFS Medi-Cal
	☑ Medicare	☑ Commercial	
Age Limitations:	☑ None	☐ Under 21	☐ Other

Purpose

To provide a standardized written process for applying clinical criteria that is objective, based on a member's individual needs, accounts for the local delivery system, and complies with all local, state, and federal law.

Policy

AmericasHealth Plan (AHP) shall utilize established utilization review (UR) criteria in the Utilization Management (UM) referral process. The UM Department shall use written criteria based on sound clinical evidence to make utilization decisions. Procedures for applying utilization criteria shall take into account both individual circumstances and the local delivery system when determining the medical appropriateness of health care services.

Actively practicing Practitioners and Utilization Management staff are involved in the development, implementation, analysis and corrective action, if necessary, of standardized clinical criteria. The clinical criteria used to make utilization decisions, and the procedure for appropriately applying these criteria, are reviewed annually.

Consistency in criteria application shall be evaluated on an annual basis or more frequently if needed. This evaluation is performed to ensure consistency in the application of criteria by physician and non-physician reviewers. The Inter-rater Reliability Survey shall be performed at least annually to satisfy this requirement.

DEFINITIONS

Clinical Criteria: Systematically developed and evidenced-based clinical practice guidelines which assist practitioners and UM staff in making decisions about appropriate health care for specific circumstances.

Procedures

DEVELOPING, REVIEWING, & APPROVING CRITERIA

Written utilization review (UR) criteria (used to authorize, modify, or deny healthcare services), and procedures for applying them, must be developed, reviewed, and approved by the UM Committee at least annually. The criteria is updated as necessary, utilizing and referencing established UR criteria standards.

AHP, or its delegated entity, shall distribute UM criteria to applicable non-staff network practitioners to solicit their opinions and expertise in the development and adoption of UM criteria:

1. AHP, or its delegated entity responsible for UM activities, shall select a random sample of five (5) cases in which prior authorization was required within the past twelve (12) months. The randomly selected cases shall be included in one (1) QI Committee packet annually and made available to non-staff network practitioners/Committee members that have clinical expertise in the area being reviewed. The cases shall be included in the QI Committee packet with the preface, *"It is a regulatory requirement that AHP must include network practitioners in the review, development, and adoption of UM criteria. As an AHP provider with clinical expertise in the area being reviewed, please examine the enclosed case and provide feedback, if applicable."*
2. The Director of Medical Management, Director of Utilization Management, or other individual with a leadership role applicable to utilization review, shall be responsible for randomly selecting the five (5) cases for Committee review.
3. The distribution and review of UM criteria shall be documented in the QI Committee minutes.

HIERARCHY OF CRITERIA

Criteria utilized for **Medicare LOB** includes:

1. Coverage exclusions listed in member Evidence of Coverage (EOC) based on CMS benefits.
2. CMS National Coverage Determinations (NCD)
3. Local Coverage Determinations available from Medicare (LCD)
4. Local Coverage Medical Policy Articles (LCA)
5. Medicare Manuals including but not limited to:
    - Medicare Managed Care Manual
    - Medicare Benefit Policy Manual
    - Program Integrity Manual
    - Medicare Claims Processing Manual
6. Milliman Care Guidelines (MCG)
7. Contracted Health Plan's Medical Policy and/or Clinical Guidelines, when available
8. CMS Drug Compendia

Criteria utilized for **Medi-Cal LOB** includes:

1. Medi-Cal http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp
2. Medi-Cal Title 22
3. Member Evidence of Coverage (EOC)
4. Contracted Health Plan's guidelines when available
5. Inter-Qual
6. Milliman Care Guidelines Apollo Guidelines current edition

Criteria utilized for **Commercial LOB** includes:

1. Federal and State Law mandates (i.e. Code of Federal Regulations, Department of Managed HealthCare);
2. Health Plan Guidelines
3. Milliman Care Guidelines current edition
4. Apollo Care Guidelines current edition

APPLICATION OF CRITERIA & DECISION-MAKING

The Utilization Management (UM) staff, Medical Director(s), and designated Physician Reviewer(s) shall review requests from members and providers using nationally recognized, evidenced-based clinical criteria to determine the medical appropriateness of services.

1. Clinical criteria shall be applied based on individual needs and characteristics of patients according to:
2. Age
3. Co-morbidity
4. Complications
5. Progress of treatment

6. Social issues with regards to family and living environment
7. Psychosocial situation

AmericasHealth Plan (AHP), or its delegated entity, also considers characteristics of the local delivery system available to specific patients including, but not limited to, the following:

1. Availability of skilled nursing facilities, sub-acute care facilities or home care in the organization's service area to support the patient after hospital discharge
2. Coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care where needed
3. Local hospitals' ability to provide all recommended services within the estimated length of stay

In the event of member complications, an insufficient delivery system, or other special circumstance that may require deviation from the norm, UM guidelines may be deemed inappropriate or inadequate to handle the member's specific needs. Cases of this nature are referred to the medical director for review and may require alternative resources such as third party review or individual case discussions. Member complications include but are not limited to:

1. Disability
2. Acute condition
3. Life-threatening illness

Appropriate, actively practicing health care practitioners shall be involved in the development, adoption, and application of medical and behavioral health care standardized criteria.

Board-certified physician consultants from appropriate specialty areas assist in making medical determinations.

Any denial that is based on lack of medical necessity shall involve a licensed physician (Medical Director or Physician Reviewer designee).

CONSISTENCY OF APPLICATION

The consistency of the clinical criteria application is evaluated annually by conducting annual Inter-rater reliability audits of all staff involved in organizational determinations. A licensed physician must oversee the UM decisions process to ensure consistent medical necessity decision-making. At least annually, AHP acts on opportunities to improve consistency, if applicable.

ACCESS TO CRITERIA

UM policies/procedures and UR criteria shall be distributed to practitioners and providers via the AHP website and at AHP Utilization Management Committee and/or Quality Improvement Committee Meetings.

1. Upon request, UM policies, procedures, and UR criteria shall be disclosed to providers, members, and/or member representatives. Medi-Cal members shall not be charged a copying/postage fee.
2. AHP dissemination of UM policies, procedures, and UR criteria to requesting members (and the public) shall include the following disclosure notice: "*The materials provided to you are guidelines used by AHP to authorize, modify or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.*"

Specific Health Plan Requirements:

ANTHEM BLUE CROSS

Specific Anthem Hierarchy Guidelines:

1. NCD.
2. Local Coverage Determination.
3. Drug compendia and/or relevant guidance from the FDA (for Part B drugs)
4. Anthem medical policies.
5. Anthem Clinical Utilization Management Guidelines.
6. American Imaging Management Specialty Health Guidelines.

7. Milliman Care Guidelines or Interqual Guidelines as adopted by the member's health plan.

SCAN HEALTH PLAN

Specific SCAN Hierarchy Guidelines:

1. NCD
2. LCD
3. Local Coverage Articles
4. Medicare Manuals including but not limited to:
    - Medicare Managed Care Manual
    - Medicare Benefit Policy Manual
    - Program Integrity Manual
    - Medicare Claims Processing Manual
5. InterQual Guidelines or Milliman Care Guidelines as adopted by the member's health plan.
6. SCAN Medical Policy
7. CMS Drug Compendia

Regulatory References

1. 42 CFR § 422.202(b)(1)(i, iii, iv), § 422.202(b)(2)
2. CA Health & Safety Code (H&SC) § 1363.5(a), § 1363.5(b)(1-3, 5), 1367.01(b)
3. National Committee for Quality Assurance (NCQA) UM Standards and Guidelines
4. NCD transmittals:
   https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/CMS-Program-Memoranda.html
5. MLN:
   https://www.cms.gov/Outreach-and-Education