

## SECTION 19 - UTILIZATION MANAGEMENT

PHP monitors potential over and under utilization of services by its Members by conducting the following:

- Utilization Management (UM)
- Pre-certification for elective hospital admissions
- Concurrent review of inpatient medical and behavioral health admissions and SNF admissions

It is the policy of PHP that persons performing utilization review functions will not be given incentives of any kind for denying payment for care or for reducing a level of service as a means of decreasing expenditures. This applies to PHP staff as well as contracted reviewers. Decisions are based solely upon the appropriateness of care and the existence of coverage for that care. There are no financial incentives for UM decision makers that will result in underutilization of services.

Physicians and nurses at PHP use clinical criteria, based on medical necessity, to make coverage decisions. Plan Providers who are seeing a Member and have questions regarding the criteria used may call PHP to receive a copy of the criteria.

### **Timeliness of Coverage Determination**

Coverage for Members will be provided in accordance with Medicare criteria and guidelines. Procedures that do not meet Medicare criteria and guidelines may not be eligible for coverage by PHP. It is the policy of PHP to process coverage determination (Utilization Management) decisions in a timely manner in order to facilitate payment for requested services. The following timelines apply for all:

- **Non-urgent pre-service** determinations, including behavioral health; a decision will be made and the Member and requesting practitioner or provider notified of denial decisions by mail within fourteen (14) calendar days of receipt of the request; extensions past fourteen (14) calendar days may be made only if they are in the best interest of the Member and require Member consent
- **Urgent pre-service** determinations, including behavioral health; a decision will be made and the Member and requesting practitioner or provider will be notified of denial decisions by mail within seventy-two (72) hours of receipt of the request
- **Urgent concurrent** determinations, including behavioral health; a decision will be made and the Member and requesting practitioner or provider will be notified of denial decisions by mail within twenty-four (24) hours of receipt of the request
- **Post-service** determinations, including behavioral health; a decision will be made and the Member and requesting practitioner or provider will be notified of denial decisions by mail within thirty (30) calendar days of receipt of the request

- **Home Health Agencies** are responsible to notify PHP within forty-eight (48) hours or within two (2) business days of providing home health services.

To ensure coverage, services must be received from a Plan Provider, unless prior approval has been obtained as outlined below in the Prior Authorization for Non-Plan Providers section.

### **Prior Authorization for Non-Plan Providers**

PHP must authorize the referral of a Member to a Non-Plan Provider prior to the service being provided (with the exception of emergency cases)\*. PHP pays for claims submitted for authorized services and considers approval of prior authorization requests for Non-Plan Providers only if **all** of the following requirements are met:

- the services are medically necessary
- the services are a covered benefit
- the services are not available from a Plan Provider and the request is reasonably prudent
- Member has previously been treated by the Non-Plan Provider and a change of provider would cause a significant setback in the progress of diagnosis or treatment. Chronic condition care may be limited to a period not to exceed ninety (90) days, but may be extended based on Medical Director review
- Members who are in their second or third trimester of pregnancy are allowed to continue care through delivery and the first post-partum visit

**\* Contact PHP at 715-838-2900 before a Member is referred to any Non-Plan Provider.**

### **Pre-certification of Hospital Admissions**

Based on medical diagnoses, information or proposed surgery, PHP will:

- Authorize coverage for a length of stay based on McKesson InterQual guidelines
- Notify the Member of the number of days authorized for elective admissions by letter
- Notify the physician of concurrent review for those admissions with no specific length of stay
- Follow the admission with the hospital's utilization review department if the Member is not discharged within the pre-certified period of time. The admission will be reviewed for medical necessity and intensity of service

If not available through the hospital utilization review department, contact the Plan Provider for additional information to determine if additional days should be covered or denied. The decision will be based on medical necessity for an acute care setting. Alternate settings and/or appropriate home health services will be explored for Members who do not meet criteria for continued coverage of acute care.

The **Plan Provider**, not the Member, is responsible for pre-certifying an admission to the hospital for medical and/or surgical treatment.

**Second Opinions**

Members are covered for a second opinion within the affiliated Provider Network.

**New Technology**

PHP follows Medicare's coverage determinations for new technology.