MedStar Family Choice

ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**115**	
Subject:	**Utilization Management (UM) Criteria**	
Section:	**Care Management**	
Initial Effective Date:	**10/01/2007**	
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Review Effective Date(s):		
Historical Review Date(s):		
Responsible Parties:	**AVP of Clinical Operations and Manager of Utilization Management**	
Responsible Department(s):	**Clinical Operations**	
Regulatory References:	**NCQA 2024: UM 7A, UM 7G, UM 11E** **MDH Memorandum Dated 12-7-2017 RE: Hepatitis C Medications Approval Timelines (Also includes drugs other than Hepatitis C)**	
Approved:	**AVP of Clinical Operations**	**Chief Medical Officer**

Purpose: **This policy describes criteria utilized, to facilitate consistency in Utilization Management (UM) decision making.**

Scope: **MedStar Family Choice, Maryland**

Policy: **MedStar Family Choice follows documented UM criteria to facilitate consistency in UM decision making. All criteria utilized in utilization management are available upon request. The request can be made independent of a specific case. Reviewers and Nonbehavioral Healthcare Medical Directors are also available to discuss any and all utilization management decisions, questions, or issues. To request specific utilization management criteria or to speak with a Medical Director, please contact us by phone during our normal business hours, 8:30 AM to 5:00 PM Monday through Friday, at 800-905-1722 or 410-933-2200 option 2, then option 1. The fax number is 410-933-2274. Messages received outside of normal business hours will be addressed the following business day.**

UM decision making is based only on appropriateness of care and service and existence of coverage. MedStar Family Choice does not specifically reward practitioners or other individuals for issuing denials of coverage. In addition, there are no financial incentives for UM decision makers that would encourage decisions that result in underutilization.

MedStar Family Choice may provide the treating practitioner the opportunity to discuss a pending medical necessity denial with a UM reviewer and/or Nonbehavioral Healthcare Medical Director prior to the denial.

Procedure:

The following criteria and processes, as documented on MedStar Family Choice web site, are utilized for UM decision making:

A. Pre-Authorization, Retrospective Review, Requests for Continuation of Outpatient Services:
    1. MedStar Family Choice follows a basic pre-authorization process: A member's practitioner forwards clinical information and requests for services to MedStar Family Choice by telephone, fax, secure email or infrequently by mail. Telephones are manned on business days from 8:30am-5pm at 410-933-2200 or 1-800-905-1722. Our fax number is 410-933-2274 and faxes are received 24 hours/day, 7 days/week. Faxes and voice messages received after hours will be addressed the next business day. The after-hours voice mail message includes the names and telephone numbers to participating providers and facilities to contact for after-hours needs. The message also contains the telephone number for MedStar Family Choice representative who is on call after hours, weekends and holidays to process pharmacy requests in a timely manner.
    2. All appropriate ICD-10/CPT/HCPCS, along with supporting clinical information, must be included in requests for pre-authorization. Requests for authorization can be included on the Maryland Uniform Consultation Referral Form or the MedStar Family Choice Prior Authorization Form with clinical information attached. Our experienced clinical staff reviews all requests. MFC pre-authorization decisions are based on the following criteria:
        i. MedStar Family Choice Protocols
        ii. MedStar Family Choice Pharmacy Policies and Procedures
        iii. InterQual
        iv. Medicare and Medicaid Guidelines including but not limited to:
            1. Transmittals from the Maryland Department of Health
            2. Local Coverage Determinations (LCD)
            3. National Coverage Determinations (NCD)
            4. Local Coverage Articles (LCA)
            5. CMS State Medicaid Director Letters
        v. Code of Maryland Regulations (COMAR)
        vi. Code of Federal Regulations (CFR)
        vii. MedStar Family Choice MCO benefit coverage
        viii. MedStar Family Choice Provider Manual
        ix. MedStar Family Choice Member Handbook

x. Food and Drug Administration (FDA) Approval
xi. Maryland Medicaid DMS/DME Program Approved List of Items
xii. Availability of services within the MFC network
xiii. MedStar Family Choice Continuity of Care Policy
xiv. UM Criteria Policy
xv. Maryland Medicaid Medical Laboratory and Professional Services Program Approved List of Items
xvi. National and International Professional Medical Society Guidelines, including but not limited to:
    1. National Comprehensive Cancer Network (NCCN)
    2. NCCN Biomarkers Compendium
    3. National Institutes of Health
    4. National Cancer Institute
xvii. U.S. Preventive Services Task Force (USPSTF)
xviii. In the absence of guidelines, use prevailing medical literature from studies and journals.
xix. Maryland Medicaid Audiology Services Fee Schedule
xx. HealthChoice Diabetes Prevention Program Manual
xxi. Maryland Department of Health Medicaid rules located on their website

3. A limited number of services require authorization from MedStar Family Choice. These are included on the Quick Authorization Guide that can be found on the MedStar Family Choice website.
4. MedStar Family Choice reserves the right to direct services to participating providers and facilities. Services outside the network may need approval. Approval will be based on the availability of services in the network and for issues of continuity of care.
5. MedStar Family Choice's utilization management decision making is based on the medical necessity of the service and the existence of Managed Care Organization (MCO) enrollment and coverage.
6. MedStar Family Choice requires up to two business days to process a complete, non-urgent pre-authorization request. Requests are considered complete when all necessary clinical information is received from the requesting practitioner. The final decision cannot take longer than fourteen days, whether or not all clinical information has been received. For all covered outpatient pre-service pharmacy and concurrent pharmacy drug authorization requests a decision to approve, deny or request further information will be made within 24 hours of the request (see Policy; 110 UM Process Policy for details for decision and notification timelines). If the service requested is denied the practitioner may contact our Clinical Operations Department to discuss the decision with the appropriate Nonbehavioral Healthcare Medical Director.
7. A limited number of services require authorization from MedStar Family Choice Clinical Operations Department before the patient receives care. The list is included in the MFC Provider Manual.
8. Retrospective requests are reviewed against the above specified criteria and are not guaranteed for approval. Retrospective services that could have been provided within the network are not likely to be retrospectively approved unless upon review the care was urgent/emergent, a COMAR defined self referral service, or a continuity of care issue.

9. DME and services that are carved out to the State of Maryland Medicaid, which include, but are not limited to, pediatric outpatient rehabilitation services and behavioral health care (mental health and substance abuse) are subject to administrative denial since they are not the liability of the MCO.
10. Request for payment of services where the claim does not match the clinical provided will be subject to denial.
11. Upon review for medical necessity, requests for ongoing services or treatment that have not demonstrated improvement in condition or benefit to the member will be subject to denial as not medically necessary.
12. Services/codes not found on the Maryland Medicaid DMS/DME approved List of Items, the Medical Laboratory, Audiology Fee Schedule or Professional Services Program Approved List of Items will not be considered a covered benefit and will be denied.

B. Pharmacy:
    1. MedStar Family Choice pays for a wide variety of medications as outlined in our formulary. If a practitioner feels it medically necessary to prescribe a medication not on the formulary, the practitioner may submit this request to MedStar Family Choice. Such a request must include clinical documentation that supports the medical need for that specific medication and any prior use of available formulary medications, when applicable. All non-formulary requests are reviewed by a Medical Director or Health Plan Pharmacist. The Medical Director or Health Plan Pharmacist will make a determination to approve, deny or request further information based on pharmacy policies and procedures and current regulations within 24 hours of the request (see 110 UM Process Policy for details for decision and notification timelines). MedStar Family Choice does not guarantee coverage of medications that do not meet medical necessity, Policies & Procedures, or regulatory guidelines. Practitioners may call MedStar Family Choice at 410-933-2200, or fax requests to 410-933-2274.
    2. Requests for Synagis (palivizumab) require a completed Statement of Medical Necessity form and authorization is based on criteria set forth by the American Academy of Pediatrics Policy Statement and published in the Red Book. The Statement of Medical Necessity form may be found on the MedStar Family Choice web site.
    3. Requests for Hepatitis C medications require a completed "Hepatitis C Therapy Prior-Authorization Form and Prescription." This form may be found on the MedStar Family Choice website. Maryland Department of Health (MDH) processes and criteria will apply.
    4. Requests for medications listed in the MDH Opioid DUR (high dose and/or long acting narcotics, methadone for pain and fentanyl) will require a completed Prior Authorization form. This form may be found on the MFC website. MFC will also accept the universal form developed by the MDH and Maryland MCOs.
    5. Medications covered by the MDH, such as behavioral health drugs, are not covered by the MedStar Family Choice MCO. These requests are subject to administrative denial since they are not the liability of the MCO.

C. Concurrent Review:
    1. MedStar Family Choice utilizes the following criteria to make concurrent review decisions:
        i. InterQual
        ii. Medicare and Medicaid Guidelines

iii. COMAR
iv. MedStar Family Choice benefit coverage
v. Availability of services within the MedStar Family Choice network

2. MedStar Family Choice reviews clinical documentation for timeliness of care and appropriate level of care. Clinical denial determinations may be issued by our Medical Directors when a delay in care or delay in discharge planning creates an inpatient day that could have been avoided if service had been provided timely.
3. While MedStar Family Choice care managers are available to assist with discharge planning, it is the responsibility of the inpatient facility to provide timely and appropriate discharge planning. Inpatient days that do not meet medical necessity as outlined in above criteria are the responsibility of the inpatient facility.
4. Services that are carved out to the State of Maryland Medicaid, which include but are not limited to behavioral health care, are subject to administrative denial since they are not the liability of the MCO.

D. Emergency Care:
1. In accordance with the Emergency Medical Treatment & Labor Act (EMTALA), MedStar Family Choice will pay claims for all medical screening examinations (MSE) when the request is made for examination or treatment for an emergency medical condition (EMC), including active labor. MFC does not consider a nurse exam or triage information as evidence of a medical screening exam.
2. In accordance with the Balanced Budget Act of 1997, MFC pays for emergency services using a prudent layperson standard. An emergency medical condition is defined as:
    i. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonable expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
3. MedStar Family Choice requires and fully reviews emergency department clinical documentation for evidence of a medical screening exam, prudent layperson guidelines, as well as evaluation of assigned treatment levels based on HSCRC guidelines for reasonable Clinical Care Time. Services that are carved out to the State of Maryland Medicaid, which include but are not limited to behavioral health care, are subject to administrative denial since they are not the liability of the MCO.

E. Request for Criteria:
1. Providers may request the UM criteria for UM decision making by calling the MedStar Family Choice Utilization Management Department at 1-800-905-1722 or 410-933-2200, option 2, then option 1. We are available Monday-Friday 8:30am-5pm.

Summary of Changes:	**11/24:** • Procedure A, # 2 added Maryland Department of Health Medicaid rules located on their website to the list of criteria options.

	07/24: • Responsible Parties and Approved By updated to titles only. • Regulatory Reference updated to reflect the 2024 NCQA standards. • MFC replaced with MedStar Family Choice. **03/24:** • Removed Carol Attia and Teresa Boileau from Responsible Parties F. Procedure A, #2 added language to say includes but not limited to and added the following criteria options: some additional criteria and transmittals to be used 1. Transmittals from the Maryland Department of Health 2. Local Coverage Determinations (LCD) 3. National Coverage Determinations (NCD) 4. Local Coverage Articles (LCA) 5. CMS State Medicaid Director Letters • Procedure A, # 2 Code of Federal Regulations added • Removed Pain Contracts from Procedure A, #2 • Procedure B, added Health Plan Pharmacist **07/23:** • Theresa Bittle was removed from Responsible Parties and Carol Attia added. • Updated Regulatory References to reflect 2023 NCQA Standards. • The approved section Theresa Bittle and Patryce Toye were removed, and Carol Attia and Dr. Karyn Wills added. • Procedure A, 1 added clarifying language regarding after hours message. • Procedure A, # 6 & 7 changed Care Management to Clinical Operations Department. **07/22:** • Updated Regulatory References to reflect 2022 NCQA Standards. • Added Nonbehavioral Healthcare to reference of Medical Director in Policy description, Procedure 1 #6. • Medication memo from state removed • Nitza Larbie removed from responsible parties Teresa Boileau added. • Fixed formatting throughout policy. **07/21:** • Updated Regulatory References to reflect 2021 NCQA Standards.

	• Changed Case Management to Clinical Operations in Responsible Departments. • Added "Maryland" to scope. • Section A added step 12 for requests for services not found on any of the fee schedules will be considered not a covered benefit and will be denied. **07/20:** • Updated Regulatory References to reflect 2020 NCQA Standards. • Section B, #5 removed the reference of HIV Medications which are carved out to the State. • Section A, # 2 "t" added HealthChoice Diabetes Prevention Program Manual. • Section A, # 6 and Section B, #1 added a reference to refer to the 110 UM Process Policy for decision and notification timelines for pharmacy requests. **07/19:** • Removal of "A" from policy number. • Update NCQA Reference for 2019 Standards. • Removal of "Maryland" from scope. • Responsible parties Priscilla Thomas removed and Nitza Larbie added. • Added to section A # 2 Maryland Medicaid Audiology Services Fee. **10/18:** • Section A. 2: Added "r" to read "In the absence of guidelines, use prevailing medical literature from studies and journals." **07/18:** • Updated NCQA Year. • Added to Regulatory Reference- MDH Memorandum dated 12-7-2017 RE: Hepatitis C Medications Approval Timelines (Also includes drugs other than Hepatitis C). • Added to Section A, 2 the following criteria we follow: Maryland Medicaid Medical Laboratory and Professional Services Program Approved List of Items, National Comprehensive Cancer Network (NCCN), NCCN Biomarkers Compendium, National Institutes of Health, National Cancer Institute, U.S. Preventive Services Task Force (USPSTF). • Modified Effective Date to Initial Effective Dates; added Historical Revision Dates and Revision Effective Dates; and added Historical Review Dates and Review Effective Dates. **01/18:**

	• Under Procedure Section A iii added language for the Quick Authorization guide. • Under Procedure Section A vi- updated 7 calendar days to 14 calendar days. • Added language to indicate that a decision or determination to approve, deny or request further information will be made on all pre-authorization and concurrent pharmacy requests within 24 hours of the request. • Under Pharmacy Section B iv added text for the MDH DUR authorization form requirements. • Replaced mental health with behavioral health. **07/17:** • Updated NCQA Year and reference to UM 11E from 12E • Changed Approved by from Carol Attia to Theresa Bittle and updated Dr. Toye's title from Sr Medical Director to Chief Medical Officer. • Physician Advisor to Medical Director. • Added MFC Prior Authorization Form to A ii. • Added to Section A ii last bullet- National and International Professional Medical Society Guidelines to the criteria we follow. • In section B iv, changed Department of Health and Mental Hygiene to Maryland Department of Health (MDH). **10/16:** • Updated Regulatory References. • Delete reference to utilizing Fee For Service rules for inpatient days while awaiting guardianship. **10/15:** • References to ICD-9 updated to ICD-10. • Removed Substance Abuse section since now carved out from MCO to State of Maryland.