HCSC
Health Care Service Corporation

2020 Blue Cross and Blue Shield of Montana (BCBSMT)

Utilization Management (UM)

Program Description

Approval Signature **Date 12/27/2019**

Note: Electronic Signatures Required

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Date: 2019.12.27 13:05:16 -07'00'

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Effective: January 1, 2020 **Last Review Date: 12/2019**

HISTORY OF DOCUMENT REVISION

Date Modified	Description of Modification
12/27/2019	Establishing a 2020 UM Program description with the goal of aligning to the HCSC UM Program Description.

Accreditation/ Regulatory References
URAC Version 7.3 •Core: 2, 5, 6-9, 10-11, 25-38 •UM: 1-5, 7-14, 17-31, 33, 35-37
State and Federal Laws and Regulations

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2020 Blue Cross and Blue Shield of Montana (BCBSMT) UM Program Description
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I. Overview

The Utilization (UM) Management Program description defines the structure of the UM programs for the BCBSMT Retail On-Exchange Marketplace and Off-Exchange products, Fully-Insured, and Self-Funded Commercial groups.

Excludes: Federal Employee Program (FEP), Government Solutions, and Behavioral Health (BH). These areas maintain their own UM Program Descriptions.

This document provides a clear definition of authority and accountability within the organization, articulates the scope and content of the Program, identifies the roles and responsibilities of individuals involved and outlines the program evaluation. BCBSMT is a division of the Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company.

In the case where utilization management is delegated, HCSC provides oversight to assure delegated programs meet its requirements, including annual review and approval of the delegate's Utilization Management program description.

II. HCSC Purpose

HCSC is dedicated to expanding access to high quality, cost-effective health care and equipping our members with information and tools so they can make the best health care decisions for themselves and their families. HCSC is committed to contributing to the well-being of the communities in which our members and employees live and work. Everything we do at HCSC is guided by a straightforward core purpose.

"To do everything in our power to stand with our members in sickness and in health"

III. Mission Statement

To promote the health and wellness of our members and communities through benefit plans that provide coverage for and access to affordable quality healthcare.

The UM Program is driven to facilitate:

- A Holistic approach to Provider and member/customer satisfaction/experience.
- Equitable Member access to appropriate, affordable care/program/service.
- Evidence based and timely utilization decisions that accommodate the clinical urgency of the situation.
- Individual consideration of screening criteria for members with special circumstances or complex conditions with use of the MCG Care Guidelines (MCG), and Medical Policies

(MP). Special circumstances include, but are not limited to, an individual who has a disability, acute condition, or life-threatening illness.
- Access to quality affordable, competitive care delivery.
- Benefit determinations that are fair, impartial, consistent and easily interpreted by members and providers.

IV. UM Program Structure

The UM Program is structured to maximize the effectiveness of care and services provided by ensuring appropriate access to quality and cost-effective care for members. UM is integrated with the Quality Improvement Program (QIP) which promotes objective, systematic monitoring, and evaluation of the program.

The BCBSMT Chief Medical Officer, provides clinical supervision, oversight and participates in the development, implementation and evaluation of the UM Program. The Chief Medical Officer reviews and approves the health care services utilization review plan and all associated UM Policies and Procedures.

UM activities are conducted in compliance with legal, regulatory, and accreditation standards developed with input from BCBSMT Committees, specialty panels and internal medical personnel. The advisory groups include practicing health care providers who are both primary and specialty care physicians.

V. Program Objectives

The UM processes support members in accessing services available to them through their benefit plans. The main objective is to identify and avoid unnecessary medical services before services are rendered and identify alternatives, thus fostering appropriate medical practice patterns, improved quality of care and cost containment.

VI. Program Scope

A. Definitions

Utilization Review

“Utilization review" means a set of formal techniques designed to monitor the use of or to evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinions, certification, concurrent review, case management, discharge planning, or retrospective review.

Preauthorization/Predetermination

There are two types of preservice review to assess benefits and medical necessity: preauthorization and predetermination. Similarities predominate over differences between these two types of preservice review. The primary difference is that preauthorization is required for certain services whereas predetermination is elective for services that do not require preauthorization. Once requested, preauthorization and predetermination are processed in the same manner including, but not limited to, which reviewers are qualified to approve and deny, and notices, including appeal rights. Furthermore, neither preauthorization nor predetermination guarantee benefit or payments because member eligibility and benefits are reassessed as of the date of service and the circumstances represented in the request must have been complete and accurate and remain materially the same as the date of service.

Medical Necessity

"Medical necessity" means health care services that a health care provider exercising prudent clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing, treating, curing, or relieving a health condition, illness, injury, or disease or its symptoms and that are:

- in accordance with generally accepted standards of practice;
- clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and
- not primarily for the convenience of the patient or health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's illness, injury, or disease.

Authorized Representative

“Authorized Representative” means a person to whom a covered person has given express written consent to represent the covered person; a person authorized by law to provide substituted consent for a covered person; a family member of the covered person; or the covered person's treating health care provider only if the covered person is unable to provide consent, with respect to a benefit, claim or an appeal of an adverse benefit determination.

B. Utilization Management Reporting

Utilization indicators may include, but are not limited to, the following:

- Admissions per thousand (1000) members
- Complaints about the UM process

- Timeliness of determination of requests
- Unplanned Readmission Rate within 30 days
- Reduction of avoidable ER visits
- Inter-rater Reliability testing

Utilization goals are established using recognized benchmarks and are approved by the designated BCBSMT Quality Improvement Committee (QIC). Quantitative and qualitative analyses are performed, and the results will be shared with the BCBSMT QIC. Potential/actual trends of over/under utilization and intervention to improve utilization are reported to the BCBSMT QIC for recommendations, as applicable and approves interventions to impact utilization trends.

C. UM Program Staffing

Non-Clinical Staff

Non-clinical staff with training in care management may process all incoming calls, provide member eligibility and benefit information, and facilitate member access to appropriate providers/facilities. Non- clinical staff may not deny utilization review requests based on initial or pre-review screening. Non-clinical staff members do not conduct utilization review. If non-clinical staff receives a call from a physician or health care provider, the non-clinical staff will not take clinical information and will immediately transfer the call to a clinical reviewer to complete the request. Non-clinical personnel will refer all requests they are unable to approve that involve clinical reviews and pre-screenings to licensed clinicians.

Utilization Management Coordinators (Preservice, Concurrent, Post Service/Retrospective)

Utilization Management Coordinators are Licensed Registered Nurses(RN) or Licensed Practical Nurses (LPN)/ Licensed Vocational Nurses (LVN).

The Utilization Management Coordinator utilizes their medical knowledge and expertise to review requests for admissions, procedures, services and level of care and may approve requests that meet established clinical review criteria and/or HCSC Medical Policy. In addition, they use established clinical criteria to assign an appropriate length of stay/service. Utilization Management Coordinators do not issue adverse determinations.

Note: Pharmacy reviews are conducted by licensed, registered Pharmacists.

Physician Reviewer (Preservice, Concurrent, Post-Service/Retrospective)

Physician Reviewers will evaluate cases based on medical knowledge, experience and current standards of practice. In addition, Physician Reviewers conduct peer to peer reviews with providers, if requested. Physician Reviewers must be appropriate health professionals, properly qualified and credentialed to render a clinical opinion about the medical/dental or behavioral health condition(s), procedure(s), and/or treatment(s) under review according to the guidelines required to meet federal/state laws and regulatory standards. Physician Reviewers are available during standard business hours for consultation with providers and UM staff.

Refer to CEUM0173 Initial Clinical Reviewers and CEUM0174 Physician Reviewers.

Physician Reviewer (Appeals)

An appeal is a request to review a non-authorization (denial/adverse determination), which includes: denials, reduction of benefits, or termination of, or a failure to provide or make a payment (in whole or in part) for a service. This is based on: medical necessity, experimental and investigational, not a covered benefit (contract exclusion), network exclusions or other limitations on otherwise covered benefits. The appeal review will be conducted by an appropriate Physician Reviewer who was not involved in or a subordinate of anyone involved in any previous non-authorization (denial/adverse) determination pertaining to the same episode of care and are in a state or territory of the United States when conducting an appeals consideration. The Physician Reviewer will be in the same profession and in a similar specialty as typically manages the medical, behavioral health, or dental conditions, procedures, and/or treatments under review, as mutually deemed appropriate.

Policy and Procedure Development and Maintenance

All aspects of UM activities and operations are governed by written policies and procedures, which are maintained in the Plan UM Department. Program policies and procedures are formally reviewed and approved annually and as indicated when revised. Initial policy approval is issued by the Plan Policy and Procedure Committee, with final approval issued by the BCBSMT Quality Improvement Committee (QIC). Policies are developed to support ongoing compliance with all state/federal agency laws and accreditation organization standards.

Refer to CEUM0140 Policy and Procedure Development and Review.

D. Clinical Review Criteria

Utilization Management Coordinators utilize MCG care guidelines and HCSC Medical Policy to determine the following:

- Medical necessity of the requested care;
- Appropriateness of the location and level of care;
- Appropriateness of the length of stay (including diagnosis related group [DRG] criteria); and
- Assignment of the next anticipated review point.

Requests that do not meet MCG care guidelines, HCSC Medical Policy, and/or potential contract exclusions are referred to Medical Directors/Physician Reviewers for determination.

MCG Care Guidelines

MCG care guidelines are nationally recognized clinical criteria utilized to screen and evaluate for medical necessity and appropriateness of services, in accordance with the terms of the member's health benefit plan. MCG care guidelines are explicitly written, created by practicing clinicians and based on current clinical principles and processes and are evidence-based. Services include requests for medical/surgical inpatient admissions (preservice and concurrent), not completed through the automated web platform. The application of the MCG care guidelines by Utilization Management Coordinators and/or Physician Reviewers facilitates collection of the pertinent information required to authorize the requested medical/surgical procedure, treatment and/or admission, and to determine length of stay (LOS) and/or frequency and duration of services requested, as well as, the appropriateness of the setting.

MCG care guidelines are evaluated annually or earlier if new data regarding indications or technologies become available. The criteria are presented annually to the BCBSMT Quality Improvement Committee (QIC) for review and approval.

Refer to CEUM0181 Clinical Review Criteria.

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Medical Policy (MP)/ Technology Assessment

HCSC Medical Policies (MPs) are based on current clinical principles and processes and provide a link between the philosophy of HCSC, its contracts and the reality of making informed decisions about quality medical care within the benefit structure. Medical policies are evaluated at least annually or earlier if new data regarding indications or technologies becomes available.

The MP development and new process is an evaluation of new medical technologies or new applications of existing technologies, including behavioral healthcare procedures, medical procedures, pharmaceuticals, and devices, is the responsibility of the HCSC Medical Policy Operations department in conjunction with designated Medical Policy Medical Directors (MPMDs) from the HCSC divisions: and of the Prime Therapeutics Pharmacy and Therapeutics (P&T) Committee. Data sources utilized for assessing new technologies or new uses for existing technologies include Blue Cross Blue Shield Association Technology Evaluation Center (BCBS TEC); Independent review of peer reviewed scientific literature from a variety of sources; and Review of government sponsored agencies or research bodies, such as, the Agency for Health Care Policy and Research (AHCPR), and the Centers for Disease Control (CDC).

Final approval of MPs by the HCSC Medical Policy Committee Medical Directors is required. Current and/or revised HCSC MPs are located on the BCBSMT Internet website for on-line access.

Review personnel use current, explicit and written HCSC MPs as guides to assist with benefit determinations regarding new technology, medical procedures, behavioral healthcare procedures, pharmaceuticals, and devices.

Refer to CEUM0183 New Medical Technologies.

E. Utilization Management Process

Preservice, Concurrent, Post Service/Retrospective

Utilization Management (UM) personnel are accessible to the member and provider community during business hours of 8:00 A.M to 5:00 P.M. Mountain Standard Time, Monday through Friday, except legal holidays. A confidential voicemail is available for after-hours messages. UM personnel will reply to after-hours messages within one business day. Requests for health care services are reviewed and a determination made regarding the authorization or denial of those services within the timeframes based on the urgency of the member's condition as required by applicable law/regulation.

Requests not completed via the automated web platform for elective or emergent inpatient admissions, select outpatient services, extended care/home infusion therapy (EC/HIT) services and transplants are reviewed through the utilization review process. Emergency care services for screening and stabilization do not require prior authorization. Non-clinical UM intake may complete requests that meet the automated web platform approval guidelines for diagnoses and procedures that do not require clinician review. This is a clerical function to facilitate claims payment and is not based on medical necessity or use/consideration of clinical information.

Utilization Management Coordinators and Licensed Pharmacists utilize MCG care guidelines and/or HCSC Medical Policy to determine the following:

- Medical necessity of the requested care;
- Appropriateness of the location and level of care;
- Appropriateness of the length of stay or service (including diagnosis related group [DRG] criteria); and
- Assignment of the next anticipated review point.

Initial Clinical Reviewers document and accept clinical information for making determinations of coverage from any reliable source. Sources include but are not limited to verbal information from physician, medical office and facility personnel as well as provider office and facility medical record information. This information is used to determine whether established clinical criteria is met for the requested service.

Utilization Management Coordinators do not issue non-authorization (denial/adverse) determinations based on initial clinical review.

Requests that do not meet MCG care guidelines, HCSC Medical Policy, and/or potential contract exclusions are referred to Physician Reviewers for determination unless the request is an absolute contract exclusion. A Physician Reviewer is available to initial reviewers to discuss determinations based on medical appropriateness. All non-certification decisions are communicated in writing to the member or individual acting on behalf of the member and the member's provider of record, including the health care provider who requested the service. If members and/or providers are not satisfied with the outcome of the decision, they have the right to an appeal. Adverse determinations may only be determined by a physician, doctor, or other health care provider with appropriate credentials to determine medical necessity or appropriateness, or the experimental or investigational nature of health care services.

Refer to CEUM0400 Clinical Review Process and CEUM0440 Accessibility to Programs.

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Referral Management

Requests to see an out-of-network (OON) provider at an in-network benefit level are reviewed utilizing internally developed guidelines. Clinical and Physician Reviewers will review OON referral requests for appropriateness.

Requests for coverage of Out of Network provider services at in network benefits may be reviewed for continuity of care when a member has a special circumstance in which the current health care treatment plan cannot be interrupted without disrupting the continuity of care and/or decreasing the quality of the outcome of that care.

Refer to CEUM0190 Referral Management and CEUM0193 Continuity of Care.

Automated Web Platform Preauthorization/ Predetermination Notification Program

The automated web platform is the automated system utilized for notification of referrals, and select inpatient admissions and outpatient services, twenty-four (24) hours a day, seven (7) days a week for network providers/facilities throughout HCSC Plan States. Physicians and/or facility personnel input data (such as diagnosis and procedure codes) to complete referrals and preauthorization/notification requests. Customization of the automated web platform system allows vectoring of OON referrals and select inpatient preauthorization and outpatient requests to UM personnel for requests requiring further review, Case Management (CM)UM intervention or OON referral management.

Care Collaboration/Discharge Planning

Care Collaboration/Discharge Planning supports the review of requests for services/stays which extend beyond the initially approved length of stay/duration, including inpatient hospital admissions. Reviews are conducted by Utilization management coordinators to:

- Evaluate medical/surgical appropriateness for admissions, or extension of services or procedure requests;
- Promote timely intervention/care collaboration to facilitate a medically appropriate transition of the member/patient from an inpatient setting to a less acute level of care;
- Promote the utilization of network providers;
- Evaluate, coordinate and implement patient specific discharge plans;
- Identify cases appropriate for referral to CM

Retrospective (Post Service) Review

Retrospective review means a review of the medical necessity and appropriateness of health care services provided to a member and is performed after completion of such health care services. "Retrospective review does not include:

- The review of a claim for an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or payment
- Subsequent review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted, or
- Reviews that should have been previously conducted.

Appeals

Appeals are formal written or verbal requests for a review of an adverse determination. Requests for appeal may be initiated by telephone, fax or in writing. Appeals are accepted from the member, member's authorized representative, physician or other practitioner and facility or another provider.

Appeal rights are provided at the time of the adverse determination notification and are available upon request to any patient, provider or facility rendering service for standard non-urgent cases as well as expedited cases involving urgent care.

F. Conflict of Interest

Plan physicians or non-physician reviewers may not review a case in which he/she has a conflict of interest. Conflicts of interest may be either personal or financial in nature**.**

Refer to CEUM0010 Employee Financial Incentive Policy.

G. Delegation of Review

Plans may elect to have preauthorization, on-site review, concurrent review, retrospective review, referral management, appeals or discharge planning performed by another entity. If any UM activities are delegated, the entity must meet the following criteria:

- Comply with Plan Program Standards.
- Comply with all federal/state laws, regulatory and accrediting agency standards that provide certification/accreditation of the UM program.
- Allow oversight by UM personnel, including an annual onsite assessment/audit.

- Provide regular reports of review and quality improvement activity as required.

***Note:** Delegation of utilization review (UR) activities shall not relieve the Plan of full responsibility for compliance with Plan Department of Insurance regulations for utilization review agents, including the conduct of those to whom UR has been delegated. Delegation of UM Program shall not relieve the Plan of full responsibility for compliance with accreditation standards and/or Federal/State regulatory requirements.

VII. Confidentiality

HCSC has established policies and procedures to ensure the confidentiality of patient information. Internal policies on confidentiality are outlined in employee and management handbooks, corporate policy manual and Health Insurance Portability and Accountability Act (HIPAA) Privacy policies. Employees receive training upon hire and must also sign a confidentiality statement during corporate orientation and annually thereafter.

Refer to HCSC Corporate Compliance policies.

VIII. UM Management Program Role in the Quality Improvement Program

The UM program is integrated with the Plan Quality Improvement Program which promotes objective monitoring and evaluation methods that are based on the use of both clinical and service indicators. The UM program is designed to provide continuous monitoring and evaluation of UM QI activities.

UM activities may include:

- Quality of Clinical Care Projects
- Quality of Service Projects
- Safety of Clinical Care Projects
- Member Experience Surveys
- PCP/Practitioner Surveys
- UM Complaints
- Utilization Data

Annually, the UM program Clinical and Service indicators and initiatives are evaluated based on outcomes and any federal/state regulatory changes.

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IX. Training, Education, and Performance

HCSC provides initial orientation prior to assuming job functions as well as educational opportunities for the development of professional competence. UM personnel are required to be educated in current principles, policies and procedures.

HCSC promotes the professional development of UM licensed personnel by providing educational opportunities that will assist them to become subject matter experts in their area of operation.

Staff Performance/Evaluations:

- All Staff receive formal annual evaluations of job performance to include quality assurance activities for any staff member whose job responsibilities include the use of clinical criteria and/or guidelines.

Refer to CEUM0170 Quality Assurance & Core Competency Criteria.

X. Provider/Practitioner/Member Education of UM Requirements

There are multiple resources available to educate providers, practitioners and members. Having multiple modalities allows the provider, practitioner or member to engage in ways that are meaningful to them and their unique learning style. Resources may include, but are not limited to:

Provider/Practitioner Education

Provider/Practitioner educational tools are developed to enhance provider knowledge of the UM Program. Education is provided by the following means:

- Organized educational programs;
- Quick-reference guides;
- Newsletters and bulletins;
- Provider Manuals;
- Internet web-site which provides access to specific data including HCSC Medical Policies; and
- Evidence based guidelines of care.

Member Education

Member educational materials are developed to increase knowledge and encourage active participation when making informed decisions regarding health care options. Member educational materials include:

- Member guide/handbooks (Members rights and responsibilities);
- Health and wellness literature;
- Contract booklets;
- Authorization requirements;
- Provider directories; and
- Web-based education/Internet website

Members with disabilities, special needs, and/or language barriers including authorized representatives can request this information via alternate means or in another language.

XI. Annual Evaluation

The overall effectiveness of the UM Program and UM Program Description are reviewed and approved by the Chief Medical Officer and the BCBSMT Quality Improvement Committee (see "Authority").

XII. Authority

Clinical Operations leadership completes an evaluation of the UM Program and updates the UM Program Description at least annually. The Chief Medical Officer participates in the development and evaluation of the BCBSMT UM Program and approves the UM Program Description. Ultimate authority and oversight of the UM program for the BCBSMT rests with the BCBSMT QI Committee.

XIII. BCBSMT Member Beneficiary Health Plan Reference

Helpful references for Montana members to learn about their BCBSMT health plan Information is available on the BCBSMT website under Member Services.

Sample Policy Documents for Qualified Health Plans-On and Off Exchange, Standard Insured Plans, and Custom Large Group Plans are available at:
https://www.bcbsmt.com/member/policy-forms/

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Attachment 1
Dental Utilization Review Program – Dental Network of America (DNoA)

A. CRITERIA

BCBSMT uses the following Criteria for its Utilization Review activities. Any entities to which BCBSMT delegates Utilization Review activities are required to use the same Criteria for BCBSMT business. 'BCBSMT business' means BCBSMT's fully-insured individual and group blocks of business and its third party administrative services business.

- Milliman Care Guidelines Criteria for observation level of care and medical/surgical inpatient admission review, rehabilitation, sub-acute, long-term care reviews, and psychiatric care both inpatient and outpatient. See attachment 2.
- BCBSMT Medical Policy. The complete BCBSMT Medical Policy Manual can be found on the web at www.bcbsmt.com.
- The American Society of Addiction Medicine (ASAM) Criteria is utilized as the behavioral health clinical screening criteria for patients with addiction disorders for all levels of care.
- Dental Policies, criteria from Dental Networks of America (DNoA) can be found at www.dnoa.com/claimsresources.htm.

B. DENTAL UTILIZATION REVIEW PROGRAM – DENTAL NETWORK OF AMERICA (DNOA)

PURPOSE

This Dental Network of America (DNoA) Utilization Review Plan shall define the policies, standards, criteria and procedures followed when processing and paying dental claims for and on behalf of BCBSMT.

RESPONSIBILITY

All dental claims processing personnel and dental consultants shall be required to follow these criteria and procedures.

UTILIZATION REVIEW APPLICATION

Dental benefits are rendered by contracted and non-contracted dentists who are compensated for services on a fee-for-service basis. Even though dentists are not required to submit claims for Preauthorization of services, Utilization Review occurs both prospectively and retrospectively.

ADVERSE DETERMINATIONS

A decision to deny or partially deny a claim payment is an Adverse Determination. BCBSMT maintains appeal and review procedures for Members and providers who wish to appeal or dispute an Adverse Determination.

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DENTALLY NECESSARY

Dentally Necessary services are services that are Medically Necessary and Appropriate for the diagnosis or treatment of a Member's dental condition according to accepted standards of dental practice and that are not provided only as a convenience. Most utilization decisions are limited to determinations of whether services are covered under the terms of the plan contract. Evidences of Coverage distributed to BCBSMT enrollees include a list of covered dental services, exclusions, limitations and other relevant information that define Member dental benefits. A denial or rejection of a Preauthorization or payment request in most instances indicates only that the service is either not a covered service or is subject to an exclusion and/or limitation. The determination is not intended to reflect any opinion of whether the service is medically/dentally required.

BCBSMT will abide by applicable federal and state (Montana) laws and regulations concerning Utilization Review and Medical/Dental Necessity determinations. Medical/dental necessity decisions will be made only by a dental consultant, who:

Is in possession of an active and unrestricted license to practice dentistry; and

Requests information relevant to the dental condition and bases decisions upon standards which are objective, valid and consistent with accepted professional standards for dentistry.

BCBSMT DENTAL PRIOR AUTHORIZATION

Pre-Authorization is recommended for some services to help providers and Members avoid unexpected expenses, benefit reductions, or claim denials. Coverage for Medically Necessary services, supplies, or treatment is determined through the prior authorization process. If Prior Authorization is not obtained, a retrospective review is performed to determine whether the services, supplies, or treatment were Medically Necessary or were a benefit of the Member's contract.

Documentation Requirements

The Prior Authorization process may require additional documentation from the dental services provider for some services and should include:

- Pertinent documentation explaining the proposed services;
- Functional aspects of the treatment;
- Projected outcome;
- Treatment plan and any other supporting documentation (e.g., study models, photographs, and x-rays); and
- Appropriate CDT codes.