

---

**Overview**

The Plan's Utilization Management (UM) program is designed to meet contractual requirements with federal regulations and the state of Missouri while providing members access to high-quality, cost-effective medically necessary care and ensuring prompt and accurate payment to our providers.

The focus of the UM program is on:

- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the member's diagnosis and level of care required;
- Providing access to medically appropriate, cost effective health care services in a culturally sensitive manner and facilitating timely communication of clinical information among providers;
- Reducing overall health care expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership;
- Facilitating communication and partnerships among members, families, providers, delegated entities and the Plan in an effort to enhance cooperation and appropriate utilization of health care services;
- Reviewing, revising and developing medical coverage policies to ensure members have appropriate access to new and emerging technology; and
- Enhancing the coordination and minimizing barriers in the assessment of behavioral health and medical health care services.

---

Medically Necessary is defined by the State of Missouri, HealthNet Managed Care contract as:

*“A service(s) furnished or proposed to be furnished that is (are) reasonable and medically necessary for the prevention, diagnosis, or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of disability; or to attain, maintain or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could not have been omitted without adversely affecting the member’s condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services must be sufficient in amount, duration, and scope to reasonable achieve their purpose and may only be limited by medical necessity.*

- a. *In reference to medically necessary care, mental health services shall be provided in accordance with a process of mental health assessment that accurately determines the clinical condition of the member and the acceptable standards of practice for such clinical conditions. The process of mental health assessment shall include distinct criteria for children and adolescents.*
- b. *The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid provide medically necessary services to children from birth through age 20, which are necessary to treat or ameliorate defects, physical or ;mental illness, or conditions identified by an HCY/EPSTD screen. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and ;may only be limited by medical necessity.”*

Medically necessary services are defined as services that include medical or allied care, goods or services furnished or ordered to:

1. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
2. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the member's needs;
3. Be consistent with the generally accepted professional medical standards and not be experimental or investigational;
4. Be reflective of the level of service that can be furnished safely and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the member, the member's caretaker or the provider.

Medically necessary or medical necessity for those services furnished in a hospital on an inpatient basis cannot, consistent with the provisions of appropriate medical care, be furnished effectively in a more economic outpatient setting or in an inpatient facility of a different type.

The fact that a provider has prescribed recommended medical or allied services does not, in itself, make such services medically necessary, a medical necessity or a covered service or benefit.

---

**UM Process**

The UM process is comprehensive and includes the following review processes:

- Notifications
- Referrals
- Prior Authorizations
- Concurrent Review
- Retrospective Review

The Plan's forms for submitting notifications and authorization requests can be found in the **Forms** section of this manual and on the Provider's area of the Plan's Web site at <http://www.harmonyhpm.com/>.

**Notifications**

- Notifications are communications to the Plan that inform the Plan of a service rendered or admission to a facility. Notification is required for prenatal services, as it enables the Plan to identify members for inclusion into the Prenatal Program and identify members who may benefit from the High Risk Pregnancy Program. OB providers are required to notify the Plan of pregnant members via fax, using the Prenatal Notification Form within 30 days of the initial visit to expedite case management and ensure timely claims reimbursement.

**Referrals**

- Referrals are requests by a PCP for a member to be evaluated and/or treated by a participating specialty physician. The PCP must document the reason for the referral and the name of the specialist in the member's medical record. The specialist, in turn, must document the receipt of a request for a consultation. The Plan does not require a written referral as a condition of payment.

---

No communication with the Plan is necessary.

Certain diagnostic tests and procedures that are considered by the Plan to be routinely part of an office visit may be conducted as part of the initial visit without authorization. For general authorization information you may refer to the **Quick Reference Guide**, a copy of which can also be found on our Web site <http://www.harmonyhpm.com/> (recommended to obtain the most recent version).

Providers may also refer Plan members to special programs or services reimbursed by Medicaid Fee-for-Service.

### **Prior Authorizations**

Prior authorization allows for efficient use of covered health care services and helps insure that members receive the most appropriate level of care within the most appropriate setting. Prior authorization may be obtained by the member's PCP or treating specialist.

Reasons for requiring authorization may include:

- Review for medical necessity
- Appropriateness of rendering provider
- Appropriateness of setting
- Case and disease management considerations

Prior authorization is the process of obtaining approval in advance of a planned inpatient admission or rendering of an outpatient service. The Plan will make an authorization decision based on the clinical information provided in the request. The Plan may request additional information that may include a medical record review.

---

Prior authorization is **required** for elective/non-urgent services as designated by the Plan. Guidelines for prior authorization requirements by service type and/or code are available by calling the plan or by referring to the **Quick Reference Guide** found in the Providers area of the Harmony Web site at <http://www.harmonyhpm.com/default.aspx>.

- The prior authorization request should include the patient's diagnosis and the CPT code describing the anticipated procedure. If the procedure performed and billed is different from that on the request, but within the same family of services, a revised authorization is not required. The attending physician or designee is responsible for obtaining the prior authorization for the elective/non-urgent procedure or admission.
- An authorization is the approval necessary to be granted payment for covered services and is provided only after the Plan agrees the treatment is necessary and a covered benefit.

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.

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

- Telephoning the Plan (have the member's name, ID number, diagnosis and service available when calling).

### **Services Requiring No Authorization**

The Plan has determined that many routine procedures and diagnostic tests may be performed without medical review to facilitate timely and effective treatment of members.

Certain diagnostic tests and procedures that are considered by the Plan to be routinely part of an office visit include colposcopy, EKG and plain film x-rays (see **Quick Reference Guide**).

### **Concurrent Review**

Concurrent review activities involve the evaluation of a continued hospital, skilled nursing or acute rehabilitation stay for medical appropriateness, using appropriate criteria. The concurrent review nurse follows the clinical status of the member through telephonic or onsite chart review and communication with the attending physician, hospital UM, Case Management staff or hospital clinical staff involved in the member's care.

Concurrent review is initiated as soon as the Plan is notified of the admission (supporting clinical information must be submitted to the Plan by the next business day following admission). Subsequent reviews are based on the severity of the individual case, needs of the member, complexity, treatment plan and discharge planning activity. The continued stay will be authorized based on medical appropriateness using InterQual<sup>TM</sup> criteria including:

- Services provided in a timely and efficient manner;
- Assuring established standards of quality care are met;

- Implementing timely and efficient transfer to lower level of care when clinically indicated and appropriate;
- Implementing timely and effective discharge planning; and
- Identification of cases appropriate for case management.

The concurrent review process incorporates the use of InterQual™ criteria to assess quality of care and the appropriate level of care for continued medical treatment. Reviews are performed by licensed nurses under the direction of the Plan medical director. In the event that InterQual™ is silent on a particular service, Medicaid criteria will be used.

To ensure the request is completed in a timely manner, providers must submit relevant clinical information along with the request for authorization and upon request of the Plan's review nurse. Failure to submit necessary documentation for concurrent review may result in non-payment.

### **Discharge Planning**

Discharge planning begins on admission, and is designed for early identification of medical/psycho-social issues that will need post-hospital intervention. The concurrent review nurse works with the attending physician, hospital discharge planner, ancillary providers and/or community resources to coordinate care and post-discharge services and facilitate a smooth transfer of the member to the appropriate level of care.

### **Retrospective Review**

The Plan performs two types of retrospective reviews.

1. **Retrospective review initiated by the Plan**  
The Plan requires documentation and coding in the medical record that justifies and supports the diagnosis, treatment and clinical outcomes accurately. Medical records are subject to retrospective audit by the Plan to ensure accurate coding and claims submission.
  
2. **Retrospective Review initiated by providers**  
In exceptional circumstances, when a service has been provided, but no authorization from the Plan has been obtained, a provider may request authorization for the service prior to the submission of the claim. Upon submission of pertinent information, the Plan will make a determination within 30 calendar days of receipt of the information. In the event of an adverse determination, the provider may request an appeal (See **Appeals and Grievances** section).

All services can be subject to retrospective review. Prior authorization or concurrent review decisions will not be reversed unless the Plan receives information that contradicts the information given when the initial determination was made.

### **Standard, Expedited and Extension of a Service Authorization Decisions**

### **Standard Service Authorization or Organization Determination**

The Plan is committed to a two-business-day turn-around time on requests for prior authorization or pre-certification authorizations. An additional two business days may be provided to obtain information to complete the request. Authorization responses will be sent by fax to the provider's fax number(s) that are included on the Authorization Request form. By contract, the Plan cannot exceed 14 calendar days from receipt of a complete request to determine whether a member's request for non-urgent services is a

---

medically appropriate and covered service. An extension may be granted for an additional 14 calendar days if the member or the provider requests an extension or if the Plan justifies to DSS a need for additional information and the extension is in the member's best interest.

**Expedited Service Authorization**

Approval or denial of non-emergency services when determined as such by the emergency room staff shall be provided by the Plan within 30 minutes of the request. Approval or denial shall be provided within 24 hours of request for services determined to be urgent by the treating provider. Approval or denial shall be provided within two business days of obtaining all necessary information for routine services. The Plan shall notify the requesting provider within two business days following the receipt of the request of service regarding any additional information necessary to make a determination. The Plan shall not exceed 14 calendar days after the receipt of the request of service to provide approval or denial. Involuntary detentions (96-hour detentions or court-ordered detentions) or commitments shall not be prior authorized. Requests for expedited decisions for prior authorization should be requested by telephone, not fax.

**Plan Criteria for  
UM Decisions**

The UM program uses review criteria that is nationally recognized and based on sound scientific, medical evidence. Physicians with an unrestricted license in the state of Missouri with professional knowledge and/or clinical expertise in the area actively participate in the discussion, adoption and application of all utilization decision-making criteria on an annual basis.

The UM program uses numerous sources of information including, but not limited to, the following when making coverage determinations:

- Medical necessity
- Member benefits
- Local and federal statutes and laws
- InterQual™
- Medicaid guidelines
- Hayes Health Technology Assessment

The nurse reviewer and/or medical director apply medical necessity criteria in context with member's individual circumstance and the capacity of the local provider delivery system. When the above criteria do not address the individual member's needs or unique circumstance, the medical director will use clinical judgment in making the determination.

Providers may request a copy of the criteria used for a specific determination of medical necessity by contacting the Health Services' Utilization Management department.

### **Second Medical Opinion**

Members may request a second medical opinion concerning surgical procedures or serious injury or illness. The member should seek consultation for a second opinion from a physician that is participating with the Plan. If the appropriate physician is not available within the Plan's service area, the member may visit a non-participating provider at no additional cost to the member.

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.

### **Third Medical Opinion**

If the member desires a third medical opinion or if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical opinion, a third medical opinion will be allowed.

---

Additionally, Missouri revised statutes require a second surgical opinion on specific elective surgical procedures. These must be provided prior to the surgery.

**Members with Special Health Care Needs**

Members with special needs are defined as adults and children/adolescents who face physical, mental or environmental challenges daily that place their health at risk and whose ability to fully function in society is limited. Examples include members with mental retardation or related conditions; members with serious chronic illnesses such as HIV, schizophrenia or degenerative neurological disorders; members with disabilities resulting from years of chronic illness such as arthritis, emphysema or diabetes; and children/adolescents and adults with certain environmental risk factors such as homelessness or family problems that lead to the need for placement in foster care.

The following is a summary of responsibilities specific to physicians who render services to Plan members who have been identified with special health care needs:

- Assess the member and develop a plan of care for those members determined to need a course of treatment or regular care;
- Coordinate treatment plan with member, family and/or specialist caring for member;
- Plan of care should adhere to community standards and DSS quality assurance and utilization review standards;
- Allow the members needing a course of treatment or regular care monitoring to have direct access through standing referrals or approved visits, as appropriate for the member's condition or needs;

- Coordinate with the Plan, if appropriate, to ensure that each member has an ongoing source of primary care appropriate to his/her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member;
  - a) Members may request a specialist as PCP through Customer Service or their case manager. If the medical director agrees the specialist is appropriate as a PCP and the specialist agrees to act as the PCP, the member will be assigned to that specialist by the Customer Service department.
- Coordinate services with community-based services and Medicaid Fee-for-Service programs to prevent duplication of services and assure continuity of care between all providers; and
- Ensure the member's privacy is protected as appropriate during the coordination process.

**Emergency/  
Urgent Care**

Emergency services are not subject to prior authorization requirements and are available to our members 24 hours a day, seven days a week.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the health of the member, including a pregnant woman or fetus;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- With respect to a pregnant woman having contractions;
  1. That there is inadequate time to effect a safe transfer to another hospital prior to delivery, or
  2. That a transfer may pose a threat to the health or safety of the woman or the fetus.
  3. That there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

Urgent care services should be used for conditions, which though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain, etc.) or to substantially restrict the member's activity (e.g., infectious illness, flu, respiratory ailments, etc.).

**Transition of Care**

For members who voluntarily enrolled, or who were automatically reenrolled after regaining Medicaid eligibility, the Plan will honor any written documentation of prior authorization of ongoing covered services for a period of 60 calendar days after the effective date of enrollment or until the

---

Plan's PCP assigned to that member reviews the member's treatment plan, whichever comes first.

For mandatory assigned Medicaid members, the Plan will honor any written documentation of prior authorization of ongoing covered services for a period of one month after the effective date of enrollment or until the PCP assigned to that member reviews the member's treatment plan, whichever comes first.

Written documentation of prior authorization of ongoing services includes the following, provided that the services were prearranged prior to the enrollment with the Plan:

1. Prior existing orders;
2. Provider appointments, e.g., dental appointments, surgeries, etc.; and
3. Prescriptions (including prescriptions at non-participating pharmacies).

The Plan will not delay service authorization if written documentation is not available in a timely manner. The Plan is not required to approve claims for which it has not received written documentation.

### **Special Authorization Requirements**

The following authorization requests have special requirements required by the State of Missouri.

#### **Sterilizations**

- The individual is at least 21 years old at the time consent is obtained;
- The member is mentally competent;
- The individual voluntarily gave informed consent in accordance with the provisions of this section, and a properly executed

Sterilization Consent form is submitted to DSS. A copy of the Sterilization Consent form may be found in the **Forms** section of this manual.

- At least 30 calendar days, but not more than 180 calendar days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.

An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least 30 calendar days before the expected date of delivery (the expected date of delivery must be provided on the consent form);

- Interpreters are provided when language barriers exist; and arrangements are made through our Customer Service department to effectively communicate the required information to an individual who is visually impaired, hearing impaired or otherwise handicapped; and
- The individual was not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

### Hysterectomies

- The properly executed Hysterectomy Acknowledgement form is attached to the claim form submitted to the Plan. A copy of the Hysterectomy Acknowledgement form along with instructions on how to complete it can be found in the **Forms** section of this manual.

- The individual is informed, verbally and in writing, prior to the hysterectomy that she will be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy);
- Prior to the hysterectomy, the member/individual and the attending physician must sign and date the Exceptions to Hysterectomy Acknowledgement form except in the case of prior sterility or emergency hysterectomy. This informed consent must be obtained regardless of diagnosis or the member's/individual's age.

Regardless of whether the requirements listed above are met, a hysterectomy is not covered under the following circumstances:

- Performed solely for the purpose of rendering a member permanently incapable of reproducing;
- Performed for more than one purpose, but the primary purpose was to render the member permanently incapable of reproducing; or
- Performed for the purpose of cancer prophylaxis.

### **Abortions**

Abortions are covered services if the provider certifies that the abortion is medically necessary to save the life of the mother or if pregnancy is the result of rape or incest. The Plan will cover treatment of medical complications occurring as a result of an elective abortion and treatments for

---

spontaneous, incomplete or threatened abortions and for ectopic pregnancies.

Abortions are not covered if used for family planning purposes.

An Abortion Certification form certifying the above situation must be properly executed and attached to the claim form when submitted to the Plan. A copy of the Abortion Certification form may be found in the **Forms** section of this manual.

The Sterilization Consent form, the Hysterectomy Acknowledgement form, the Exceptions to Hysterectomy Acknowledgement form and Abortion Certification form are the only forms accepted by the Plan in the reimbursement of these procedures and they can be found in the **Forms** section of this manual.

Claims for reimbursement of sterilizations, hysterectomies or abortions performed without the documentation required by federal regulation or with incomplete/inaccurate information will be denied.

### **After-Hours Utilization Management**

The Plan provides authorization of inpatient admissions 24 hours a day, seven days a week. Physicians requesting after-hours authorization for inpatient admission should refer to their **Quick Reference Guide**.

### **Delegated Entities**

The Plan delegates some utilization management activities to external entities and provides oversight and accountability of those entities with DSS approval.

In order to receive a delegation status for utilization management activities, the delegated entity must demonstrate that ongoing, functioning systems are in place and meet the required utilization management standards. There must be

a mutually agreed upon written delegation agreement describing the responsibilities of the Plan and the delegated entities.

Delegation of select functions may occur only after an initial audit of the utilization management activities has been completed and there is evidence that the Plan's delegation requirements are met. These requirements include; a written description of the specific utilization management delegated activities, semi-annual reporting requirements, evaluation mechanisms and remedies available to the Plan if the delegated entity does not fulfill its obligations. On an annual basis, or more frequently audits of the delegated entity are performed to ensure compliance with the Plan's delegation requirements.

