

#### Overview

The Plan's Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and the State of New York while providing members access to high quality, cost effective medically necessary care and ensuring prompt and accurate payment to our providers.

The focus of the UM program is on:

- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the member's diagnosis and level of care required;
- Providing access to medically appropriate, cost effective health care services in a culturally sensitive manner and facilitating timely communication of clinical information among providers;
- Reducing overall health care expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership;
- Facilitating communication and partnerships among members, families, providers, delegated entities and the Plan in an effort to enhance cooperation and appropriate utilization of health care services;
- Reviewing, revising and developing medical coverage policies to provide members with appropriate access to new and emerging technology; and
- Enhancing the coordination and minimizing barriers in the assessment of behavioral and medical health care services.

*Medically necessary services* are defined as services that include medical or allied care, goods or services furnished or ordered to:

1. Be necessary to protect life, to prevent significant

illness or significant disability or to alleviate severe pain;

2. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the member's needs;
3. Be consistent with the generally accepted professional medical standards and not be experimental or investigational;
4. Be reflective of the level of service that can be rendered safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker or the provider.

*Medically necessary services or medical necessity* for those services provided in a hospital on an inpatient basis are those that cannot, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed recommended or approved medical or allied goods or services do not, in itself, make such goods or services medically necessary, a medical necessity or a covered service/benefit.

**UM Process**

The UM process is comprehensive and includes the following review processes:

- Notifications
- Referrals
- Prior Authorizations
- Concurrent Review
- Retrospective Review

The Plan's forms for submitting notifications and authorization requests can be found in the **Forms** section of this manual and on the Provider's area of the WellCare Web site at [www.wellcare.com](http://www.wellcare.com).

#### Notification

*Notifications* are communications that inform the Plan of a service rendered or admission to a facility. Notification is required for the following;

- Notification of prenatal services as it enables the Plan to identify members for inclusion into the Prenatal Program and members who may benefit from the High Risk Pregnancy Program. OB providers are required to notify the Plan of pregnant members via fax, using the Prenatal Notification Form within 30 days of the initial visit to expedite case management and ensure timely claims reimbursement.

#### Referrals

- A *referral* is a request by a PCP for a member to be evaluated and/or treated by a participating specialty physician. The Plan does not require an authorization as a condition of payment. A written or faxed script to the specialist is required. The specialist must document the receipt of a request for a consultation. The medical record must document the reason for the referral and the name of the specialist. **No communication with the Plan is necessary.** Certain diagnostic tests and procedures considered by the Plan to be routinely part of an office visit may be conducted as part of the initial visit without authorization. For general authorization information you may refer to the Quick Reference Guide, a copy of which can also be found on our Web site [www.wellcare.com](http://www.wellcare.com).

#### Prior Authorization

Prior authorization allows for efficient use of covered healthcare services and helps ensure that members receive the most appropriate level of care within the most

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appropriate setting. Prior authorization may be obtained by the member's PCP or treating specialist.

Reasons for requiring authorization may include:

- Review for medical necessity
- Appropriateness of rendering provider
- Appropriateness of setting

*Prior authorization* is the process of obtaining approval in advance of a planned inpatient admission or rendering of an outpatient service.

The Plan will make an authorization decision based on the clinical information provided with the request but may sometimes request additional information that may include a medical record review.

Once the determination is made the Plan will provide notice of the determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three (3) business days of receipt of the necessary information.

Prior authorization is **required** for elective/non-urgent services as designated by the Plan. Guidelines for prior authorization requirements by service type and/or code are available by calling the plan, or by referring to the **Quick Reference Guide** found in the Providers area of the Web site at [www.wellcare.com](http://www.wellcare.com).

- The prior authorization request should include the patient's diagnosis and the CPT code describing the anticipated procedure. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not required. The attending physician or designee is responsible for obtaining the prior authorization for the elective/non-urgent procedure or admission.
- An *authorization* is the approval necessary to be granted payment for covered services and is provided only after the Plan agrees the

treatment is necessary and a covered benefit.

An Authorization Request form must be completed by the provider in order to obtain an authorization from the Plan.

A copy of this form is included in the **Forms** section of this manual.

- Authorization Request forms must be filled out completely and legibly in order to be processed quickly.
- A current and operating fax number with area code must be included in order to receive an authorization number from the Plan.

Providers may request a “**stat**” **authorization** (for services that are urgent in nature) by:

- Telephoning the Plan (have the member’s name, member ID number, diagnosis and service available when calling).

### Services Requiring No Authorization

The Plan has determined that many routine procedures and diagnostic tests may be performed without medical review to facilitate timely and effective treatment of members.

Certain diagnostic tests and procedures that are considered by the Plan to be routinely part of an office visit include colposcopy, EKG and plain film x-rays (see Quick Reference Guide).

### Concurrent Review

*Concurrent review* activities involve the evaluation of a continued hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, using appropriate criteria. The concurrent review nurse follows the clinical status of the member through telephonic or onsite chart review and communication with the attending physician, hospital UM, Case Management staff or hospital clinical

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staff involved in the member's care.

Concurrent review is initiated as soon as the Plan is notified of the admission and submitted supporting clinical information which must be sent to the Plan by the next business day following admission. Subsequent reviews are based on the severity of the individual case, needs of the member, complexity, treatment plan and discharge planning activity. The continued stay will be authorized based on medical appropriateness using InterQual™ criteria including:

- Services provided in a timely and efficient manner;
- Assuring established standards of quality care are met;
- Implementing timely and efficient transfer to lower level of care when clinically indicated and appropriate;
- Implementing timely and effective discharge planning; and
- Identification of cases appropriate for case management.

The concurrent review process incorporates the use of InterQual™ criteria to assess quality of care and the appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the Plan medical director.

To ensure the request is completed in a timely manner, providers must submit relevant clinical information along with the request for authorization. Failure to submit necessary documentation for concurrent review may result in non-payment.

### **Discharge Planning**

*Discharge planning* begins on admission, and is designed for early identification of medical/psychosocial issues that will need post-hospital intervention. The concurrent review

nurse works with the attending physician, hospital discharge planner, ancillary providers and/or community resources to coordinate care and post-discharge services and facilitate a smooth transfer of the member to the appropriate level of care.

**Retrospective Review**

*Retrospective review* is performed when a service has been provided, the claim has been adjudicated and no authorization has been given. Determinations for authorization involving health care services that have been delivered will be made within 30 calendar days of receipt of necessary information.

All services are subject to retrospective review. Prior authorization or concurrent review decisions will not be reversed unless the Plan receives information that contradicts the information given when the initial termination was made.

**Plan Criteria for UM Decisions**

The UM program uses review criteria that is nationally recognized and based on sound scientific, medical evidence. Physicians with an unrestricted license in the state of New York with professional knowledge and/or clinical expertise in the area actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

The UM program uses numerous sources of information including, but not limited to, the following when making coverage determinations:

- Medical necessity
- Member benefits
- Local and Federal statutes and laws
- InterQual
- Medicaid/Medicare guidelines
- Hayes, Inc. Online™ (Medical Technology)

The nurse reviewer and/or medical director apply medical necessity criteria in context with member's individual circumstance and the capacity of the local provider delivery system. When the above criteria do not address

the individual member's needs or unique circumstance, the medical director will use clinical judgment in making the determination.

Providers may request a copy of the criteria used for a specific determination of medical necessity by contacting the Health Services' Utilization Management Department.

**Second Medical Opinion**

Members may request a second medical opinion concerning surgical procedures or serious injury or illness. The member should seek consultation for a second opinion from a physician that is participating with the Plan. If the appropriate physician is not available within the Plan's service area, the member may visit a non-participating provider at no additional cost to the member.

It is the responsibility of the PCP to coordinate tests ordered as a result of a second opinion with participating providers and develop a treatment plan for the member after review of the second medical opinion.

**Members with Special Health Care Needs**

*Members with special needs* are defined as adult and children or adolescents who face physical, mental or environmental challenges daily that place at risk their health and ability to fully function in society. They include for example, members with mental retardation or related conditions; members with serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders; members with disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes; and children or adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

The following is a summary of responsibilities specific to physicians who render services to Plan members who have been identified with special health care needs:

- Assess the member and develop a plan of care if determined to need a course of treatment or

regular care;

- Coordinate treatment plan with the member, family and/or specialist caring for member;
- Plan of care should adhere to community standards and NYDOH quality assurance and utilization review standards;
- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the member's condition or needs;
- Coordinate with the Plan, if appropriate, to source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member;
  - a) Members may request a specialist as PCP through Customer Service or their case manager. If the medical director agrees the specialist is appropriate as a PCP and the specialist agrees to act as the PCP, the member will be assigned to that specialist by the Customer Service department.
- Coordinate services with community-based services and Medicaid Fee-for-Service programs to prevent duplication of services and assure continuity of care between all providers; and
- Ensure the member's privacy is protected as appropriate during the coordination process.

**Standard,  
Expedited and  
Extension of a  
Service**

**Service Authorization Decision**

The Plan is committed to a 48 hour turn-around time on requests for prior authorization or pre-authorization. Authorization responses will be sent by fax to the

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**Authorization Decision**

providers' fax number(s) that are included on the Authorization Request form.

**Pre-Authorization**

For pre-authorization decisions, the Plan must make decisions and notify members and providers by phone and in writing:

- Within three (3) business days of receipt of necessary information; or
- For **Medicaid/FHP**, as fast as the member's condition requires and
  1. within three (3) business days of receipt of an expedited authorization request ;or
  2. in all other cases, within three (3) business days of receipt of necessary information but no more than 14 days of the request.

If the Plan makes a decision to approve, reduce, suspend or terminate a service authorization request, the Plan will notice the member and the provider by phone and in writing of that decision.

**Expedited Service Authorization**

In the event the provider indicates or the Plan determines, that following the standard time frame could seriously jeopardize the member's life or health, the Plan will make an expedited authorization determination and provide notice within three (3) business days. The Plan may extend the three (3) business days time period up to 14 calendar days if the member or the provider requests an extension, or if the Plan justifies to NYSDOH a need for additional information.

Requests for expedited decisions for pre-authorization should be requested by telephone, not fax. Members and/or providers may submit a verbal or written request for an expedited decision. To submit a verbal or written request the provider needs to notify or call the Plan and

request an expedited review. For contact information, please refer to the Quick Reference Guide.

#### **Concurrent Review Authorization**

For Concurrent Review requests the Plan will make a decision and notify member and provider by phone and in writing:

- within one (1) business day after receipt of necessary information. [Note: this requirement may be satisfied by notice to the provider, by telephone and in writing, within one (1) business day of receipt of necessary information.]
- for **Medicaid/FHP**, as fast as the member's condition requires and
  1. within one (1) business day of receipt of necessary information but no more than three (3) business days of an expedited authorization request; or
  2. in the case of a request for Home Health Care Services following an inpatient admission, within one (1) business day after receipt of necessary information, except when the day subsequent to the Service Authorization Requests falls on a weekend or holiday, seventy-two (72) hours after receipt of necessary information; but in any event no more that three (3) business days after receipt of the Service Authorization Request; or
  3. in all other cases, within one (1) business day of receipt of necessary information but no more than 14 days of the request.

For Retrospective Review the Plan will make decisions within 30 days of receipt of necessary information.

- For **Medicaid/FHP**, notice must be mailed to enrollee on the date of a payment denial, in whole or in part.

**Additional requirements for Medicaid/FHP**

Expedited and standard review timeframes for pre-authorization and concurrent review may be extended by an additional 14 days if:

1. The member, designee or provider requests an extension; or
2. The Plan demonstrates there is a need for more information and the extension is in the member's best interest. Notice of extension to member is required.

Expedited review must be conducted when the Plan or provider indicates delay would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum functions. Members have the right to request expedited review, but the Plan may deny and a notice will process under standard timeframes.

**After-Hours Utilization Management**

The Plan provides authorization of inpatient admissions 24 hours a day, seven days a week. Physicians requesting after-hours authorization for inpatient admission should refer to the Quick Reference Guide.

**Delegated Entities**

The Plan delegates some utilization management activities to external entities and provides oversight and accountability of those entities with NYDOH approval. In order to receive a delegation status for utilization management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required utilization management standards. There must be a mutually agreed upon written delegation agreement describing the responsibilities of the Plan and the delegated entities.