

9 - Utilization Management

Health Plan of Nevada (HPN) defines Utilization Management as the process of evaluation and determination for appropriateness of health care services. Listed below are just a few of the functions performed by our Utilization Management System:

- Prior Authorization (Pre-service Determinations)
- Admission and Health Care Services/Telephone Advice Nurse (Patient and Provider Access Center)
- Concurrent Review
- Denials, and Appeals Process
- Retrospective Review (Post-service Determinations)

9.1 Prior Authorization (Pre-service Determinations)

Definition: Pre-service determinations involve cases or services that must be approved, in whole or part, in advance to member's obtaining medical care or services. Prior authorization and precertification are pre-service claim determinations.

Prior authorization is the assessment and screening of requests for health care services from providers. The screening determines if the treatment is compatible with the diagnosis, if the member has benefits for services requested, and if the requested services are to be provided by a participating provider in an appropriate setting. This allows members' access to cost-effective, specialized care, necessary for their medical conditions, through their primary care physician.

The Health Plan's Prior Authorization Department is responsible for the processes of notification and prior authorization with Clinical Review for medical necessity and final determination of selected medical procedures, treatments, services or equipment.

9.2 Notification

Specialty-specific procedures, treatments and services must be processed through the Prior Authorization Department however; they do not require review by licensed personnel. The notification process includes checking eligibility, benefit coverage, and determination of appropriate site and provider. These requests are built into the computer system for provider payment purposes only. Services are to be done by designated providers and facilities. If not, prior authorization with clinical review by licensed personnel will be required.

9.3 Medical Necessity Determination

The Prior Authorization process includes checking member eligibility and benefit coverage, clinical review to determine medical necessity and determination of appropriate site and provider. Clinical review involves gathering all relevant clinical information that supports determinations of medical necessity of requests for medical treatment or services.

Nationally accepted guideline criteria, including, but not limited to; MCG, locally and nationally developed health plan criteria, and CMS and NCQA guidelines and regulations are applied based on the needs of individual members and the local delivery systems. The UM criteria utilized in rendering a decision is available to providers on our web site at

www.healthplanofnevada.com/Provider or upon request by contacting the Prior Authorization Department at **(702) 243-8499** or **(800) 288-2264**.

HPN also utilizes consultants from appropriate specialty areas. Consultants representing the specialties of cardiology, gastroenterology, hematology, infectious disease, nephrology, neurology, orthopedics, pediatrics, urology, etc. are used for review of individual cases when appropriate. All consultants are either board certified by one of the American Boards of Medical Specialties or other specialty certification appropriate to the practitioner's discipline.

Prior authorization staff has the authority to approve all situations that meet criteria and to refer potential denials or questionable cases to the Medical Director for review. Only the Medical Director may issue a prior authorization denial for decisions involving medical necessity review. Notifications of denial with appeal rights are given to members in writing and to providers verbally, by fax and in writing.

The purpose of the prior authorization function is to ensure that every HPN member receives quality care delivered to promote wellness, through utilization of appropriate resources, in the most appropriate setting and in the most cost-effective manner. This is achieved through the evaluation and determination of the appropriateness of the member's and practitioner's use of medical resources prior to services being rendered and the provision of any needed assistance to health care providers and/or the member to ensure appropriate use of resources.

9.4 Services That Require Prior Authorization

Services that require prior authorization with clinical review include, but are **not** limited to:

- Non-emergent/urgent elective admissions to an inpatient facility
- Skilled Nursing Facility and Rehabilitation
- Orthognathic surgery, including all TMJ (Most Orthognathic surgeries are excluded and TMJ has coverage limitations)
- Bariatric Surgery
- Transplants
- Out of Plan or out of area providers/facilities/services
- Custom DME and DME purchases (unless under capitation with HPN), Prosthetic/Orthotic devices
- Infertility services (excluded for Medicaid) and Sterilization Reversals (Sterilization reversals excluded for all products)
- All Perinatal Requests
- Level II Ultrasounds
- OB Delivery
- Sleep disorder studies and Surgeries
- Complex Radiology (e.g. MRI's, SPECT Scans, CT Scans, PET scans, and Nuclear Medicine)
- Selected outpatient facility-based procedures
- Selected injectable medications
- Therapies (Physical, occupational, and speech unless under capitation)
- Complex Diagnostic Testing (e.g. Echo-Cardiograms, Stress Tests, Nerve Conduction Studies, and EMG's.)
- Genetic lab testing
- Dental outpatient surgery site and anesthesia

Note: Prior authorization of urgently/emergently needed care is NOT required. However, notification of such services is expected.

A prior authorization request may be initiated by a licensed facility, physician, or other ordering provider, patient or responsible patient representative including a family member. Patient prior authorization requests should be submitted by the provider using the appropriate prior authorization request form.

9.5 Prior Authorization Timeframes

Routine Requests:

Routine requests are reviewed with a determination rendered within the timeframes required by the Department of Labor, Centers for Medicare and Medicaid Services (CMS) and Nevada Division of Healthcare Financing and Policy- Managed Care Division. If additional clinical information is needed to render a decision, the provider will be contacted by phone and/or fax to supply the necessary information.

The UM criteria that is utilized to render a decision is available to providers on our web site www.healthplanofnevada.com/Provider or providers may request a copy by contacting the prior authorization department at **(702) 243-8499** or **(800) 288-2264**.

Urgent (Expedited) Requests:

Urgent (expedited) requests are for those services, which are related to urgent medical care conditions that have the potential to become an emergency in the absence of treatment.

Urgent (expedited) requests are reviewed with a determination rendered and provider notified within the requirements of the Department of Labor, the Centers for Medicare and Medicaid Services (CMS) and Nevada Division of Healthcare Financing and Policy-Managed Care Division which is 72 hours, although we do strive to provide the determination within one calendar day.

9.6 How to Obtain Prior Authorization for Services

We are committed to providing exceptional service to our members and providers. Our online provider center offers benefit and claim information, referral and prior authorization submissions, and more!

All Health Plan of Nevada Inc, and Sierra Health and Life Insurance Company providers are required to submit all Routine prior authorization requests online using the [online provider center](#). Stat/urgent prior authorization request can be submitted through the online center as well. Stat/urgent requests can also be called or faxed to the UM department at the numbers below.

- Website: online via the [online provider center](#)
- Fax:
 - Las Vegas area **(702) 304-7411**
 - Toll free **(800) 282-8845**

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- Phone:
 - Las Vegas area (702) 243-8499
 - Toll free (800) 288-2264
 - (888) 224-4036

Note: UM Representatives are available Monday – Friday from 8:00 a.m. - 5: 00 p.m. (Pacific Standard Time) to assist you.

Note: If your group is not currently set up with an online provider center Administrator account you may submit a request online via the [online provider center](#) website by clicking on “Create an Account” and following the on screen instructions. Online provider center tutorials are available online through the HPN website. Provider Services is available to answer any specific questions you may have regarding the application.

It is the responsibility of the requesting provider to provide pertinent case specific clinical information to support the request for medical services or treatment.

Hospital Admit Notifications and Utilization Review

Telephone Numbers (for Members in area):

| | |
|--------------------|----------------|
| Admit Notification | (702) 242-7770 |
| Concurrent Review | (702) 797-2100 |
| Toll Free | (877) 487-6659 |

| | |
|-------------|----------------|
| Fax Numbers | (702) 667-4623 |
| | (800) 645-6941 |

Telephone Numbers (for Members out-of-area):

| | |
|--------------------|----------------|
| Admit Notification | (800) 365-9687 |
| Utilization Review | (800) 216-7525 |

| | |
|------------|----------------|
| Fax Number | (702) 800-8168 |
|------------|----------------|

Business Hours: Monday – Friday, 8:00 a.m. – 5:00 p.m. Pacific Standard Time

For Hospital Admission Notification and Utilization review **after hours and weekends** contact the Access Center at:

Telephone Numbers:

| | |
|------------------------|----------------|
| Las Vegas area | (702) 242-7330 |
| Outside Las Vegas area | (800) 288-2264 |

| | |
|---------------------|----------------|
| Fax (Clinical data) | (702) 242-7025 |
|---------------------|----------------|

Please check the online center regularly for UM notes and decision on your prior authorization requests and admission notifications. The UM team documents throughout the day. These notes can be viewed in the online center by requesting and servicing providers listed in the request. Providers listed in the request can access the online center to view case notes related to requests for additional clinical information, preferred level of care and/or providers, and approval/denial decisions prior receiving to formal written or verbal communication.

9.7 Patient and Provider Access Center (After Hours Admission and Healthcare Services/Telephone Advice Nurse)

Understanding the importance of quick and accurate information, the HPN Admission and Healthcare Services and Telephone Advice Nurse line have joined together to develop a department specifically designed to assist members, physicians and all other providers with health care information and services.

This 24-hour information and care management system provides access to a “one-stop-shop” staffed with specially trained registered nurse professionals who work to meet the service and care needs of members and providers. As liaisons, Registered Nurse staff members are actively involved in coordinating care by assisting with admissions and healthcare services and health care triage advice to HPN members.

Staff assists with urgent/emergent hospital admissions and after-hours prior authorization for urgent outpatient services, patient transfers and referrals for other health care services such as Home Health, Hospice, Case Management, Durable Medical Equipment and Infusion Therapy.

The Telephone Advice Nurse program provides quick, comprehensive solutions to member’s health concerns no matter what the time of day or night. Specially trained registered nurses are available 24 hours a day to offer simple, accurate advice regarding specific symptoms, illness or injury or simply answer member’s questions about a particular health concern. If a member does need to see a physician or visit an urgent care clinic, the nurse will direct the member to an urgent care clinic or assist scheduling an appointment.

For information and assistance from the Access Center:

Telephone Numbers:

| | |
|------------------------------|-----------------------|
| Las Vegas area | (702) 242-7330 |
| Toll free | (800) 288-2264 |
| Telephone Advice Nurse (TAN) | (702) 242-7330 |

Fax Numbers:

| | |
|----------------|-----------------------|
| Las Vegas area | (702) 242 7025 |
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Note: Prior authorization is NOT required for emergency procedures or services for screening and stabilization in cases where a prudent layperson, acting reasonably, based on presenting systems, would have believed that an emergency existed.

9.8 Inpatient Concurrent Review

At HPN, the Continuity of Care department provides initial and ongoing assessments of members receiving care in the inpatient setting in order to ensure the appropriate level of care the member is receiving based on medical necessity. In order to accomplish this task HPN provides hospitalists, case managers and Medical Director leadership to perform daily case reviews telephonically and/or on-site on all members hospitalized in an acute care facility, a rehabilitation facility or a sub-acute or skilled facility. The functions of Case Management include review of medical status for appropriate length of stay and level of care, discharge planning, case management, and referrals for ongoing post hospital care. Nationally accepted guidelines and criteria are used to make medical necessity determinations.

Only the Medical Director issues denials for continued stay. Notifications of denial with appeal rights are given to members in writing and to providers verbally as well as in writing.

HPN's Continuity of Care Department is available 7 days a week from 8:00 a.m. – 5:00 p.m. (Pacific Standard Time) and can be reached at **(702) 797-2100**.

9.9 Denial and Appeal Process (Commercial Plans)

Denial

A denial, or adverse determination, is the determination by a Plan Medical Director that the services requested are not medically necessary after review of the clinical information submitted with the request for services. Only a licensed physician can make utilization management denial decisions based on medical necessity. Prior authorization staff communicates the denial verbally and through written correspondence to the requesting provider. The provider is informed at that time of their right to physician-to-physician communication regarding the impending denial, as well as the appeal process. During the physician to physician communication the requesting physician provides NEW or ADDITIONAL clinical information that was not originally submitted with the initial request.

No financial incentives or other types of compensation are given to UM decision-makers for the reduction or denial of services or care. Decision-making is based on appropriateness of care (medical necessity of the service, appropriateness of providers of care), eligibility of the member, benefit coverage for the service, the individual needs of the member and the availability of services within the local healthcare delivery network.

Appeal

A formal appeals process is set into action when requested by a member, his/her designee or his/her provider(s). These requests are evaluated by a Medical Director or a Physician Peer Reviewer. This physician will be in the same or similar specialty that usually provides the service being requested and will not have been involved in the initial decision to deny the requested service. A provider can appeal on behalf of a member a denial for a specific procedure, treatment or service by contacting the Prior Authorization Department either by phone, mail or fax. Member requests to appeal a denial for a specific procedure, treatment or service are received in the Member Services Department

For appeals, please call: **(702) 243-8499** or **(800) 288-2264**. Additional directions will be outlined in the denial letter.

An expedited (immediate) appeal review by the health plan, for continued stay denials and denials for services that would threaten life or limb of the member if not received immediately can be requested by the member..

9.10 Medicaid Action, Notice of Action and Appeals

Please see Section 8.10 for Medicaid Guidelines

9.11 Retrospective (Post-Service) Review

Retrospective (post service) review is the process of assessing the appropriateness of the medical care, services, treatments and procedures, and the providers of that care, after the care has been rendered. It is normally conducted by review of the members' medical record(s), including admitting diagnosis and presenting symptoms, as applicable.

Retrospective (post-service) Review is required for:

- Emergency admissions to out-of-area or out-of-plan facilities,
- Outpatient and emergency room care received in non-contracted facilities,
- Other care and services received by members when the provider of care will not cooperate with Health Plan review procedures and
- Other unauthorized care.

Medical Adjudication Department Nurses, who are a part of the Claims department, conduct all reviews using the MCG, Medicare or health plan protocols to review cases. This process can take up to 30 days. Only the Medical Director can issue denial decisions based on medical necessity of services.