ITASCA MEDICAL CARE (IMCare)
POLICY AND PROCEDURE

Title: Pre-Service Review (Preauthorization or Service Authorization)	**Index:** Utilization Management
NCQA Standard #: UM2: Clinical Criteria for UM Decisions; UM5: Timeliness of UM Decisions; UM6: Clinical Information; UM8-Policies for Appeals	
Statute/CFR#: MN Statutes, Section 62M.04, 62M.05 and 62M.09 – Utilization Review Act	
Effective Date: 04/30/2006	**Policy Number:** 2.07.22
Written by: QI/UM Staff	**Reviewed/Revised Date:** 04/03/2018

POLICY
Itasca Medical Care (IMCare) will perform pre-service review (pre-authorization) for services (non-behavioral health and behavioral health) listed in the IMCare preauthorization list and within the established timeframe for urgent and non-urgent requests. IMCare allows a provider or provider's designee, or responsible enrollee representative, including a family member, to request a pre-service review.

Pre-service Decision: Any case or service that IMCare must approve, in whole or in part, in advance of the enrollee obtaining medical care or services.

Pre-service urgent (expedited): determination and notification within 72 hours of request

Pre-service non-urgent: determination and notification within ten (10) business days of request IMCare may deny the request if the agency does not receive the information needed to make a decision within this time frame. The enrollee may request an appeal of the agency determination.

Out-of-network provider(s) will require a referral from an in-network provider, with the exception of open access services, and receive prior authorization.

Timeliness of Utilization Management Decisions and Access to Staff:
IMCare will make Utilization Management (UM) decisions in a timely manner to minimize disruption in the provision of health care. An expedited initial determination is utilized if the attending health care professional believes that an expedited initial determination is warranted. Expedited service authorizations are intended for cases where the provider, attending health care professional, or IMCare determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health, or ability to attain, maintain or regain maximum function.

Enrollees and practitioners will be able to access an IMCare nurse or the IMCare medical director to discuss UM issues. Staff is available eight (8) hours a day during normal business hours and available after normal business hours for UM issues/questions. Staff identifies themselves by name, title and organization when initiating or returning calls regarding UM issues. TDD/TTY and language assistance services are available for enrollees who need them in order to discuss UM issues.

Standard Review Determination
IMCare permits providers to submit requests for prior authorization of health care services without unreasonable delay by telephone, facsimile, secure e-mail, or voice mail twenty four (24) hours a day, seven (7) days a week.

When an initial determination is made to approve a requested service, IMCare notifies the attending healthcare professional promptly by telephone, by facsimile to a verified number, or by electronic mail to a secure mailbox. Providers are also notified in writing, by way of the authorization approval notice. IMCare sends written notification to the attending healthcare professional and hospital, if applicable, or maintains documentation of telephone, facsimile, or e-mail notification.

When an initial determination is made to deny, reduce, or terminate services notification must be provided by telephone by facsimile to a verified number, or by electronic mail to a secure mailbox within one (1) working day after making the determination to the attending health care professional and hospital as applicable. Written notification must also be sent to the hospital as applicable and attending health care professional if notification occurred by telephone. The written notification must include the principal reason(s) for the determination and the process for initiating an appeal of the determination. Reasons for a determination not to approve may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the provider or enrollee.

When a determination is made to deny, reduce, or terminate services, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act.

IMCare notifies attending health care providers and enrollee verbally of all determinations, and follows up with written notification. IMCare maintains an audit trail which includes: the date, the name of the person spoken to, the enrollee, the service procedure and/or admission certified, and the date of service, procedure or admission. When a service, procedure or admission is approved, IMCare assigns an authorization number. This number is also provided at the time of notification.

If an enrollee is subject to a change in health plans, IMCare must provide, upon request, authorization to receive services that are otherwise covered under the terms of IMCare through the enrollee's current provider. Services shall be provided for up to one hundred-twenty (120) days if the enrollee is engaged in a current course of treatment for one (1) or more of the following conditions:

- An acute condition
- A life-threatening mental or physical illness
- Pregnancy beyond the first trimester of pregnancy

- A physical or mental disability defined as an inability to engage in one (1) or more major life activities, provided that the disability has lasted or can be expected to last for at least one (1) year, or can be expected to result in death
- A disabling or chronic condition that is in an acute phase, or
- For the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of one hundred-eighty (180) days or less.

Expedited Review Determination
An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

Notification of an expedited initial determination to either approve or not to approve must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than seventy –two (72) hours from the initial request. When an expedited initial determination is made not to certify, IMCare must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal process and the procedure for initiating an internal expedited appeal, and the procedure to do so.

Extension of Review Determination Time Frames
IMCare may extend the time frame for a standard or expedited authorization determination up to fourteen (14) additional calendar days, if:

- The enrollee, or the provider, requests extension; or
- IMCare justifies, to the state agency upon request, a need for additional information and how the extension is in the enrollee's best interest.

Denial Decisions
IMCare shall not deny or limit coverage of a service which the enrollee has received solely on the basis of lack of service authorization, to the extent that the service would otherwise have been covered by IMCare had service authorization been obtained. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease. Qualified and licensed health care professionals will make determinations. Appropriate professionals include the Medical Director, Dental Director, behavioral health associate, chiropractor, or other board-certified physicians contracted with IMCare.

The behavioral health associate, who is a psychiatric physician, reviews requests for outpatient services in which IMCare has concluded that a determination not to approve a mental health or substance abuse service for clinical reasons is appropriate.

Criteria
IMCare will use written criteria based on sound objective and based on clinical evidence to make utilization decisions and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. Practitioners can have access to criteria at any time upon request.

When making a determination of coverage based on medical necessity, IMCare obtains relevant clinical information and consults with the treating practitioner, when appropriate.

Information upon Which Utilization Review is Conducted
IMCare must collect only the information necessary to certify the admission, procedure of treatment, and length of stay. IMCare may request, but may not require providers to supply, numerically encoded diagnoses or procedures as part of the process. IMCare must not routinely request copies of medical records for all patients reviewed. Copies of the pertinent portion of the medical record should be required only when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay. IMCare may request copies of medical records retrospectively for a number of purposes including auditing the services provided, quality assurance review, ensuring compliance with the terms of the benefit plan, the provider contract, or the compliance with utilization review activities. If the enrollee or provider will not release the necessary information to IMCare, the authorization may be denied. For authorization purposes, data requests must be limited to the data elements list in MN Statutes, section 62M.04 subd. 3. Information in addition to that described in subdivision 3 may be requested when there is significant lack of agreement between IMCare and the provider regarding the appropriateness of authorization during the review process. For purposes of this subdivision, "significant lack of agreement" means that the utilization review organization has:

1. Tentatively determined, through its professional staff, that a service cannot be authorized;
2. Referred the case to a physician for review; and
3. Talked to, or attempted to talk to, the attending health care professional for further information.

Confidentiality
Information obtained during the process of utilization review will be:

1. Kept confidential in accordance with applicable federal and state laws;
2. Used solely for the purposes of utilization review, quality assurance, discharge planning, and case management; and
3. Shared only with those organizations or persons that have the authority to receive such information.

All UM documents including authorization, and documentation forms, along with any medical records obtained for UM activities, are retained/stored for ten (10) years.

PROCEDURE

1. The IMCare Medical Support Specialist will:
    a. Receive appropriate authorization and referral from provider via facsimile, date of request. The form(s) include(s) information to process request such as:
        - Enrollee information such as name, ID number, date of birth
        - Provider information
        - Place and date of service
        - Service type
        - Diagnoses: primary, secondary and tertiary diagnosis as applicable
        - Consulting provider/facility
        - Clinical information such as signs, symptoms, prior treatment, testing results, proposed treatment plan or plan of care
    b. For verbal requests, obtains the above information from the requesting provider. For non-participating providers, with appropriate referral, the following information is also collected:
        - Attending physician information name, address, phone number, Tax ID # (TIN)
        - Facility information (name, address, contact phone number, type of facility (inpatient acute, skilled nursing facility (SNF), hospice, sub-acute, facility provider TIN#
    c. Enter the authorization request in CaseTrakker.

2. The IMCare QI/UM Nurse will:
    a. Follow timeline indicated on authorization request or, if not already identified, clarify if urgent (expedited) or non-urgent request, and document in CaseTrakker following the appropriate timeframe.
    b. If clinical information is inadequate to assess medical necessity, the QI/UM Nurse requests information from the provider or facility within five (5) days of the request. The QI/UM nurse documents the date of request, specific clinical information necessary to certify the service (i.e., admission, procedure or treatment, length of stay) needed, the person who was given the request and the date that the information is needed (up to five (5) days) in CaseTrakker. Extension of request up to fourteen (14) business days may be made with notification to the enrollee and provider. Enrollee is given the right to file a grievance if she/he disagrees with the extension request or if enrollee requests.
    c. Review the clinical information against the UM department medical necessity criteria, clinical practice guidelines and any medical policies, if applicable. Criteria are applied consistently to medical necessity decisions, and in a manner that is responsive to the individual enrollee needs (ex: age, co-morbidities, complications, progress of treatment, psychosocial situation and enrollee's home environment) and the characteristics of the local delivery system.
        - If the enrollee lacks the necessary benefit, the QI/UM Nurse will issue a benefit denial letter to the enrollee and requesting provider/facility according to policy.
        - If the request meets medical necessity criteria and/or medical policies, the QI/UM nurse may approve the service. The attending healthcare professional is

notified verbally by telephone by facsimile to a verified number, or by electronic mail to a secure mailbox. The provider is also notified in writing. The provider/ facility will be informed to initiate a concurrent review twenty-four (24) hours prior to the last covered day/service, as appropriate.

- If the request does not meet medical necessity criteria or medical policy, the QI/UM nurse will forward the case to the appropriate physician reviewer for further review and medical necessity determination.

d. Identify if the enrollee has special health care needs and would benefit from case management or a specialist referral.

Physician reviewers include the Medical Director, Dental Director, Behavioral Health Associate, chiropractor, or other board-certified physicians contracted with IMCare.

If the provider or facility did not submit the requested clinical information or the enrollee or provider will not release the necessary information within the established timeframe, the QI/UM nurse may confer with the physician reviewer to determine whether to:

- Deny the request for lack of information, or
- Forward the case to a physician reviewer with the available clinical information received.

3. The IMCare Physician Reviewer will:
   a. Review the clinical findings against the UM Department criteria, clinical practice guidelines and/or medical policy, taking into consideration individual enrollee needs and characteristics of the local delivery system. The physician reviewer may contact the requesting physician for discussion before making the determination.
   b. If the physician reviewer needs assistance in making medical necessity determinations, he/she will contact the appropriate board-certified consultant. The physician reviewer documents the outcome of consultation, the person who was contacted, and date contacted in CaseTrakker.
   c. An initial determination on all requests for utilization review must be communicated to the attending healthcare professional and enrollee within ten (10) business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to IMCare.
   d. If the physician reviewer denies the request, he/she must document the rationale for the determination, reference the criteria, and identify alternative services, when appropriate. If the requesting provider was contacted, the physician reviewer will document that a conversation occurred and the outcome of the discussion in CaseTrakker.

The behavioral health associate, who is a psychiatric physician, reviews requests for outpatient services in which IMCare has concluded that a determination not to certify a mental health or substance abuse service for clinical reasons is appropriate.

4. Based on the outcome of the QI/UM Nurse review and/or Physician Reviewer review, the IMCare QI/UM Nurse will:

a. Documents the result of the review on CaseTrakker as Approved, Not Approved, or Partially Approved.
b. Notification of determination:
   - Notification of an *urgent (expedited) request* to either approve, not approve (deny), or partially approve must be provided by telephone, facsimile to a verified number, or by electronic mail to a secure mailbox to the attending health care professional, hospital and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than seventy-two (72) hours from the initial request.
      - Includes documentation of the notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission certified; and the date of the service, procedure, or admission.
   - Notification of approval of a *non-urgent request* must be made promptly by telephone, facsimile to a verified number, or by electronic mail to a secure mailbox, with same documentation of contact as indicated above to the attending health care professional.
   - Notification of a not approved or partially approved *non-urgent request* must be provided by telephone, facsimile to a verified number, or by electronic mail to a secure mailbox with same documentation of contact as indicated above, within one (1) working day after making the determination to the attending health care professional and hospital; and a written notification must be sent to the attending health care professional, hospital, and enrollee.

The process for an out-of-network provider requiring authorization should include the following:

1. Complete the "Itasca Medical Care (IMCare) Authorization Request" form.
   a. The PCP may complete this form when making a referral, or
   b. The out-of-network provider may complete this form after obtaining a referral from the enrollee's PCP
2. Fax the completed form to IMCare with any relevant documents that support the request.

When an urgent request is denied or partially denied, IMCare must notify the enrollee and the attending health care professional of the right to submit an expedited appeal to IMCare's internal expedited appeal process, and the procedure for initiating an internal expedited appeal. When a non-urgent request is denied or partially denied, IMCare must verbally inform, during the notification process, the enrollee and the attending healthcare professional of the right to request an expedited appeal. IMCare's written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process, and the procedure for initiating the internal appeal.

a. If service is denied, initiate the Denial, Termination or Reduction (DTR) Notice in CaseTrakker, and disseminate letters to the enrollee and provider(s). Include enrollee rights notice and language block in the mailing. DTR notices are mailed by United States mail.
b. Document review in CaseTrakker. When the case is closed, a copy of the authorization and documentation form is forwarded to the Health Plan Compliance Coordinator.

c. Upon request, the QI/UM Nurse provides the attending healthcare professional, facility or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the basis for the criteria.

3. The IMCare Medical Support Specialist will:
   a. Update CaseTrakker with the Amysis authorization number, and written notification date, for approved services.
   b. Generate and mail enrollee and provider authorization letters. Include enrollee rights and language block with the letter.

4. The Health Plan Compliance Coordinator will:
   a. Maintain a file on each Denial, Termination, or Reduction (DTR) notice for service generated.
   b. Generate the DTR report on CaseTrakker, and submit to DHS quarterly. The process for quarterly reporting is in the business office manual.
   c. Maintains copies of any additional documentation and CaseTrakker entry for additional reporting to the Provider Advisory Committee, the Stakeholder Advisory Subcommittee, and External QI/UM. Prepares DTR files for MDH and other external audits. DTR data is also reported periodically to the Itasca County Board of Commissioners and is aggregated for the annual Program Evaluation.
   d. Analyze and report DTR activity to Quality and Medical Directors.

5. The IMCare Quality Director will:
   a. Monitor the DTR activity to determine if there are constant variables that require additional training and/or education of staff or contracted and/or delegated providers.
   b. Include DTR analysis and reporting in the Annual Program Evaluation.

6. The Medical Director will:
   a. Review and report the DTR activity to the Provider Advisory Subcommittee and QI Committee.