

Overview

The Plan's Utilization Management (UM) Program is designed to meet contractual requirements with federal regulations and the state of Florida 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 ensure members have appropriate access to new and emerging technology; and
- Enhancing the coordination and minimizing barriers in the delivery of behavioral health 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 furnished 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 or medical necessity for those services furnished in a hospital on an inpatient basis 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 does 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
- Pre-service reviews (Prior Authorizations)
- Concurrent review
- Post-service reviews

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.

Notification

Notifications are communications to the Plan 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 identify 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 referral or prescription to the specialist is recommended. However, if the member is unable to physically deliver the referral form to the specialist, the PCP must fax or telephone the referral to the specialist. 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 at www.wellcare.com.

Pre-service Review for Prior Authorization

Prior authorization allows for efficient use of covered

health care services and helps ensure that members receive the most appropriate level of care within the most 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
- Case and disease management considerations

Pre-service review for 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 in the request. The Plan may request additional information that may include a medical record review.

Prior authorization is **required** for elective or 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 Provider area of 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 or 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.

Contracted providers may submit authorization requests through the WellCare provider web portal or

by faxing a completed Authorization Request Form to the Utilization Management department of the plan. A copy of this form is included in the **Forms** section of the manual.

- This form 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.

Providers may request an expedited (quick) review of a request for services that are medically urgent in nature by:

- Calling the Plan (have the member's name, ID number, diagnosis and intended 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, such as 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 specific clinical criteria. The Concurrent Review Nurse follows the clinical status of the member through telephonic or on-site chart review and communication with the attending physician, hospital UM, Case Management staff or hospital clinical staff involved in the member's care.

Concurrent review is initiated as soon as the Plan is notified of the 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 and upon request of the Plan's review nurse. 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/psycho-social 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.

Post-Service Review

Post Service authorization reviews are performed when the request for authorization is received after a service has been provided; or, in the case of an inpatient stay, after the patient has been discharged from a facility. Determinations for authorization involving health care services that have been delivered will be made within 30 calendar days of receipt of necessary information.

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 Florida 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 criteria when making coverage determinations:

- medical necessity
- member benefits
- local and federal statutes and laws
- InterQual™
- Medicaid and Medicare guidelines
- Hayes Health Technology Assessment

The nurse reviewer and/or medical director apply medical necessity criteria in context with the member's individual circumstance and 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.

Second Medical Opinion

In accordance with Florida statute 641.51, members may request a second medical opinion concerning surgical procedures, serious injury or illness. The member may choose a physician that participates with the Plan or a non-participating physician within the Plan's service area (Some restrictions may apply if a non-participating physician is selected for the second opinion.) 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 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 for members determined to need a course of treatment or ongoing care;
- Coordinate treatment plan with member, family and/or specialist caring for member;
- Plan of care should adhere to community standards and any applicable Agency quality assurance and utilization review standards;
- Allow members needing a course of treatment or ongoing care monitoring to have direct access

through standing referrals or pre-approved visits, as appropriate for the member's condition or needs.

- Coordinate with the Plan, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member;
 - 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 other managed care organizations to prevent duplication of services and share results of its identification and assessment of the member's needs; and

Ensure the member's privacy is protected as appropriate during the coordination process.

Authorization Decision Time Frames and Reconsiderations

Service Authorization Decision Time Frames

The Plan is committed to providing a timely authorization decision response to requesting providers to ensure that services can be delivered appropriately

- Routine determinations – Prior authorization determinations for non-urgent services shall be made and a notice of determination provided by telephone and verbally, and/or in writing to the provider within 14 calendar days (or sooner as required by the needs of the enrollee) of receipt of necessary information sufficient to make an informed decision. Authorization responses will be

sent via fax to the fax number provided on the Authorization Request form, located in the Forms section of this manual.

- Urgent (Expedited) determinations – If the service being requested is medically urgent and the member's health will be jeopardized by waiting for an authorization decision given in the routine time frame, members or providers may submit an oral or written request for an expedited decision. To submit an oral 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. Prior authorization determinations for urgent services shall be made no later than 72 hours after receipt of the request for service. The provider may contact the Plan by telephone for the most rapid response to an authorization request.

Extensions – If the provider or the member feels that a request for medically necessary service has been submitted, however the requestor is not able to submit appropriate clinical information to support an authorization decision, the Plan may allow an extension for an additional 14 calendar days if the extension is in the member's best interest. The extension may be initiated by the Plan if the Plan justifies to AHCA or CMS a need for additional information and the extension is in the member's best interest.

Reconsideration – If the Plan renders an adverse determination decision to a service authorization request, the Plan will notify the requesting provider of the opportunity and process for reconsideration of the decision. The reconsideration process includes a peer-to-peer discussion between a requesting physician and the Plan's medical director who made the adverse determination for the presentation of additional clinical information to support the medical necessity of the

requested service.

Emergency/ Urgent Care

Emergency services are not subject to prior authorization requirements and are available to our members 24 hours a day, seven days a week.

An *emergency medical condition* is a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the health of the member, including a pregnant woman or fetus;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- With respect to a pregnant woman having contractions:
 - That there is inadequate time to effect a safe transfer to another hospital prior to delivery, or
 - That a transfer may pose a threat to the health or safety of the woman or the fetus.
 - That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Urgent Care services for conditions that, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or to substantially restrict the member's activity (e.g., infectious illness, flu, respiratory ailments, etc.) do not require authorization when provided in an urgent-care setting.

Transition of Care

For newly enrolled Medicaid members, the Plan will honor any written documentation of prior authorization of ongoing covered services for a period of 30 calendar days after the effective date of enrollment or until the Plan's PCP assigned to that member reviews the member's treatment plan, whichever comes first.

Written documentation of prior authorization of ongoing services includes the following, provided that the services were arranged prior to the enrollment with the Plan:

1. Prior existing orders
2. Provider appointments, e.g. dental appointments, surgeries, etc.; and
3. Prescriptions (including non-participating pharmacies).

The Plan will not delay Service Authorization if written documentation is not available in a timely manner. The Plan is not required to approve claims for which it has not received written documentation.

For Medicare members, the Plan will honor any written documentation of prior authorization of ongoing covered services for a period of 30 calendar days after the effective date of enrollment or until the PCP assigned to that member reviews the member's treatment plan, whichever comes first.

Special Requirements for Payment of Services

The following services have special requirements required by the State of Florida.

Sterilizations

- The individual is at least 21 years old at the time consent is obtained
- The member is mentally competent;

- The individual voluntarily gave informed consent in accordance with the provisions of this section, and a properly executed “Sterilization Consent Form” is submitted with the claim.
- At least 30 calendar days, but not more than 180 calendar days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.
- An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be provided on the consent form);
- Interpreters are provided when language barriers exist and arrangements are made through our Customer Service department to effectively communicate the required information to an individual who is visually impaired, hearing impaired or otherwise handicapped; and
- The individual was not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

Hysterectomies

- The properly executed Hysterectomy Acknowledgement form is attached to the claim form submitted to the Plan.
- The individual is informed, verbally and in writing, prior to the hysterectomy that she will be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);

- Prior to the hysterectomy, the member/individual and the attending physician must sign and date the Exception to Hysterectomy Acknowledgement form except in the case of prior sterility or emergency hysterectomy. This informed consent must be obtained regardless of diagnosis or the member's (individual's) age and a copy submitted with the claim.

Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:

- Performed solely for the purpose of rendering a member permanently incapable of reproducing;
- Performed for more than one purpose but the primary purpose was to render the member permanently incapable of reproducing; or
- Performed for the purpose of cancer prophylaxis.

Abortions

Abortions are covered services if the provider certifies that the abortion is medically necessary to save the life of the mother or if pregnancy is the result of rape or incest. The Plan will cover treatment of medical complications occurring as a result of an elective abortion and treatments for spontaneous, incomplete or threatened abortions and for ectopic pregnancies.

Abortions are not covered if used for family planning purposes.

An Abortion Certification form certifying the above situation must be properly executed and attached to the claim form when submitted to the Plan.

The Sterilization Consent form, the Hysterectomy Acknowledgement form, the Exception to Hysterectomy Acknowledgement form and Abortion Certification Form are located in the **Forms** section of this manual.

These forms are the only forms accepted by the Plan in the reimbursement of sterilizations, hysterectomies, abortions and prior-approved medical services.

NOTE: Reimbursement is not available for sterilizations, hysterectomies or abortions performed without the documentation required by federal regulations. As such, claims for payment submitted without the required documentation or with incomplete or inaccurate documentation will be denied.

**Medicare QIO
Review
Process of
SNF/HHA/CORF
Terminations**

Providers should ensure delivery of written notification two days in advance of services ending for skilled nursing facilities, home health agencies or outpatient rehabilitation facilities. In the event a member appeals the termination of services, the Plan will work collaboratively with the provider to obtain medical information necessary to review these cases within the allotted time frame.

**Hospitalist
Program**

Hospitalists provide attending physician coverage in selected markets for members admitted to contracted facilities. Hospitalists provide the following services:

- Emergency room assessment of a member;
- Direct admissions to facilities where the PCP may not provide that service;
- Manages care as needed throughout the inpatient medical admission for members 16 years of age and older, excluding obstetrical and gynecological cases; and
- Refer members to the PCP upon discharge for follow-up care and communicating the treatment or discharge plan verbally within 24 hours and in writing within seven days.

**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 their **Quick Reference Guide**.

**Delegated
Entities**

The Plan delegates some utilization management activities to external entities and provides oversight and accountability of those entities.

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.

Delegation of select functions may occur only after an initial audit of the utilization management activities has been completed and there is evidence that the Plan's delegation requirements are met. These requirements include; a written description of the specific utilization management delegated activities, reporting requirements, evaluation mechanisms and remedies available to the Plan if the delegated entity does not fulfill its obligations.

On an annual basis, or more frequently audits of the delegated entity are performed to ensure compliance with the Plan's delegation requirements.