Samaritan Health Plans | InterCommunity Health Network CCO

Utilization Management and Service Authorization

Prepared by Clinical Services Division

2023

References:

- *Centers for Medicare and Medicaid Services (CMS).*
- *Code of Federal Regulations (CFR).*
- *Oregon Health Authority (OHA).*
- *National Committee for Quality Assurance (NCQA).*
- *MCG Health CareWebQI.*
- *Samaritan Health Plans Care Coordination Department approved policies.*
- *Samaritan Advantage Health Plan HMO Approved Special Needs Plan Model of Care.*
- *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.*

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Program overview

The Utilization Management Department, also known as UM, is integrated within the Clinical Services Division. The medical director, associate vice president for the Clinical Services Division, Quality Improvement Committee and UM director oversee the program operations. Utilization review is conducted according to department policies, procedures and clinical criteria. Benefits and clinical criteria are reviewed. Decisions and notifications must adhere to time frames, policies and plan documents. Prospective (pre-service), concurrent and retrospective post-service reviews are performed to provide a basis for decision-making. UM decisions are made by qualified, licensed health care professionals who have the knowledge and skills to assess clinical information and to evaluate working diagnoses and proposed treatment plans. Utilization management is supported by board-certified UM physician reviewers and behavioral health physicians and doctoral-level practitioners who hold a current license to practice without restrictions. These licensed providers oversee UM decisions to ensure consistent and appropriate medical-necessity determinations. Inter-rater reliability reviews are conducted to ensure consistent application of the utilization criteria. The Utilization Management Department utilizes the Cognizant software program, Facets and Clinical Care Advance. Health plan activities related to members and providers, including authorizations, claims, customer services, appeals, quality and case management are documented in the systems. Clinical and supporting documentation submitted to Samaritan Health Plans is electronically stored within the Clinical Care Advance system.

Monitoring for over-utilization and underutilization occurs through utilization, medical management and case management reports as well as clinical performance measures, including the Healthcare Effectiveness Data and Information Set, also known as HEDIS. Race, ethnic, cultural and linguistic disparities are used to identify actions for improvement. All sources of member satisfaction surveys, complaints, appeals and grievances are reviewed to identify potential areas of concern. Practitioner medical, pharmacy and utilization profiles are also reviewed.

Education and support

Samaritan Health Plans/InterCommunity Health Network Coordinated Care Organization, also known as SHP/IHN-CCO, provides a Health Insurance Portability and Accountability Act compliant, internet-based portal, called Provider Connect. This is accessible via OneHealthPort and allows providers easy access to real-time authorization information, submission, eligibility and claims.

Provider education is accomplished through Provider Connect, special trainings, annual updates and seminars or through news bulletins or clinical education provided by the chief medical officer, Network Strategy and Contracting Department and/or Quality Department.

Members may receive education about benefits, UM and care management through welcome letters, periodic newsletters, quality initiatives or projects or individual communication through the efforts of Clinical Services Department staff.

Prior authorization requirements

Decisions regarding what services should require prior authorization are made to target services that are high risk (of complications or side effects), frequently overused (by providers) and high cost (to members and the health plan). Services that are low risk, low cost and not overused by providers are generally not targeted to require prior authorization.

The availability of a nationally recognized, evidence-based guideline (from organizations like MCG Health or the Center for Medicare and Medicaid Services) that can be used to review a service for medical necessity/medical appropriateness also contributes to decisions about what services may require prior authorization.

For the InterCommunity Health Network Coordinated Care Organization line of business, also known as IHN-CCO, information contained within the Oregon Prioritized List, including Guideline Notes published by the Oregon Health Authority, also contributes to decisions about what services should require prior authorization.

Prior authorization lists are managed by the UM Department. They are updated annually with input from multiple departments within Samaritan Health Plans, also known as SHP, including the Clinical Services Division, and require external regulatory review.

Minimum health record requirements for hospitals and behavioral health hospitals

Each member's record must include information needed to perform prior authorization. This information must include, at least, the following:

- Identification of the member.
- The name of the member's health care provider.
- Date of admission and dates of application for and authorization of Medicaid benefits, if application is made after admission.
- The plan of care.
- Initial and subsequent continued stay review dates.
- Date of operating room reservation, if applicable.
- Justification of emergency admission, if applicable.
- Reasons and plan for continued stay, if the attending provider believes continued stay is necessary.
- Other supporting material that the committee believes appropriate to be included in the record.

For more specific information, please reference the SHP **medical record standards**.

Prior authorization list

The **prior authorization list** includes services and procedures requiring review prior to the member receiving care. The list is plan-specific and published on the Samaritan Health Plans website and in the member benefit materials. The prior authorization list is designed to eliminate barriers for members with chronic conditions and/or special health care needs. UM policies, procedures and criteria outline utilization requirements for most procedures, diagnostic treatments, provider specialties and code or item-specific detailed requirements prior to authorizing. Authorization request determinations are made using evidence-based, established local, state or nationally accepted criteria adhering to regulatory and plan-specific requirements.

Authorization specialist review

The authorization specialist's role is to verify eligibility, benefits and provider status. They perform data entry and process determination letters, as well as request and track medical and health records. With training and supervision, the authorization specialist may process certain authorizations following written guidelines for the auto-authorization process. The authorization specialist will refer all requests that do not meet criteria for auto-authorization to clinical review for organizational determination.

Clinical review

All authorization requests that do not meet the auto-authorization list written guidelines or that require clinical criteria review will be reviewed by a licensed registered nurse (RN) (UM nurse), licensed practical nurse (clinical care guide), licensed clinical social worker/licensed professional counselor (behavioral health care manager), certified durable medical equipment coordinator or other appropriately licensed clinical specialist to complete the review. Authorization requests requiring clinical review will have the appropriate criteria applied as part of the review process. Criteria source examples may include but are not limited to: Oregon Health Authority Prioritized List of Health Services, Guideline Notes, Oregon Administrative Rules, Oregon Revised Statutes, national and local Medicare coverage determinations, medical coverage policies and MCG guidelines.

Service types

- **Alcohol and drug residential:** outpatient chemical dependency services or substance use disorder services for SHP/IHN-CCO members include inpatient hospitalization for medical detoxification, intensive outpatient and outpatient substance use treatment. We currently contract with multiple substance use providers across several counties to meet the needs of our members seeking substance use treatment. Coordinating resources is a collaborative effort between UM, Care Coordination, providers, hospitals, community programs and resources.
- **Ambulance/medical transport:** medically necessary transportation of a member to hospital, facility or medical service. Methods of transportation include land, water or air.
- **Dental services:** diagnostic treatment and all aspects of oral health delivery for members in a comprehensive, continuously accessible, coordinated and person-centered process. Services provided by a qualified dental professional in an office or inpatient setting.

- **Diagnostic studies:** examination to identify diagnosis. Services include all testing and imaging to determine a condition, disease or illness provided in an outpatient facility or inpatient setting. This includes CT scans, PET scans and other diagnostic tests excluding MRI/MRA.
- **Durable medical equipment:** Durable medical equipment, prosthetics, orthotic devices or supplies are authorized by certified DME coordinators and appropriately trained RNs within the department. Authorization requirements may be plan-specific.
- **Emergency services:** services furnished in an emergency department and ancillary services routinely available to an emergency department that may be needed to stabilize a patient do not require referrals or prior authorization. The definition of an emergency is based on a prudent layperson's judgement. An emergent condition requires stabilization and may require ongoing care coordination and case management.
- **Hospital:** inpatient/facility services where the UM nurse and/or behavioral health care manager team members telephonically coordinate care, review documentation for quality and care and facilitate transitions for members at contracted and out-of-network facilities.
- **Inpatient mental health:** mental health treatment provided at the Samaritan Health Services Mental Health Unit and through the SHP/IHN-CCO network of contracted mental health facility providers. Members are triaged from the emergency room, home, community or from another facility for care. This setting offers the highest level of physical security and most intensive level of intervention. Concurrent review for inpatient mental health is provided by the UM Department using MCG guidelines for reviewing medical necessity and length of stay.
- **Mental health:** includes outpatient services in the treatment of conditions of psychological and emotional well-being. Excludes hospital and residential services.
- **Magnetic resonance imaging:** diagnostic services that use magnetic fields and radio waves to produce a detailed image of the body's soft tissue and bones. This service type also includes magnetic resonance angiogram to provide pictures of blood vessels inside the body.
- **Non-emergency medical transport:** transportation to and from medical appointments for members with no other means of transportation.
- **Occupational, physical and speech therapy:** services provided in an inpatient facility or outpatient setting by a qualified provider. Therapies for members recuperating from medical procedures, surgical conditions or mental illness that encourage rehabilitation through the performance of activities required for daily life.
- **Outpatient services:** certain outpatient services, including diagnostic, procedural, limited specialist visits, speech therapy, occupational and physical therapy, transplants and other procedures or services requiring prior authorization, are published in the member benefit guide.
- **Out-of-network services:** nonparticipating or non-contracted providers will have their requests processed in the same manner as contracted providers. Service and treatment will be approved on a case-by-case basis and depend on the plan and/or individual case considerations. Behavioral health services may be provided by non-contracted providers when:
  - Service to a contracted provider is not available in an appropriate time frame.
  - Member resides outside the CCO region (i.e. in a behavior rehabilitation services or adult residential program).
  - Specialty provider required for services is not available through the network.

- **Pain management:** medical approach that draws on disciplines in science and alternative healing to study the prevention, diagnosis and treatment of pain. Pain management services provided in an outpatient setting by a qualified provider.
- **Primary care provider:** services provided in an outpatient setting by member's primary care provider who is a credentialed and qualified billing provider.
- **Psychiatric day treatment:** comprehensive, interdisciplinary, non-residential, community-based program consisting of psychiatric treatment, family treatment and therapeutic activities integrated with an accredited education program.
- **Residential rehabilitation:** treatment received at a residential substance abuse facility or psychiatric residential treatment center. This 24/7 setting is an alternative to more intensive inpatient treatment and authorized when the benefit allows to treat psychiatric illness and substance use disorder as clinically appropriate.
- **Skilled nursing facility:** SNF services provided in a medical rehab facility. This covers a continuum of medical and social services designed to support the needs of members recovering from conditions that affect their ability to perform everyday activities.
- **Specialty care:** surgical or medical specialty care provided in an outpatient or inpatient setting by a qualified provider.

Review types

- **Pre-service review:** A review of services/treatments prior to the service date is considered pre-service or prior authorization. Prior authorization requests account for the highest volume of requests reviewed in the department. These include planned inpatient hospitalizations or procedures, outpatient services and home health items, services and/or equipment.
- **Concurrent review:** a review to determine extending a previously approved, ongoing course of treatment or services. Concurrent reviews are typically associated with inpatient care, skilled nursing facility, residential behavioral health care, intensive outpatient behavioral health care and ongoing ambulatory care.
- **Post-service review:** The process of reviewing services or treatment after the date of service occurs is considered a post-service review. Post-service review of services that require prior authorization is limited by exception reasons. If an exception is granted the same criteria and plan benefits and guidelines are applied to the request or case as would be applied for pre-service requests.

Utilization management criteria

The plan's evidence of coverage, or plan document, use federal and state guidelines to determine benefits. Nationally recognized criteria, federal (CMS), state, internal practice guidelines and company-developed clinical standards are used to determine clinical and medical appropriateness of services.

The criteria are selected, developed, approved and overseen by the SHP/IHN-CCO leadership team. The organization gives practitioners with clinical expertise in the area being reviewed, the opportunity to advise or comment on the development or adoption of criteria. The SHP leadership team works closely with Clinical Services Division leadership to ensure clinical consistency and appropriateness of all criteria utilized by the Care Coordination Department.

Complete criteria sets are maintained electronically and are available for reference to authorized entities, providers and members upon request.

Evidence-based criteria

SHP/IHN-CCO performs utilization management using nationally recognized evidence-based guidelines from MCG Health. Care guidelines from MCG Health provide evidence-based medicine's best practices and care plan tools across the continuum of treatment, providing clinical decision support and documentation which enables efficient transitions between care settings. Eight of the largest United States health plans and nearly 1,900 hospitals use MCG Health's evidence-based guidelines and software. MCG Health's informed care strategies affect over 208 million covered lives.

Criteria examples

- **American Society of Addiction Medicine**.
- **MCG CareWebQI MCG Health**.
- For Samaritan's Medicare Advantage Health Plans, we use applicable content from:
  - Medicare National Coverage Determinations, Local Coverage Determinations and the Medicare Benefit Policy Manual.
  - **CMS Medicare National Coverage Determinations**.
  - **CMS Medicare Local Coverage Determinations**.
  - **Medicare Benefit Policy Manual**.
- InterCommunity Health Network CCO follows coverage guidelines and funding limitations that govern the Oregon Health Plan (Oregon Medicaid) established by the Oregon legislature and Oregon Health Authority in the Prioritized List of Health Services and Oregon Administrative Rules:
  - **Oregon Medicaid Prioritized List** (which includes above the line and below the line information as well as guideline notes developed by the state Health Evidence Review Commission).
  - **Oregon Administrative Rules**.

On the rare occasion that no appropriate guideline exists from the sources above, SHP/IHN-CCO uses a small number of internally developed Samaritan Health Plans medical coverage policies, found at **samhealthplans.org/MedicalCoveragePolicies**.

It should be noted that the conclusion a service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by SHP/IHN-CCO) for a member. The member's benefit plan determines coverage. Each benefit plan defines which services are covered, which are excluded and which are subject to dollar caps or other limits.

Clinical reviewers consider the individual characteristics of the member, i.e., age, comorbidity, complications, progress of treatment, psychosocial situation, care supports and home environment when applying criteria.

Request types

Requests for services or items and decision notification time frames are consistent with applicable state and federal laws and regulations and accreditation standards. Detailed explanations and timelines are outlined in decision support tools and department policies and procedures.

- **Expedited:** When a service request is expedited, a provider is documenting that the member's health condition cannot wait the standard authorization time frame to receive a response (see table 1).
- **Standard:** Each line of business has a regulatory time frame to process a standard request. When a request is incomplete or requires a more extensive review, additional time may be necessary to process the request. It is the responsibility of the plan to reach out a minimum of three times within the standard timeframe to request additional documentation and then refer to the plan medical director for follow-up (see timelines below).
- **Retroactive:** A post-service or retroactive request may be reviewed up to 30 or 90 days past the date of service depending on the line of business. If exception criteria are met, retroactive requests are processed within 14 days of receipt for all lines of business except Samaritan Employer Group Plans which are processed within two business days.

Notification process

Members may receive written notification of the authorization determination by mail. Each plan requirement is documented in Clinical Services Division policies and procedures. In addition, phone calls, faxes, letters and e-mails are documented and maintained per regulatory requirements.

Prior authorization request processing timeline requirements:

Line of business	Expedited time frame	Standard time frame
Samaritan Advantage Health Plans	72 hours	14 days
Samaritan Advantage Health Plans Part B drugs	24 hours	72 hours
IHN-CCO	72 hours	14 days
IHN-CCO provider administered drugs	72 hours	72 hours
Samaritan Choice Plans	72 hours	14 days
Samaritan Employer Group Plans	72 hours	Two business days

Table 1

Denials/appeals

A denial is a decision to limit or deny authorization of a requested service or item that is published as requiring authorization from UM. This is defined by Centers for Medicaid and Medicare as an **adverse organizational determination**.

Whenever issuance of a denial is warranted, the member will receive notice in writing which is copied to the provider. The written notification of a denial of coverage is based upon medical appropriateness or benefit limitation and will include, but is not limited to:

- Reason for the adverse determination in terms specific to the member's condition.
- Description of the member's treatment interventions requested.
- Specific criteria deemed to be appropriate to apply to the specific request indicating (when appropriate and applicable) which portion of the criteria was not found to be met.
- Description of the member's appeal rights and how to initiate an appeal.

The chief medical officer or medical director is available to discuss the decision with the provider regarding an adverse determination. This is called a "peer-to-peer" consultation. The intent is to provide an opportunity to discuss the details of a specific case for better understanding as to why the request may not have met the required criteria. A "peer-to-peer" is carried out after an adverse determination (denial) and prior to appeal.

Any request that is denied can be appealed by a member or their authorized representative. All lines of business have individual appeal processes including internal and external review. An impartial provider, who was not involved in the initial denial, makes the redetermination of medical necessity.

Confidentiality

Clinical Services Division staff follow all Samaritan Health System and Samaritan Health Plans HIPAA policies as they relate to procedures, access, safeguards and security of protected health information. SHP/IHN-CCO ensures that, through the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E, to the extent they are applicable. The policies are reviewed with all staff upon hire and annually.

Financial incentives

SHP/IHN-CCO does not use financial or other incentives to encourage over or underutilization. Decision-making is based only on member eligibility and appropriateness of care and service.

SHP/IHN-CCO physicians and staff make decisions about which care and services are provided based on the member's clinical needs, the appropriateness of care and service and the member's coverage. SHP/IHN-CCO does not make decisions regarding hiring, promoting or terminating its physicians or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. SHP/IHN-CCO does not specifically reward, hire, promote or terminate practitioners or other individuals for issuing denials of coverage or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care or services. To maintain and improve the health of our members, all physicians and health care professionals should be especially diligent in identifying any potential underutilization of care or services.

Quality and performance improvement

Care Coordination takes a systematic and data-driven approach to evaluating, maintaining and improving the quality and safety of services delivered to our members. The department is focused on training and continuous improvement and uses the Agency for Healthcare Research and Quality **PDSA model of improvement**.

Inter-rater reliability

The purpose of inter-rater reliability testing is to monitor and evaluate consistency of internal utilization review decision-making according to established standards. These standards address specifications for conducting effective and efficient utilization management services. The results are evaluated for opportunities to improve consistency in decision-making. IRR testing is completed on an annual basis by all clinical and medical reviewers making determinations, including medical directors, nurses, providers and behavioral health professionals.

Case study examples are compiled of typical authorizations encountered within the department that require clinical and/or medical review. The testing for these cases uses the criteria for the specific plan represented. This includes MCG evidence-based software, CMS standards, Medicare Benefit Policy Manual, Medical Coverage Guidelines (National Coverage Determinations and Local Coverage Determinations), SHP approved clinical policies, American Society of Addiction Medicine and Oregon Administrative Rules including Guideline Notes and the Prioritized List. Documented determinations of the case studies are compared for percentage of agreement of the reviewers. An overall percentage of 90% or higher is the acceptable standard. Corrective action is taken with staff who score below 90%.

The annual IRR review will be completed annually each calendar year. The most current annual IRR percentage rate is 96%.

Prior authorization list

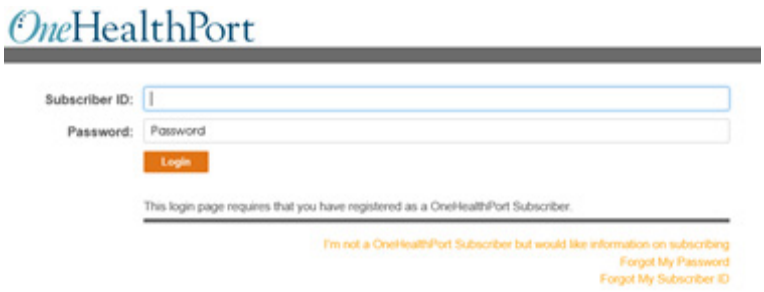
Current prior authorization lists may be found on the Samaritan Health Plans website: **samhealthplans.org/Authorizations**.

Utilization Management policies

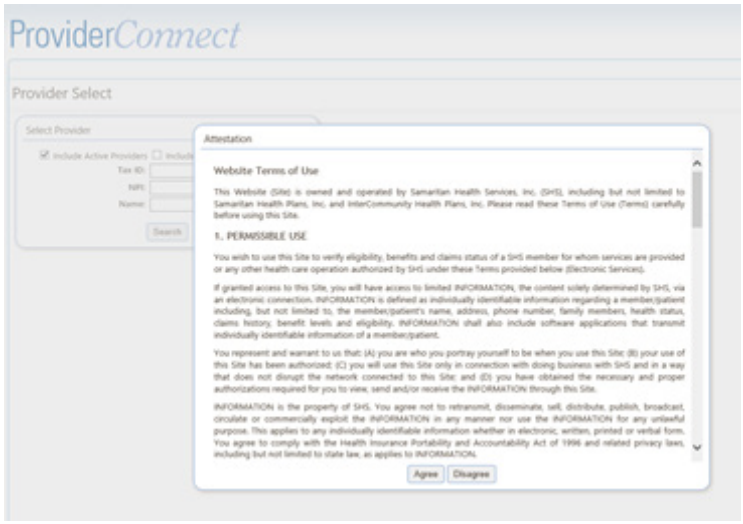
The policies referenced in this handbook are available upon request by calling Customer Service at **541-768-4550** or toll free **800-832-4580**.

Online prior authorization instructions

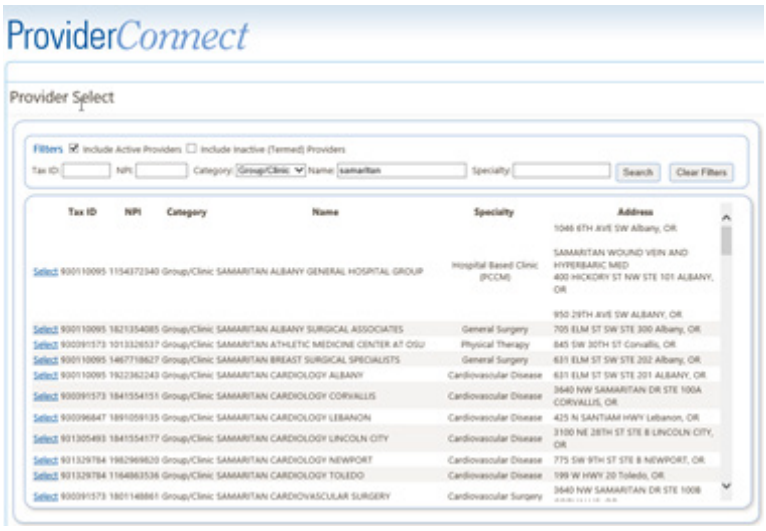
1. Navigate to **One Health Port**. Select the Single Sign-On login link, then select Samaritan Health Plans from the Participating Sites by clicking on the corresponding logo.
2. Log in with your One Health Port assigned user name and password.



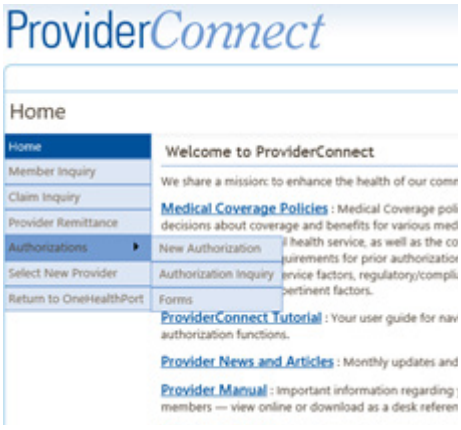
3. Agree to Terms of Use.



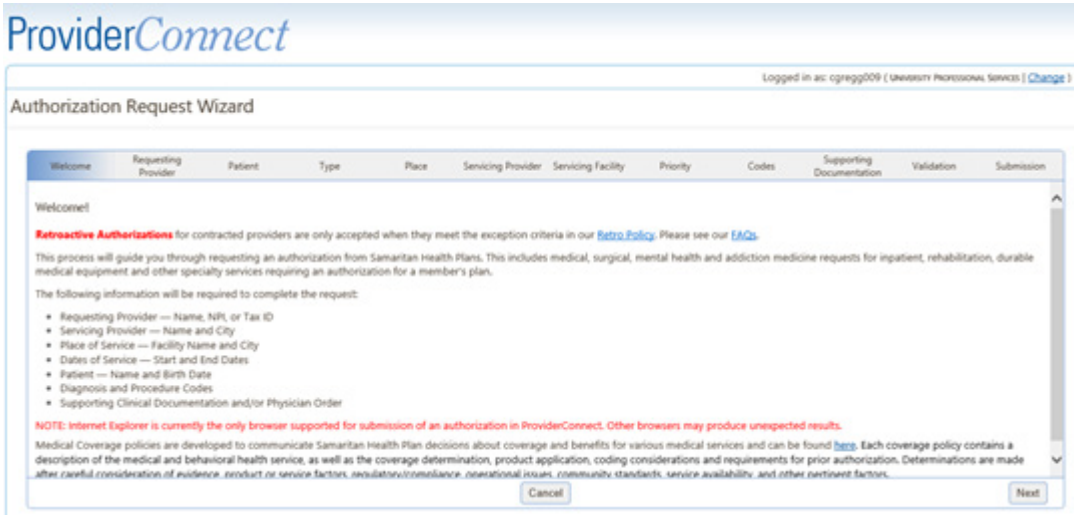
4. Using only one search item, select the practitioner or group that is requesting the prior authorization for care.



5. Select the tab for Authorizations, then select New Authorization.

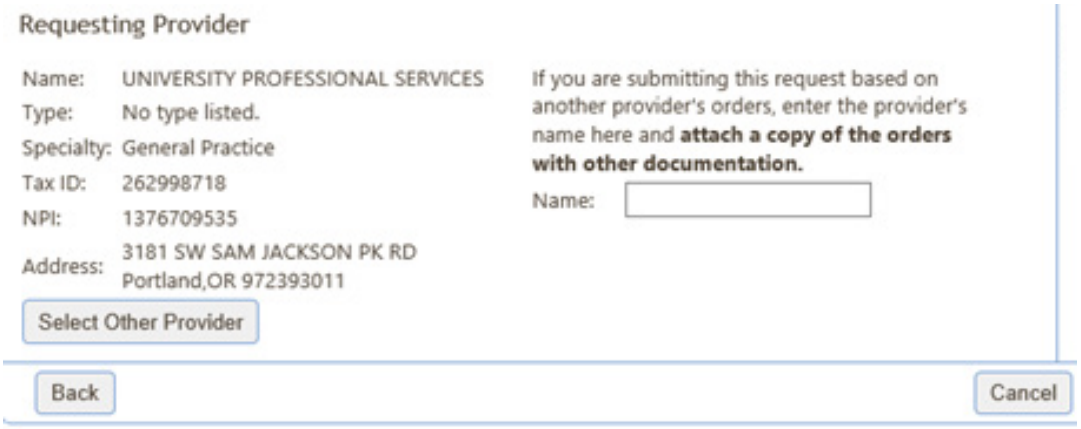


6. Read the authorization requirements on the Welcome screen, then click Next.

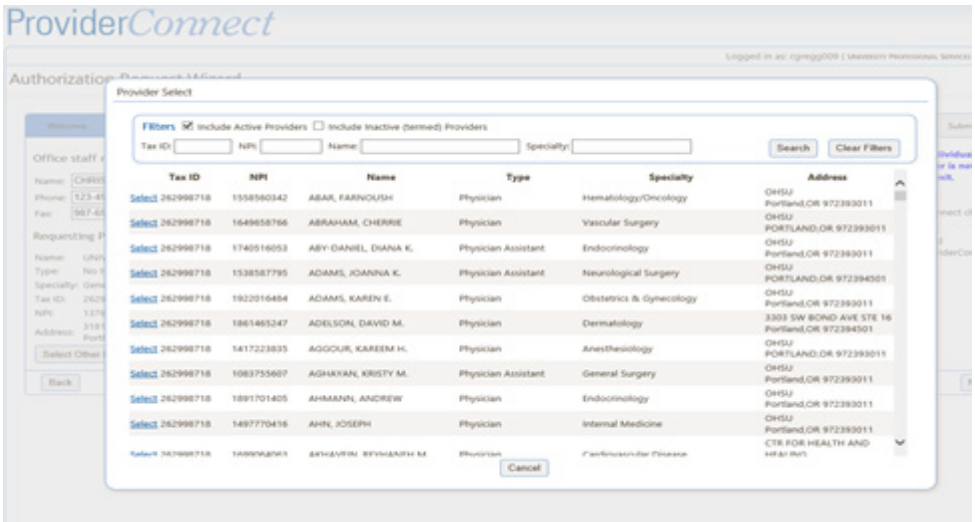


7. The next screen is for the requesting staff information (referral specialist), followed by the requesting provider information. The requesting provider typically must be an individual practitioner, not a group or facility. Depending on the specific request, proceed according to one of the options below:
   a. If the practitioner referring/requesting the care is already showing under Requesting Provider, go to step 12.
   b. If the provider you selected in step 4 is requesting a prior authorization for care prescribed by an ordering practitioner, as is often the case for DME, type the name of the ordering practitioner in the Name field and go to step 12.
   c. If the individual practitioner referring/requesting the care is associated to the group/clinic showing under Requesting Provider, go to step 8.
   d. If the practitioner referring/requesting the care is not associated to the group/clinic showing under Requesting Provider, go to step 11.

8. To select a practitioner associated to a group, click the Select Other Provider button.

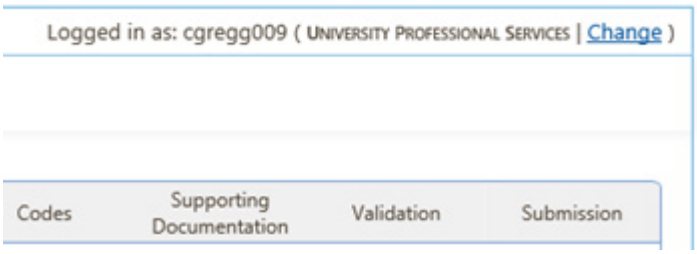


9. Enter the practitioner's name in the Name box, and/or select the practitioner from the list.

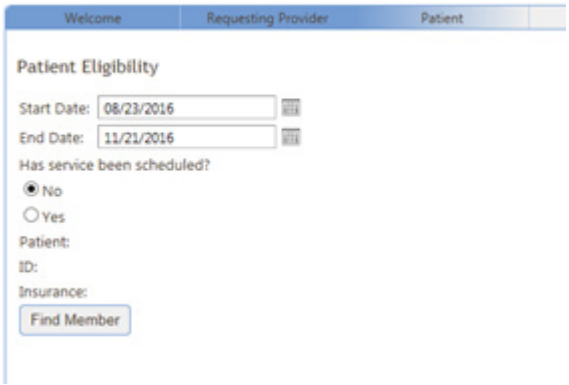


10. The selected practitioner will then appear under Requesting Provider. Go to step 12.

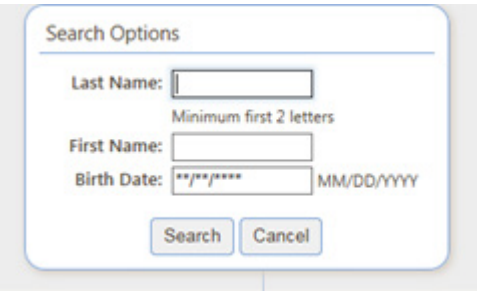
11. To select a practitioner not associated to the provider currently showing under Requesting Provider, click the Change link in the upper, right-hand corner of the page. You will be returned to the Select Provider option in step 4 and begin again from there.



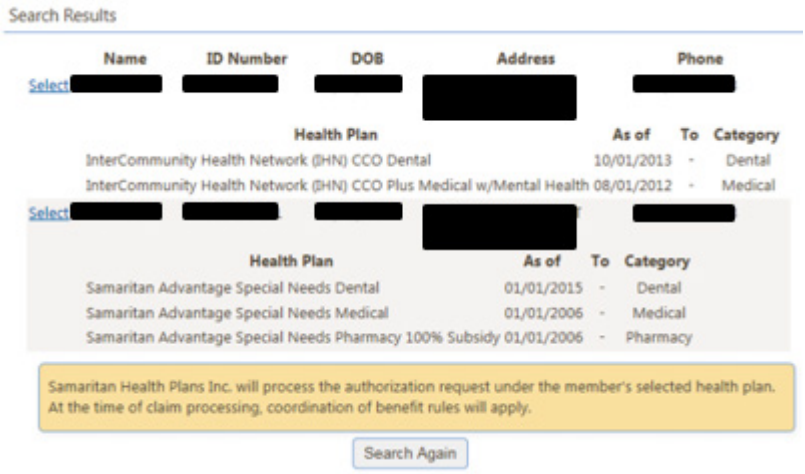
12. Enter your name and contact information or the information for the referral specialist in your office and click Next.
13. Enter the start and end date of the requested care and select Yes if the service has been scheduled. You will be prompted to enter a scheduled date.
14. Click Find Member to check member eligibility. If submitting a retroactive request, use the start and end date of the retroactive request.

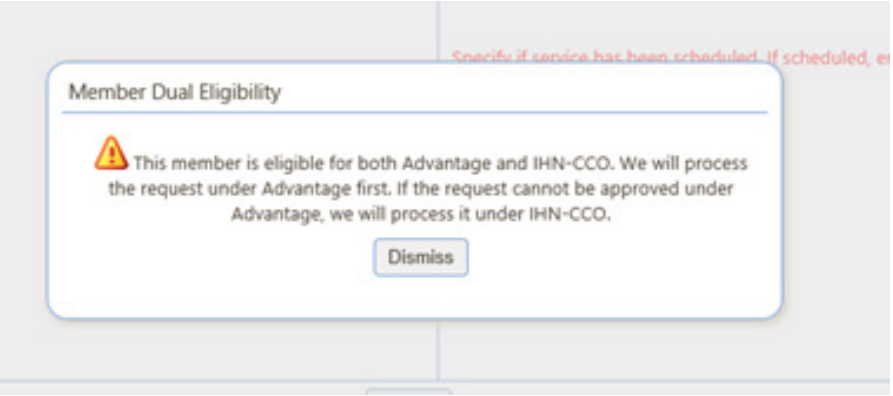


15. Enter the member's name and date of birth. It is best to use the first two letters of each name along with the birth date. This will provide all possible plans the member may have.

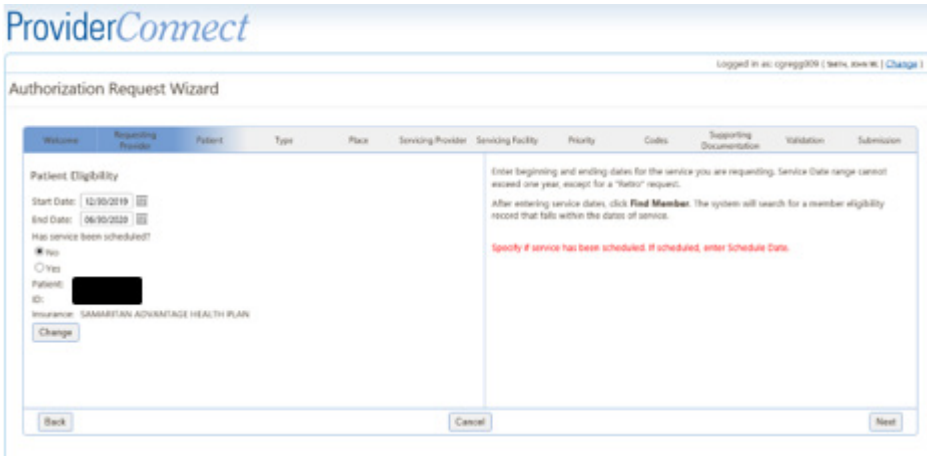


16. If the member is dual eligible, choose the primary plan. If the secondary plan is selected, the system will default back to the primary with a message.



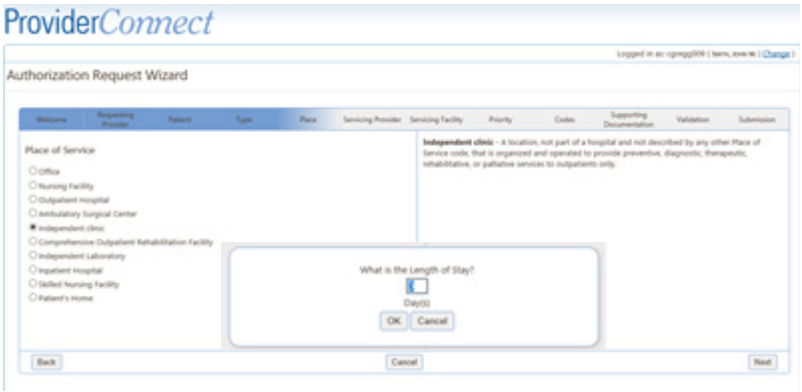


17. Once the member is selected, click Next.

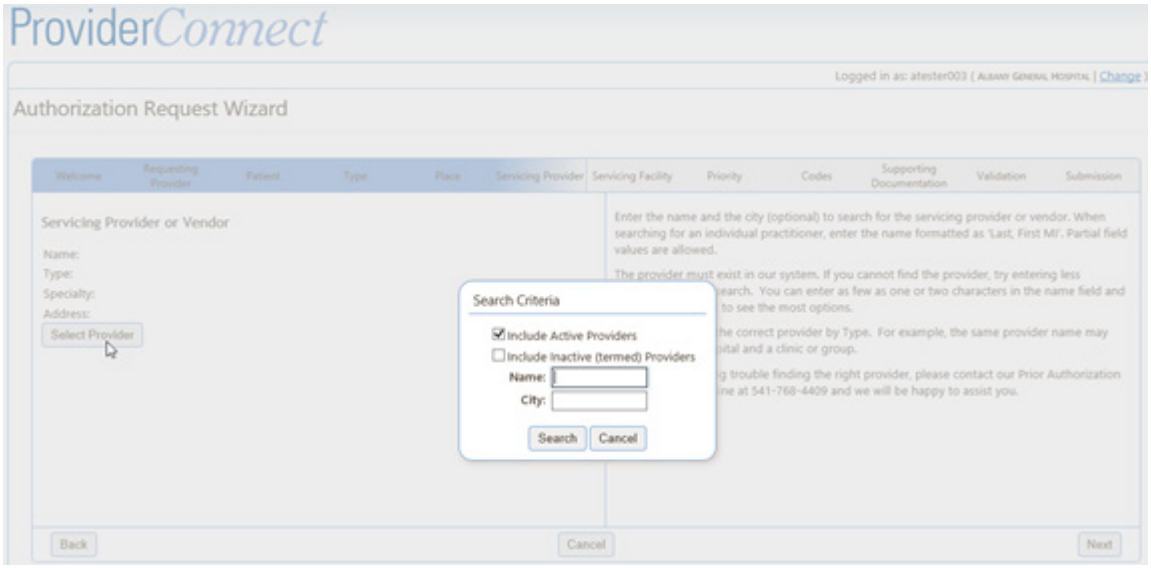


18. Indicate the type of the request. The Request Type selected will determine which of the following steps you are presented with.

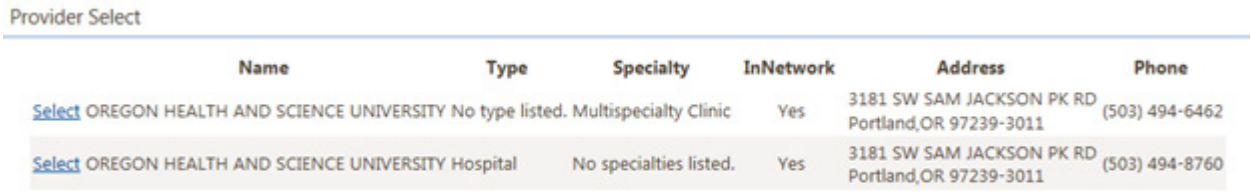
19. If presented, select the Place of Service (type of location where the service will take place) and click Next. If an inpatient service type is selected, you will be prompted to enter the Length of Stay.



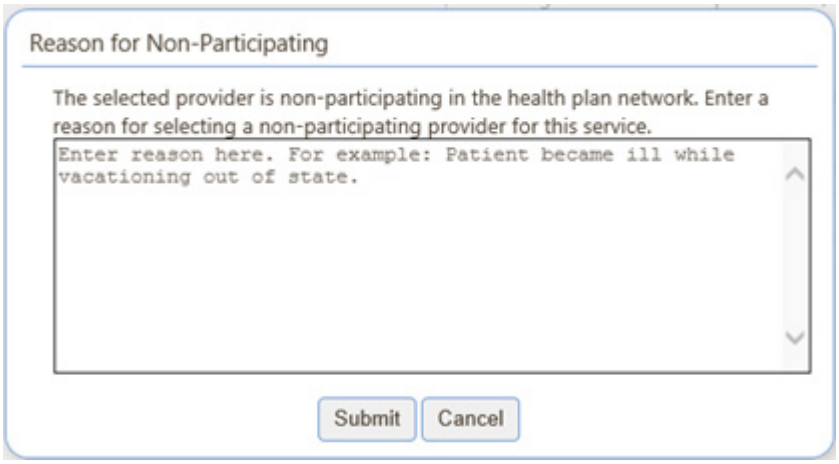
20. If presented, select the servicing provider or vendor by clicking on select Provider. When using the search criteria, use the least amount of information possible to give the system a wider search range. By doing this, you will be more likely to find what you are looking for.



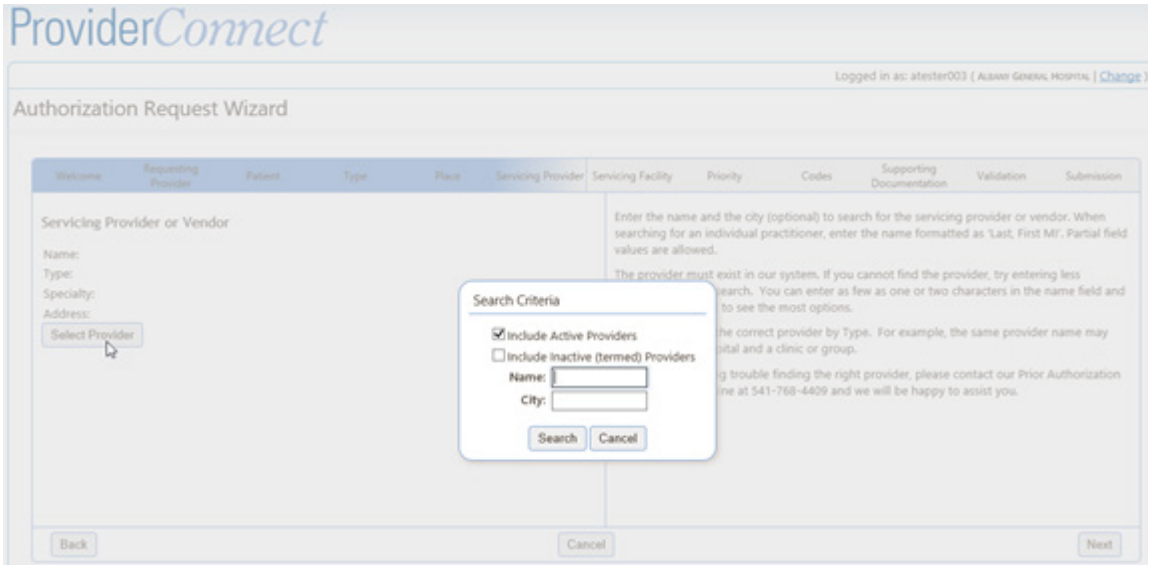
21. Be sure to check the provider type to make sure the correct servicing provider is being selected.



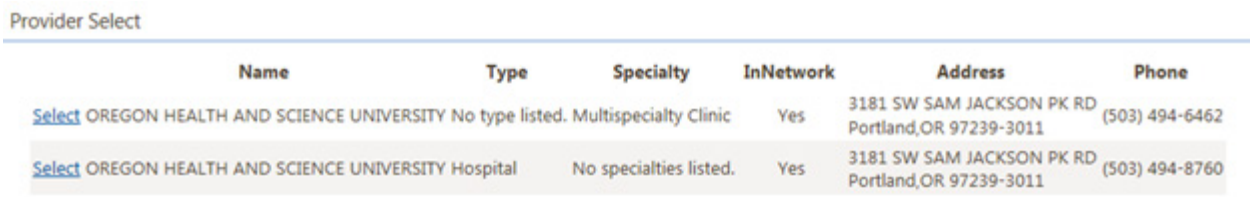
22. If the selected servicing provider is out of network for the member, you will be prompted to indicate a reason for selecting a non-participating provider.



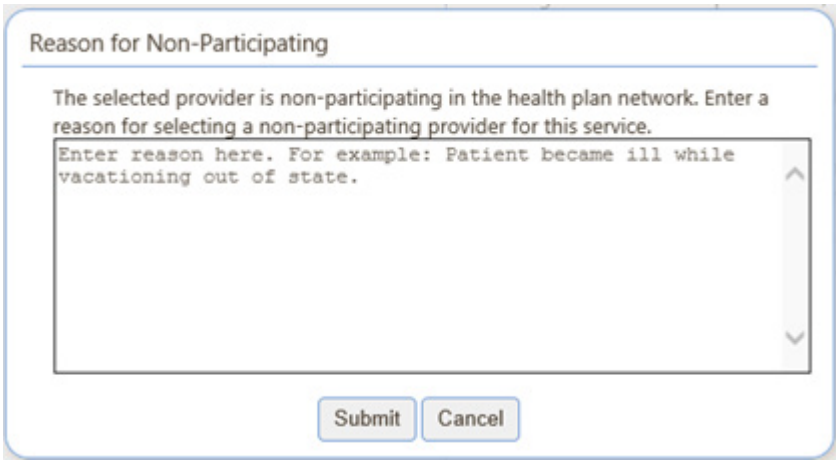
23. The servicing provider section will populate once the provider is selected. Click Next to move to the next applicable step.
24. If presented, select the servicing facility by clicking on Select Facility. For inpatient, use the facility name where surgery/service is being done. When using the search criteria, use the least amount of information possible to give the system a wider search range. By doing this, you will be more likely to find what you are looking for.



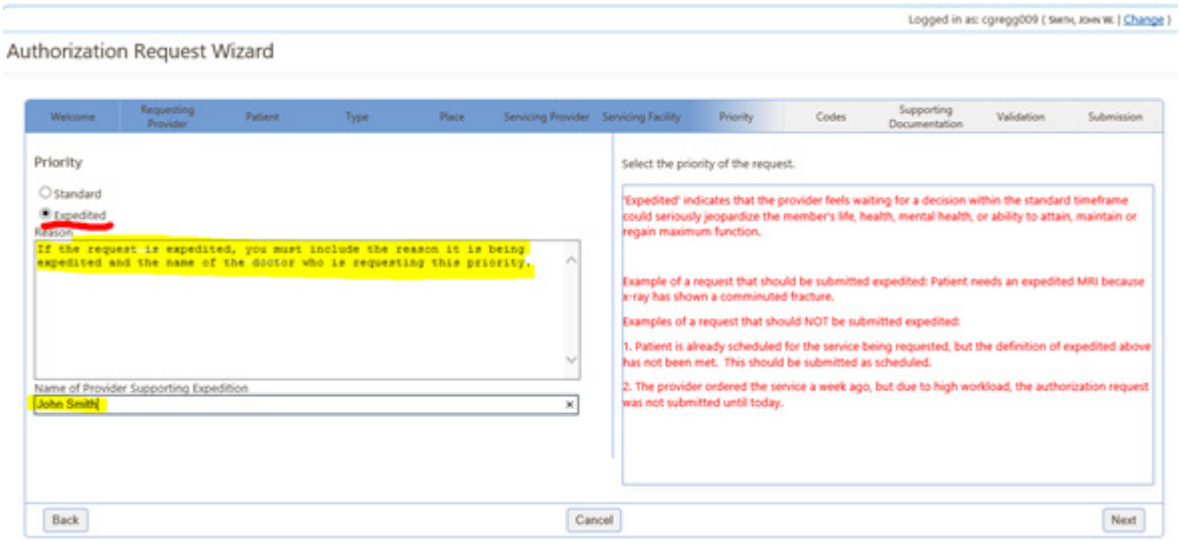
25. If the selected servicing facility is out-of-network for the member, you will be prompted to indicate a reason for selecting a non-participating facility.



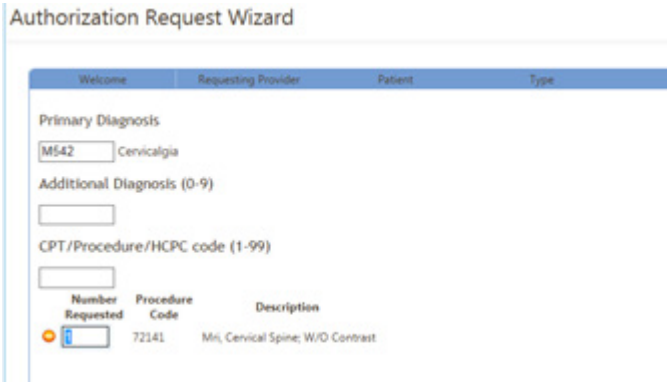
26. The servicing facility section will populate once the provider is selected. Click Next.



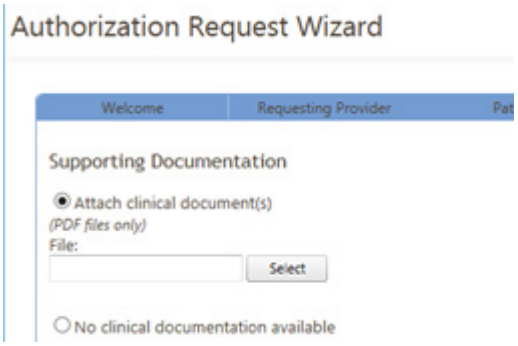
27. Select the priority of the request. Keep in mind expedited requests are only for those where waiting the standard time frame (14 days) could place the member's life, health or ability to regain maximum function in serious jeopardy. Scheduled does not mean expedited. Click Next.

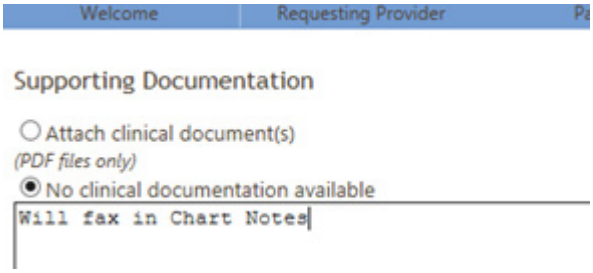


28. Enter the diagnosis and procedure code(s). Once, the first several characters are entered, the system will provide a list of matches to choose from. DME requests should include modifiers to specify if the item is a purchase or rental.

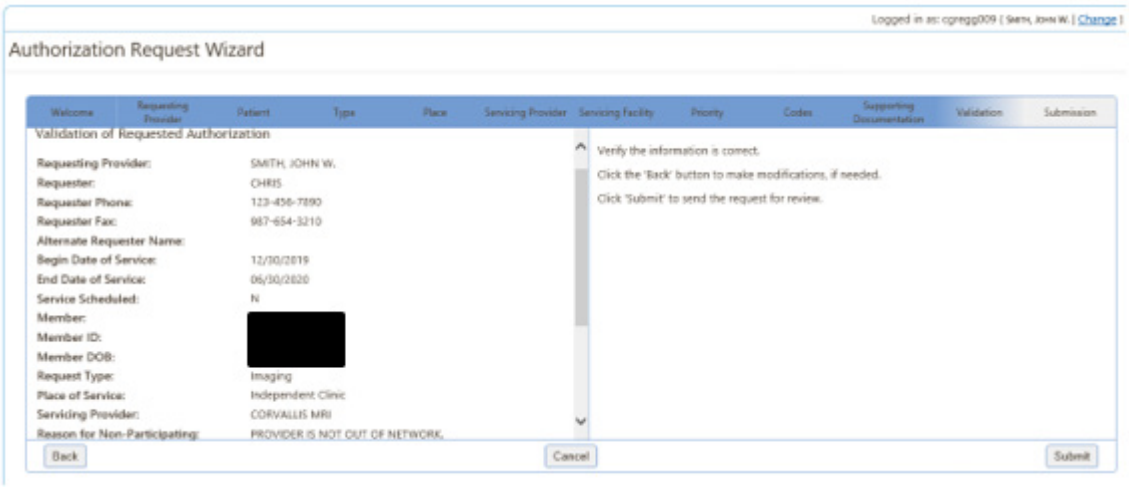


29. Clinical documentation in a PDF format should be attached here and will reduce processing time frame. If unable to attach documentation, indicate the reason in the box.





30. Confirm all information to validate your request and click Submit, if complete. If information needs to be changed, click the back button to make necessary corrections.



If an error message occurs, double check the dates of service and/or member eligibility. For assistance, contact the Wizard Assistance line at **541-768-4409**.

Samaritan Health Plans | InterCommunity Health Network CCO

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Visit us online at **samhealthplans.org** or **IHNtogether.org**

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