Utilization management
An overview
Objectives

• Share key information about the utilization management (UM) process
• Provide solutions to common issues that cause delays
• Answer questions and hear concerns from the UniCare Health Plan of West Virginia, Inc. (UniCare) provider community
UniCare facts

UniCare has been in operation since November 2003.

We started in four counties with 700 members.

Today, we have a statewide membership.

We service Expansion, Temporary Assistance for Needy Families (TANF) and Social Security Income (SSI) members.

With a membership of about 145,000, we’re currently the largest MCO in West Virginia.
## Departments

<table>
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<th>Health Care Management</th>
<th>Behavioral Health</th>
<th>Network Education</th>
<th>Marketing</th>
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<tr>
<td>Claims and Operations</td>
<td>Quality</td>
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<td>Government Relations</td>
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Our primary goal

To ensure members receive the quality care they need while effectively managing Medicaid dollars
Health Care Management

All programs are structured to ensure our members receive the highest quality services indicated for their medical condition in a timely manner.

UniCare uses approved medical review criteria to ensure members are provided the right services at the right level of care and by the right health care provider. These programs work in a collaborative manner throughout the care continuum.
Case management

- UM staff works closely with our case managers to ensure member needs are met.
- Case management staff helps with transportation, complex care needs, disease management, coordination of care and postdischarge management, as well as reducing avoidable readmissions and ER utilization.
- Case management referrals are based on the needs identified in the clinical information submitted to UM.
- Providers or members can also request case management by calling our Customer Care Center at 1-800-782-0095.
UM policies

• UM staff reviews the available medical records against our Medical Policies, AIM Specialty Health® (AIM) guidelines, Clinical UM Guidelines and MCG Care Guidelines, which are developed using evidence-based criteria. This decision-making process is in place to prevent the overutilization or underutilization of resources based on the member’s coverage.

• We do not reward practitioners or other individuals for issuing denials of coverage or care. Decisions about hiring, promoting or terminating practitioners or other staff are not based on the likelihood or perceived likelihood that they support or tend to support denials of benefits.

• Financial incentives for UM decision-makers do not encourage decisions that result in underutilization or create barriers to care and service.
UM staff background

Our nurses have backgrounds in the following specialties:

• Trauma
• Oncology
• Rehabilitation
• Long-term care
• Neonatal intensive care unit
• Women’s health
• Medical/surgical
• Critical care (cardiovascular, neurology and medical)
• Surgery
• Transplant
• Pediatrics
Large geographical area

Our UM staff comes from various locations, but as we fill positions, we make every effort to hire in-state. Our UM staff is currently in the following areas:

• West Virginia
  o Morgantown
  o Charleston
  o Parkersburg
  o Summersville

• Indiana
• South Carolina
Which services require prior authorization (PA)?

- All inpatient hospitalizations (including transfers that are nonemergent or not to a higher level of care)
- Advanced imaging
- Outpatient therapy
- Certain outpatient surgeries
- Sleep studies
- Genetic testing
- Durable medical equipment
- Home health services
- All out-of-network requests

When deciding which services are subject to review, we look at utilization, potential for abuse, local and national trends, cost, and our state contract.
PA vs. Continued Stay Review (CSR)

PA is for planned admissions or procedures, such as:
- Hysterectomy.
- Knee replacement.
- Advanced imaging.

CSR is for emergency admissions and inpatient extensions such as:
- Myocardial infarction.
- Chronic obstructive pulmonary disease exacerbation.
- Acute withdrawal.
- Any case where the member stays longer than the approved days.
UM process
High-level overview

Provider sends in clinical

Case meets criteria: Nurse approves

Case does not meet: Nurse sends to PCR for review

Nurse completes case and notifies provider

PCR reviews and approves or denies

Specialty review may occur

PCR routes back to nurse to complete case

Nurse completes case and notifies provider

MMS may complete notification

MMMS may complete notification

Post denial: case may go to G&A or p2p

CSR: nurse continues to follow through d/c, review as necessary
How to start a request

• Fax: The PA Request Form is on the provider website at http://www.unicare.com > Providers > State Sponsored Plan Providers > West Virginia - Medicaid Managed Care.

• Availity Portal: Online requests will be covered in a separate webinar.

• Phone

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>PA phone:</td>
<td>1-866-655-7423</td>
</tr>
<tr>
<td>PA fax:</td>
<td>1-855-402-6983</td>
</tr>
<tr>
<td>CSR fax:</td>
<td>1-855-402-6985</td>
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Precertification Look-Up Tool (PLUTO)

- PLUTO is located on the UniCare provider website at www.unicare.com.
- It allows providers to look up specific codes to see if they’re covered and if PA is required.
- You must enter each service you’re requesting.

Tips:
- Capitalize letters in HCPCS codes.
- Select Find Code rather than using the Enter key on your keyboard.
Required information

• Member name, ID and DOB
• ICD-10 code(s)
• CPT/HCPCS code(s)
• Number of units
• Referring/ordering provider
• Servicing provider
• Servicing facility (if applicable)

• Provider contact information
• TIN and NPI (for all providers/facilities)
• Date(s) of service (including the number of days requested for inpatient stays)
• Clinical information to support the request
## Turnaround times

<table>
<thead>
<tr>
<th>Type</th>
<th>Time frame</th>
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<tbody>
<tr>
<td>Routine pre-service</td>
<td>7 calendar days</td>
</tr>
<tr>
<td>Urgent pre-service (including urgent discharge needs)</td>
<td>2 business days</td>
</tr>
<tr>
<td>Current inpatient requests</td>
<td>3 calendar days</td>
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</tbody>
</table>
Urgent criteria

A request is considered urgent when waiting the normal time frame for review could do one of the following:

• Seriously jeopardize the life or health of a member or the member’s ability to regain maximum function based on a prudent layperson’s judgment

• Subject the member to severe pain that cannot adequately be managed without treatment

• Delay a member’s discharge from an inpatient hospital
## Examples: urgent vs. nonurgent

<table>
<thead>
<tr>
<th>Urgent</th>
<th>Nonurgent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal CT scan for new hematuria</td>
<td>Sleep study</td>
</tr>
<tr>
<td>MRI L-spine with signs of compression</td>
<td>Tonsillectomy and adenoidectomy (T&amp;A)</td>
</tr>
<tr>
<td>CT scan of the chest for suspected pulmonary embolism</td>
<td>MRI L-spine for a history of chronic, stable low-back pain</td>
</tr>
<tr>
<td>Member is currently inpatient and needs wound vac for discharge</td>
<td>Forgetting to request PA for a service scheduled for the next day</td>
</tr>
</tbody>
</table>
## Hierarchy

1. **Federal and state mandates**
   - Federal mandates for inpatient stays following a delivery

2. **Medical benefits**
   - Coverage based on West Virginia Bureau for Medical Services contractual requirements
   - UniCare medical policies
   - AIM
   - Health plan adopted guidelines
   - MCG Care Guidelines

3. **Reimbursement policies and claims processing guidelines**
Criteria procedures

- We use evidence-based criteria to review all requests.
- The medical policy and technology assessment committee meets quarterly.
- All Medical Policies and Clinical UM Guidelines are reviewed annually.
- New technology is reviewed as it becomes available.
- When no policy is available, we refer to national standards (CMS, CDC, AHRQ, NCCN) or the appropriate physician specialty society (AAFP, AAP, APA, ASH, ISDA) to make a determination.
- All medical necessity denials are reviewed by a physician.
Medical Policies and Clinical UM Guidelines

• Outpatient procedures
  o T&A
  o Genetic testing
  o Spinal fusion and other spine procedures

• Durable medical equipment
  o Custom wheelchairs
  o Life vests
  o Insulin pumps

• Other services
  o Home Health
  o Physical/occupational/speech therapy

All policies are available at www.unicare.com > Providers > State Sponsored Plan providers > West Virginia - Medicaid Managed Care.
AIM guidelines

• Our nurses review requests for advanced imaging, radiation therapy, musculoskeletal services and sleep management services using AIM criteria.
• Both pediatric and adult guidelines are available.
• All policies are available at www.aimspecialtyhealth.com/marketing/guidelines/185/index.html.
MCG Care Guidelines

• Used for inpatient requests and certain outpatient procedures
• Provides indications for admission and recommended length of stay
• Helps differentiate observation from inpatient necessity
• Includes pediatric and adult guidelines for certain diagnoses as well as common complications, extended stay criteria and discharge planning information

Please note, there are some custom edits to the MCG Care Guidelines criteria. Individual guidelines are available upon request; due to licensing restrictions, we cannot publish them.
Clinical information

The amount of clinical information you submit depends on the request, but there must be enough information to support the request.

Examples are on the following slides.
Requesting MRI of the lumbar spine: criteria

Nonspecific low back pain

• In a patient where focused history and physical exam suggest nonspecific lumbar pain and/or referred buttock or lower extremity pain and all of the following are met:
  • Patient is a potential candidate for surgery or epidural steroid injection
  • Patient has, following clinical examination, completed a minimum of six consecutive weeks of physician supervised conservative therapy for the current episode of pain, including but not limited to any of the following:
    o NSAIDs
    o Muscle relaxants
    o Steroids
    o Physical therapy; **AND**
  • After trial of conservative therapy as listed above, patient fails to show substantial improvement on clinical re-evaluation
Requesting MRI of the lumbar spine: clinical to submit

• Document whether the patient is a candidate for surgery or epidural steroid injections.
• Detail any conservative treatment the patient has undergone.
• Complete and document the re-evaluation.
  ○ This can be copies of records, a note or entry in Availity, and/or actual patient and office visit notes. As long as we receive enough information to make a decision, you are free to use whichever format works best for you.
Requesting T&A: criteria

Tonsillectomy is considered medically necessary for individuals less than 18 years of age who meet one or more of the criteria below:

A. A history of recurrent throat infection with a frequency of at least one of the following:
   • 7 episodes in the past year
   • 5 episodes per year for 2 years
   • 3 episodes per year for 3 years

   Additionally, documentation in the medical record for each episode of sore throat indicates at least one of the following:
   • Temperature greater than 38.3 °C (100.8 °F)
   • Cervical adenopathy
   • Tonsillar exudates or erythema
   • Positive test for Group A β-hemolytic streptococcus (GABHS).
Requesting T&A: clinical to submit

• Submit documentation of recurrent throat infections meeting the criteria in the previous slide. Include documentation of fever, cervical adenopathy, tonsillar exudate/erythema and strep.

• The PCP tracking tool and forms are located on the provider website at www.unicare.com.
Minimum necessary

• We attempt to obtain and use the minimum necessary information we need in order to do our jobs appropriately.

• Please do not send the entire medical record. We do not need it.

• Becoming familiar with the criteria will help you decide what to send.
UM denials
Denial letters

UniCare sends a denial letter each time a denial is issued.

Denial letters:

• Are member-specific.
• Cite the criteria used for the denial.
• Include the reason the denial was issued, such as:
  - Insufficient information.
  - No conservative treatment documented.
  - Inappropriate level of care.
  - Service is non covered or limits exceeded
• Include information on appeals and how to file them.

Make sure to read the letter in its entirety to determine next steps.
Example: member denial

We cannot approve surgery (tonsillectomy and adenoidectomy) for your child. This is because it is not medically necessary. Your child is having problems (throat infections). She breathes through her mouth. Records do not show that her tonsils are enlarged. Records do not show certain things (documentation in the medical record for each episode of sore throat which includes at least one of the following: Temperature greater than 38.3 C; or cervical adenopathy; or tonsillar exudates or erythema; or Positive test for Group A hemolytic streptococcus). We used Health Plan Clinical UM Guideline CG-SURG-30 Tonsillectomy for Children with or without Adenoidectomy (Publish date: June 6, 2018) to decide this.
Example: member denial (cont.)

We cannot approve the surgery to remove your womb (hysterectomy). This is because it is not medically necessary. You have pain. We do not know how long you have had this pain. We do not know what else you have tried. Records do not show you had surgery (laparoscopy) to look for a cause. We used *MCG Care Guideline*, 22nd Edition, modified by the health plan, for *Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted, W0010* to decide this.
Options after a denial is issued
Peer-to-peer reviews

- Discuss your case with the physician who made the decision.
- You can receive an immediate decision during the discussion.
- Peer-to-peer reviews must be requested within 24 hours of the denial notice.
- Call the peer-to-peer line at 1-866-902-4628, option 3 and leave the following information:
  - Name, title and contact information
  - Availability to return your call
  - Member name, DOB and reference number
  - Clinical information to help with the decision (if available)
New requests

• Submit a new request when there is new information that was not provided during the initial review.
• This option is only available for outpatient, pre-service requests.
• Follow the normal process to start a new case.
• We will make a decision within the standard turnaround time.
Appeals

• The appeals process is outlined in the denial notice. Appeals may be requested up to 60 days after a denial notice. Please send the appeal request via either of these methods:
  o Fax: **1-866-387-2968**
  o Mail: UniCare Health Plan of West Virginia, Inc.
    Attn: Grievance and Appeals Department
    P.O. Box 91
    Charleston, WV 25321-0091
• You must provide all relevant clinical information.
• Standard appeals are completed within 30 days of your request.
  o We will use the same criteria we use for urgent PA requests.
• Appeals are reviewed by a different physician than the one who issued the initial denial.
State fair hearing

• If UniCare appeals are exhausted, the next step is a state fair hearing.

• Request within 90 days of appeal letter.

Bureau for Medical Services
Office of Medicaid Managed Care
350 Capitol Street, Room 251
Charleston, WV 25301-3708
Common issues
Not enough information

Examples:

• There is no documentation of conservative therapy for advanced imaging or spinal injections.

• There is no documentation of recurrent throat infections for T&A requests.

• There were less than 48 hours of clinical for inpatient admissions.
  
  ○ Most MCG Care Guidelines require that the member fails the observation setting before approving an inpatient admission.
Out-of-network requests

• Please make every effort to refer members to an in-network provider. You may use the provider finder at www.unicare.com or call our Customer Care Center at 1-800-782-0095.
  o For complicated care and coordination, call our Customer Care Center and request a case management referral.
• Out-of-network requests will be approved if no in-network provider is available or to ensure continuity of care for new members.
• For genetic testing:
  o We see frequent requests for genetic testing to be done at specialty laboratories.
  o LabCorp provides comprehensive genetic testing services, including BRCA gene tests.
Changes in requests

Claims must match what was entered in the PA request. To request a change, call or fax your UM intake to make sure it is processed appropriately. Examples of items you may need to change include:

• An MRI without contrast to an MRI with contrast.
• The date(s) of service.
• The facility.

You can make changes on the Availity Portal as long as the service hasn’t been rendered. If it has been rendered, please contact UM to make the change.
UniCare care management platform

• Updated UM system is coming in October
• More customizable for our market
• Better insight and reporting
• Integration with member and provider data
What does this mean for you?

• Improved efficiency
• Information gathered in a different sequence during calls
• Letters will look different
• Authorization numbers will have a different format
• Place of service will match CMS approved POS
• No claims impact — Continue to submit with the auth number you receive
Provider resources
We’re here to support you

• Provider workshops
• Provider newsletters
• Network representatives
• UniCare provider website
  o Important contact information
  o PLUTO
  o *Medical Policies and Clinical UM Guidelines*
  o Provider manuals
  o Benefit matrices
  o Reimbursement policies
Questions or concerns?
Thank you

www.unicare.com
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UWVPEC-0900-18 September 2018