
Overview

The focus of Utilization Management (UM) is to provide members access to quality care, effectively coordinate health care services and to monitor the appropriate utilization of services. *Quality care* is generally defined as treatment that:

- Improves a member's physical and emotional status;
- Promotes health and early access to treatment;
- Involves the member and/ or member's representative in decision-making given by practitioners sensitive to illness-related activity;
- Bases decisions on accepted medical principles;
- Uses technology and other resources effectively; and
- Sufficiently documents medical records.

Medically Necessary or *Medical Necessity* shall mean health care services that a health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with Generally Accepted Standards of Medical Practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Considered effective for the patient's illness, injury or disease;
- Not primarily for the convenience of the patient or health care provider;
- 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 that patient's illness, injury or disease.

**Plan Criteria for
UM Decisions**

The Plan's UM department utilizes various criteria, which may include the following, when making coverage determinations:

- InterQual
- Local and federal statutes and laws
- Member benefits
- Hayes Technology Assessment

**Prior
Authorization
Procedures**

The Plan shall:

- Not require prior authorization for emergency services, post-stabilization services or urgent care services, as referenced in the Plan's **Rapid Reference Guide** and Authorization Guides;
- Require prior authorization for all non-emergency inpatient and outpatient admissions except for normal newborn deliveries as referenced within the Plan's **Rapid Reference Guide** and Authorization Guides;
- Require prior authorization for all non-emergent, out-of-network services, as referenced in the Plan's **Rapid Reference Guide** and Authorization Guides;
- Conduct prior authorization by a currently licensed, registered or certified health care professional who is appropriately trained in the principles, procedures and standards of utilization review;
- Notify the provider of prior authorization determinations in accordance with predetermined time frames;
- Require that members obtain a referral from their PCP prior to accessing non-emergency specialized services or as identified within specific provider contracts.

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.

- 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.
- If an office does not have a fax machine, contact Outpatient Services at the telephone number listed on the **Rapid Reference Guide**.

Requesting an Authorization

Providers may request a routine in-network and out-of-network authorization by:

- Faxing an **Authorization Request Form** to the Plan, preferably at least 10 days prior to the start of the service or procedure.

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

- Faxing an **Authorization Request Form** to the Plan noting the word **“stat”** on the request, or;
- Calling the Outpatient Services department. (Have the member’s name and ID number available when calling).

Stat and *Urgent* are defined as any service that if delayed could affect the member’s health or functional capabilities and should be performed as soon as possible.

Plan’s Final Determination

The Plan may take up to 14 business days to make a final determination for routine authorizations. However, the Plan will attempt to make a final determination within two business days of receipt of the initial request for a routine

authorization. “Stat” authorizations are reviewed and approved as soon as possible.

It is the provider’s responsibility to respond as quickly as possible to any requests for further information as requested from the Plan. Non-receipt of essential information may cause a denial of requested services.

Services Requiring Referrals and Authorizations

For specific instructions on services requiring a Plan authorization and/or referral, refer to the **Rapid Reference Guide** or visit the Web site at www.harmonyhpi.com.

Authorization Decision Time Frames and Reconsideration**Service Authorization Decision Time Frames**

The Plan will provide a timely authorization decision response to requesting providers to assure that services can be delivered appropriately.

Expedited Determinations

Expedited determinations – If waiting for the time allowed for a standard determination will jeopardize the member’s health or ability to function, the provider or member may request an expedited service authorization decision.

- The Plan will provide an expedited determination for any request made or supported by a physician.
- If the request is filed by a member, the Plan will evaluate the request to determine whether to process it as an expedited determination, based on the medical information provided.
- If the expedited determination is not granted, the request will be processed within the 14 day time frame.
- A response will be provided within 24 hours. The provider may contact the Plan by telephone for the most rapid response to an authorization request.

- To file a verbal or written expedited determination requests, refer to **Rapid Reference Guide** for contact numbers. The Plan will document the verbal request in writing.
- Specifically state, "I want an expedited or 24-hour decision," or "I believe that my health/the health of my patient could be seriously harmed by waiting 14 days for a standard decision," and provide supporting medical documentation.
- For expedited determinations, an extension of up to five business days is permitted, if the extension of time benefits the member.

Routine/Urgent Determinations

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 member) of receipt of necessary information sufficient to make an informed decision.

Urgent determinations – If the service being requested is medically urgent, providers may request that a decision be made more quickly. Prior authorization determinations for urgent services shall be made within 24 hours of receipt of the necessary information, but no later than three business days after receipt of the request for service.

Extensions – If the provider or the member feels that a request for a 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. As an example, if the member needs time to provide the Plan with additional information or to complete additional diagnostic tests.

- The extension may be initiated by the Plan, if the Plan justifies to the Illinois Department of Healthcare and Family Services (HFS) a need for additional

information and the extension is in the member's best interest.

**Denial
Determinations**

If the Plan makes a decision to deny, reduce, suspend or terminate a service authorization request or extension, the Plan will notify the member and the provider in writing of that decision.

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.

Written notification of the denial is sent to the member, requesting provider and service provider by mail. The written denial notification will:

- Provide the Utilization Review criteria or covered benefits provision used in the adverse determination;
- Identify the specific reason(s) for denial;
- Suggest a level of service that is covered under the member's benefit plan, when appropriate;
- Identify the physician who rendered the adverse determination; and
- Explain how to appeal, including time frames involved and documentation required.

**Emergency/
Urgent/Post
Stabilization
Care**

Emergency Services are available to members 24 hours a day, seven days a week to treat an emergency medical condition.

Emergency, urgent and post stabilization services and care do not require prior authorization. Members are instructed, in case of an emergency, to call 911 or proceed to the nearest hospital emergency room. Members have the right to use any type of provider, hospital or facility in the case of emergency. Members should notify their PCP as soon as possible following emergency treatment in order to receive appropriate follow-up care.

Concurrent Review

The Plan's concurrent review involves oversight of members admitted to hospitals, rehabilitation centers, skilled nursing facilities and other inpatient settings. The concurrent review nurse follows the clinical status of the member on an ongoing basis through on-site, telephonic or faxed chart review, communication with the physicians and/or other health care professionals involved in the member's care. The concurrent review process incorporates the use of clinical guidelines developed from peer-reviewed, evidence-based literature to assess quality care and the appropriate level of admission and continued medical treatment. Reviews are performed by licensed nurses under the direction of the Plan's medical director. Admission and/or continued stay denials are determined by the Plan's medical director.

Discharge Planning

Discharge planning is an essential part of the concurrent review process. It may include coordinating services required to assist in arranging for and implementing a member's transition to a more appropriate or lower level of care, as needed. The concurrent review nurse coordinates services with the PCP, attending physician and/or the discharge planning personnel at the hospital. Coordination of discharge planning activities should be implemented upon the members admission to the hospital or other health care facility.

After Hours Utilization Management

Currently, Harmony utilizes Primary Care Net, an after-hours nurse triage line that verifies member eligibility, locates pharmacies, receives and transmits necessary information from hospitals and other facilities to Harmony for appropriate follow-up and authorization of services. In addition to this service, Harmony provides the availability of a nurse on-call.

Physicians requesting after-hours authorization for inpatient admission should refer to their **Rapid Reference Guide** for the number to contact an after-hours nurse. Discharge planning needs that may occur after normal business hours will be handled by the Plan's after-hours nurse.

Transition of Members

As per the Illinois Senate Bill 251, new members enrolling in the Plan may request to continue an "ongoing course of treatment" for up to 90 days from the date of enrollment or until the completion of pregnancy or post-partum care for members in their third trimester of pregnancy. The Plan will evaluate each request and authorize continuation of services with non-contracted providers until the member can be safely transitioned in network.

Second Medical Opinion

Members may request a second medical opinion concerning surgical procedures or serious injury or illness. The member may choose a physician that is participating with the Plan or a non-participating physician that is within the Plan's service area. 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.

Request for Ancillary Services

Requests for ancillary services require the provider to complete an **Authorization Request Form**, as identified within the Plan's **Rapid Reference Guide** and Authorization Guides. Please see the **Forms** section of this manual.

The additional information needed for each service is outlined below.

Home Health Care

1. Initial Home Health Care request:
 - Medical reason for the home health service;
 - MD prescription with the type of skilled service, frequency and duration;

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- Homebound status;
 - Name of participating/in-network home health provider.
2. Continuation of Home Health Care request:
- Complete home health evaluation note and most recent home health progress summary note;
 - Homebound status;
3. Home Infusion Therapy and IV Drug request:
- Drug name;
 - Dosage;
 - Frequency and duration;
 - Type of access IV line;
 - Mode of delivery (gravity or pump);
 - If member received this IV drug before;
 - Available caregiver to teach and train.
4. Home Wound Care and Wound Care Supplies request:
- Wound location;
 - Dimensions;
 - Necrotic tissue;
 - Viable tissue;
 - Drainage;
 - Odor;
 - Surrounding tissue;
 - Skin condition.

Durable Medical Equipment

1. Home Oxygen Therapy:
- Most recent ABG PO₂ rate of 55 percent or lower, Pulse Oximetry saturation rate of 88 percent or lower;
 - Flow rate, frequency and duration;

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- Delivery device and type of system.
2. Continuous Positive Air Way Device (CPAP, Bi-PAP):
 - Most recent Polysomnogram narrative results with and without titration.
 3. Manual Wheelchairs and Accessories:
 - Most recent functional mobility status report (non-ambulatory, ability to self propel etc.)
 - Height and weight;
 - Any specific body characteristic or limitations that need to be accommodated in the wheelchair by an extra optional device.
 4. Electric Wheelchairs, Electric Scooters and Accessories:
 - Same information as manual wheelchair; and
 - Upper body limitations that prevent the effective use of a manual wheelchair (i.e., inability to move upper extremities or severe reduction in movement).
 5. Hospital Bed and Accessories:
 - Medically necessary bed positioning not feasible on a regular bed;
 - Height and weight;
 - Special needs to be accommodated by an optional device.
 6. Orthotic and Prosthetic Devices:
 - Covered HCPCS code for the orthotic or prosthetic item.

Outpatient Therapy

1. Continuation of Outpatient Therapy requests (after initial evaluation and two visits):
 - Complete initial therapy evaluation and progress summary notes with objective, measurable, clinical findings and updated goals;
 - MD prescription with frequency and duration.

Delegated Entities

All participating providers or entities delegated for Utilization Management shall apply the same standards as defined in this section. Compliance of delegated entities is monitored on a monthly basis and formal audits are conducted annually.

Contact Information

Refer to the **Rapid Reference Guide** for telephone numbers of the Plan's Utilization Management department.