

NHP/NHIC-Clinical Criteria for Utilization Decisions

Abstract/Purpose:

The Care Management (CM) Department applies nationally recognized utilization criteria and regionally developed medical policy and standards of care for utilization management reviews.

I. Policy:

The Care Management (CM) Department applies nationally recognized utilization criteria and regionally developed medical policy and standards of care for utilization management reviews. Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) uses the following criteria:

- Milliman CareGuidelines Chronic Care Guidelines
- Milliman CareGuidelines Recovery Facility Guidelines
- Milliman CareGuidelines Ambulatory Care Guidelines
- Milliman CareGuidelines Home Care Guidelines
- InterQual Care Planning Procedures Criteria
- InterQual Level of Care – Acute Criteria, Adult
- InterQual Level of Care – Acute Criteria, Pediatric
- InterQual Level of Care Criteria - Behavioral Health
- NHP/NHIC Care Management Medical Policy Manual
- Ingenix Complete Guide to Medicare Coverage
- CMS National Coverage Decisions, WI Carrier criteria, Medicare Part B
 - **The Medicare Coverage homepage**, located at www.cms.hhs.gov/coverage provides a listing of all national coverage determinations, as well as a searchable database.

- **The Medicare National Coverage Determinations Manual**, Pub. 100-3, is the primary record of Medicare national coverage policies, and includes a discussion of the circumstances under which items and services are covered. This manual may be accessed at www.cms.hhs.gov/manuals/103_cov_determ/.
- CMS's new policies and procedures (including additional information on new coverage) are transmitted through the program transmittals. Links to the program transmittals may be found at www.cms.hhs.gov/manuals/transmittals/.

II. **General Facts:**

- NHP/NHIC applies CMS National and Local Coverage Determination criteria to Medicare Advantage requests.
- NHP/NHIC purchases Milliman CareGuidelines, InterQual and Ingenix and receives updates as they become available. These nationally recognized, standardized Utilization Criteria (UM) criteria are reviewed at least annually and recommended to the Quality Management Committee (QMC) for approval and use by the Medical Policy Committee (MPC).
- Regional Medical Policies are developed in collaboration with participating network physicians, often when local practice differs from the national norm. These policies are reviewed and updated annually, or when a significant change in standard of care is identified, by the Medical Policy Committee (MPC) which then makes a recommendation to the Quality Management Committee (QMC) for approval and use.
- Regionally developed Medical Policy and care standards are used in conjunction with or in lieu of the commercial standardized criteria when the parameters of a request for service are not clearly addressed by the standard criteria, or when local practice differs.
- All criteria used for utilization decisions are based on clinically sound evidence and allow for decision-making options that are responsive to the individual patient's needs and characteristics of the local delivery system.

- The Medical Director and the Director of Health Management always retain the authority to authorize care that is in the best interest of the member.
- The Medical Director makes all medical necessity determinations based upon his/her clinical knowledge and experience, taking into consideration the patient's age, comorbidities, complications, and other individual circumstances. (The Medical Director consults with board certified practitioners when additional expertise is required. See policy - Use of Board-Certified Practitioners for Consultation on Medical Necessity Decisions.)
- Criteria are applied consistently to medical necessity decisions. At least annually, the Care Management (CM) Department evaluates the consistency with which reviewers use criteria, and corrective action plans are developed if excessive variation is found. (see NHP/NHIC policies - Inter-Reviewer Reliability for CM Coordinators and CM Referral Technicians and Medical Director Inter-Rater Reliability.)
- The exception to this policy applies to the NHP/NHIC pharmacy guidelines. The pharmacy guidelines are reviewed and/or revised by the NHP/NHIC P & T Committee and approved by the QMC.

III. **Procedure:**

- **CMS and Commercial UM Criteria**
 - Responsibility: Director Health Management or designee
 - Action:
 - Receives standardized UM criteria updates.
 - Reviews the criteria for significant change. Consults with Medical Director and Director Health Management as needed.
 - Summarizes changes and requests review by participating practitioners with appropriate clinical expertise.
 - Receives feedback and prepares presentation for MPC in collaboration with the Medical Director.

- Presents updated UM Criteria to the MPC for review and recommendation for approval by the QMC.
 - Presents reviewed UM Criteria to the QMC for approval.
 - Communicates significant changes to the participating network physicians
- **Regionally Developed Medical Policy and Care Standards**
 - Responsibility: Care Management Staff or Medical Director
 - Action:
 - Identifies the need for a Medical Policy or additional specific care standards.
 - Refer to NHP/NHIC Medical Policy - Medical Policy Development
 - Develops a draft of the document in collaboration with the appropriate participating network practitioners and the Director Health Management as needed.
 - Responsibility: Medical Director or Designee
 - Action:
 - Presents updated UM Criteria to the MPC for review and recommendation for approval by the QMC.
 - Presents reviewed UM Criteria to the QMC for approval.
 - Communicates significant changes to the participating network physicians.
- **CM Staff Application of Medical Criteria**
 - Responsibility: CM Referral Technician
 - Action:
 - Receives request for medical service requiring prior authorization.
 - Date stamps request and forwards to appropriate CM Coordinator.
 - Assists with entering authorization as directed once decision has been made.
 - Responsibility: CM Coordinator
 - Action:

- Receives request for medical service requiring prior authorization.
- Gathers adequate medial information to facilitate decision making.
- Reviews request against national criteria, then local medical policies, technology assessments and other medical information provided by the practitioner requesting service.
- Approves medical service when criteria met, and enters authorization or delegates authorization entry to CM tech.
- Refers requests for medical service requiring authorization but not meeting medical criteria to Medical Director for denial or approval with exception.