

## WORK PROCESS

<b>DEPARTMENT:</b> Medical Management	<b>DOCUMENT NAME:</b> Medical Necessity Review (TruCare)
<b>PAGE:</b> 1 of 9	<b>REPLACES:</b> CC.UM.02.01
<b>APPROVED DATE:</b> 8/01/2011	<b>RETIRED:</b>
<b>EFFECTIVE DATE:</b> 7/1/2012	<b>REVIEWED/REVISED:</b> 8/12; 07/13; 5/14; 1/15; 10/15; 1/16; 3/16; 7/16; 9/16; 4/17; 6/17; 7/17,3/18, 4/18, 10/18,1/19, 3/19,5/19, 6/19,8/19, 2/20, 1/21
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**SCOPE:** Coordinated Care Medical Management Department

### **PURPOSE:**

To ensure utilization management (UM) decisions are conducted by appropriate professionals and all relevant information is used in making medical necessity determinations in the TruCare medical documentation system.

### **WORK PROCESS:**

#### ***Level I Review***

The UM designee for Coordinated Care reviews all relevant information to determine if a Level I or Level II review is indicated.

1. Automatically referred for Level II review - services or procedures that:
  - Require benefit interpretation
  - Are not addressed in InterQual/ASAM criteria and no local criteria or policy exists
  - Are potentially experimental or are new technology/procedures

If *any* of the above applies, the UM designee informs the requesting party of the necessity for further review, enters the request in the authorization system, and forwards the request to a Medical Director for a Level II Review.

2. If a Level I review is indicated, the UM designee reviews all relevant clinical information about the member's condition, taking into account the greater and particular needs of diverse populations as reflected in health disparities, risk factors, risk factors, and historical trauma and the need for culturally appropriate care; including but not limited to: age, co-morbidities, cultural considerations, adverse childhood experiences (ACEs) for members of any age, complications, progress of treatment, psychosocial issues, home environment, support structure, acute vs. chronic condition and/or life-threatening illness), against InterQual Criteria, American Society of Addiction Medicine (ASAM), WAC, internal medical/clinical policies or other applicable guidelines. For concurrent review see policy WA.UM.02.02 *Concurrent Review of Inpatient Hospitalization*. Determinations and provider notifications are made according to the expediency of the case as described in the *Timeliness of UM Decisions and Notifications* (UM.05) policy.
3. Clinical information meets criteria: when the request meets the associated InterQual screening criteria or other predetermined criteria, the UM designee

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approves the request, enters an approved authorization into the TruCare® authorization system and issues an authorization number. Note: *Some services will be reviewed using InterQual/ Policies with a variance table. These variances describe additional criteria that must be met, allow for approval when some InterQual criteria points are not met or when differences in local policy exist. See Table 1.*

4. **Clinical information is insufficient:** see WA.UM.05 *Timeliness of UM Decisions and Notifications* policy.
  
5. **Clinical information does not meet criteria:** when the information does not meet the screening criteria or guideline documents all information in the TruCare authorization system, including the managing physician and his/her contact information. The UM designee creates an *Advisor Review* in the TruCare authorization system, notifying the Medical Director of the need for a Level II Review.
  - Only a Medical Director(or other appropriate healthcare practitioner per Plan policy WA.UM.04 *Appropriate UM Professionals*) can make an adverse determination decision.
  - When referring for Level II Review, UM designee for Coordinated Care creates an *Advisor Review* in TruCare, which generates a date and time stamped *Task* in TruCare to the Medical Director. The *Review Notes* should outline the clinical information and reason for the referral to the Medical Director, including why the request is not meeting the standard medical necessity review criteria. The Medical Director replies back by completing the *Advisor Review* in TruCare. For documentation purposes, the *Advisor Review* needs to be completed by the Medical Director within the TruCare authorization system, even if the discussion with the Medical Director and the decision takes place face-to-face or telephonically.

### **Level II Review**

1. The Medical Director, or other designated qualified practitioner reviews the UM designee's TruCare *Authorization Detail, Line Item Detail*, and UM designee's *Clinical Review* (if applicable). The Medical Director will also review the associated medical/clinical policy or criteria as applicable.
2. The Medical Director, or designee, takes into consideration all documentation pertaining to the case, including any factors that may require special consideration such as:
  - Age, ACEs for members of any age, health disparities, historical trauma co-morbidities, complications, progress of treatment, psychosocial

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issues, home environment, support structure, acute vs. chronic condition, and/or life-threatening illness.

- Local delivery system including availability and coverage of benefits for skilled nursing facilities, sub-acute care facilities, or home care in the local service area and/or the local hospitals' ability to provide all recommended services within the estimated length of stay
  - Cultural appropriateness of requested care
3. If additional and/or clarifying information is needed due to insufficient or conflicting information obtained during the Level I review, Coordinated Cares' Medical Director may discuss the case with the requesting/treating provider. Only the treating/ordering provider may participate in this peer-to-peer discussion.
  4. The Medical Director may also consult with a board-certified participating physician from the appropriate specialty, if needed for additional or clarifying information. When there is no contracted specialist available, the Medical Director may contact a specialist in the community for input. For Behavioral Health determinations, the request must be reviewed by a physician board-certified or board eligible in General Psychiatry or Child Psychiatry, a licensed doctoral level psychologist, a physician board certified or board eligible in Addiction Medicine/subspecialty in Addiction Psychiatry by ASAM or a pharmacist as appropriate. Specifically for inpatient psychiatric treatment the request must be reviewed by a physician board certified or board eligible in General Psychiatry and Inpatient SUD treatment requests must be reviewed by a physician board-certified or board-eligible in Addiction Medicine, a Subspecialty in Addiction Psychiatry or by ASAM. The behavioral health professionals above must be licensed in the State of Washington; except when a WA licensed behavioral health professional is *temporarily* unavailable.
  5. The Medical Director makes the determination to approve, reduce, or deny the service or level of care requested.
  6. The Medical Director and/or Coordinated Care UM designee enters all information and rationale related to the determination in the TruCare authorization system *Advisor Review* and *Notification* sections, to include:
    - *Date of Review*
    - *Reviewed By*
    - *Reviewer Specialty*
    - *Review Reason*
    - *Peer to Peer* contact (PST date/time) by the Medical Director

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- How Received Information
  - *Criteria Source*
  - *Clinical Review Notes*
  - *Rationale* for Medical Director Determination
  - Date and time of oral notification to requesting provider/servicing facility
  - Date and time of written notification to requesting provider/servicing facility/member
7. If the Medical Director *approves* the authorization, he/she completes the *Advisor Review* determination and the TruCare workflow task assigns the UM designee with completing the authorization *Determination and Notification*.
8. The Medical Director may reduce the level of care or service requested as outlined in policy CC.UM.02.02, *Inpatient Leveling of Care*.
9. If after review of all required information, the Medical Director decides to *deny* the request, a standard letter is sent from the clinical authorization system which includes a detailed paragraph explaining the Medical Director's reason(s) for the denial and the process for an appeal (see UM.07, *Adverse Determination (Denial) Letters*).
- Only the Medical Director or other designated qualified practitioner can make a denial decision.
    1. When external medical review is used to supplement Medical Director staffing, all denial decisions are reviewed and co-signed by Plan Medical Director in accordance with CC.UM.04.02 *Use of Board Certified Consultants*
  - The Medical Director may work with Coordinated Care UM designee to draft the denial letter.
  - The letter will include the name of the Medical Director and indicate their unique electronic signature is on file.
  - For adverse benefit determinations UM Designee sends out the denial letter within the timeframes as noted in the WA.UM.05 *Timeliness of UM Decisions and Notifications policy*.
10. ***Non-Covered Medical Equipment:*** In cases involving a request for non-covered Medical Equipment a medical necessity review will be completed by Prior Authorization Nurse according to WSR 18-24-021.
11. ***Exception to the Rule:*** Per WAC 182-501-0160, in cases involving a request for a non-covered health care service the Medical Director will review the request under the exception to rule process (ETR). The Medical Director has

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final authority to approve or deny a request for exception to rule. The Medical Director may approve the request for an ETR if the following criteria are met.

- The member’s clinical condition is so different from the majority that there is no equally effective, less costly covered service or equipment that meets the client's need(s). OR
- The member's health care professional certifies that medical treatment or service which are covered under the client's medical assistance program and which, under accepted standards of medical practice, are indicated as appropriate for the treatment of the illness or condition, have been found to be:
  - Medically ineffective in the treatment of the client's condition; or
  - Inappropriate for that specific client.

Additionally:

- The item or service(s) for which an exception is requested falls within accepted standards and precepts of good medical practice; and
- Represent cost-effective use of public funds; and
  - The request service or item is not excluded under the State statute *and*
  - The request for the services or item is made no more than ninety (90) days from the administrative denial for the non-covered code.
- A member may request an appeal and an exception to rule simultaneously. The request for appeal does not change the timeframe for the request for ETR.
- The ETR request must be made no later than ninety (90) days from the date of denial.
- The requested clinical information is provided within thirty (30) days from the date of request.

For IFC, the UM Nurse would coordinate with the Coordinated Care FC Health Care Coordinator on any requests for ETR. The Health Care Coordinator will coordinate this information with Children’s Administration (CA) and Foster Well-Being (FWB) units. Medical Director documents the Advisor Review and completes the *Advisor Decision* field in TruCare to indicate reason(s) for approval or denial. Members do not have a right to a fair hearing on exception to rule decisions.

**12.Limitation extensions (LE)** can be requested when a provider is exceeding the stated limits for nondurable medical equipment/medical supplies scope, amount, duration, and/or frequency of treatment, equipment, related supplies and/or drugs according to WAC 182-501-0169. The UM designee may review the medical necessity of a request for a Limitation extension as a

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Level 1 review. Limitation extensions are considered based on the following criteria.

- The member has shown a level of improvement related to the requested health care service and there's a reasonable probability of continued improvement if the requested health care service is extended; *and*
- The reasonable probability the client's condition will worsen if the requested health care service is not extended
- For IFC, the UM Nurse would coordinate with the Coordinated Care FC Health Care Coordinator on any requests for LE. The Health Care Coordinator will coordinate this information with Department of Children, Youth and Families (DCYF).

**Exception to ETR/LE processing: All requests for members under age 21 are reviewed in accordance with EPSDT requirements under WAC 182-534-0100.**

EPSDT services are exempt from specific coverage or service limitations. Services not otherwise covered under the Medicaid program are available to children under EPSDT. These services must be medically necessary, safe and effective, and not experimental. Requests for members under age 21 shall receive a medical necessity review to determine if it is medically necessary, safe and effective, and not experimental. If an excluded service appears to meet medical necessity criteria the clinical reviewer will route the request to [hcamcprograms@hca.wa.gov](mailto:hcamcprograms@hca.wa.gov) for technical assistance per the *CCW EPSDT workflow*.

13. The Medical Director may also approve services or settings that are in lieu of services that are covered by the State Plan under the following circumstances:

- Prior written approval from HCA is obtained (HCA will respond within thirty (30) calendar days of the request from the Plan or as expeditiously as the member's health requires. If the in lieu of service is approved the state may provide credit for the in lieu of service in rate setting. The request must meet the following :
  - The alternative service or setting is medically appropriate and cost-effective substitute for the service or setting
    - A cost-benefit analysis will be performed at the direction of the State to determine if the proposed alternative is cost effective
  - The member is not required to use the alternative service or setting
  - The services are authorized

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- Institutes of Mental Disease (no more than fifteen (15) day’s worth of inpatient psychiatric treatment): are expressly considered an in lieu of service per State contract. IMDs must meet all DBHR licensing and certification standards and be medically necessary.
  - All costs and encounter reporting requirements are the same for any provided in lieu of services
14. Timeliness for determinations follow the requirements in WAC 182-501-0160; all standard timeframes for notifications apply.

**Table 1: InterQual/Corporate Policy Variances**

Interqual Subset/Policy	Variance
<b>All Acute Subsets</b>	<b>If IV fluids are running at 100ml/hr or more weight does not need to be documented and the review can be approved if all other criteria are met.</b>
<b>All Acute Subsets- Critical/Intermediate Level of care EXCEPT EXTENDED STAY</b>	<b>If member meets all criteria points but respiratory interventions q1-2 hours while on NIPPV or mechanical intervention at the critical/intermediate level of care the review can be approved</b>
<b>Elective Inpatient Surgical Prior Authorizations</b>	<b>If a requested surgery is on the inpatient list in InterQual no other criteria need to be met when <i>prior</i> authorizing an elective surgery unless the procedure requires a separate clinical review.</b>
<b>All Acute Subsets- Critical/Intermediate Level of care</b>	<b>If member in critical/intermediate level of care on continuous IV drip and meets all other criteria points “administration continuous and monitoring q1-q2hr” does not have to be documented and the review can be approved</b>

### ***Reconsiderations***

If an adverse benefit denial is issued a reconsideration of the decision may be submitted without following the formal appeals process under the following circumstances:

- The request is pre-service
- The request for reconsideration is submitted within 45 days of the denial
- The submitted information directly addresses the reasons for the denial and was not included as part of the original request
- It is the first request for reconsideration

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The reconsideration will follow the above Level 1 or Level 2 process as outlined above. The authorization determination will reflect “authorization update”.

### ***Predetermination Request***

A request from a member, provider or facility to determine if a service is a benefit for the plan. A pre-determination request is processed within five (5) calendar days from the date of the request. Information included in the Predetermination notice is as follows:

- If the service is a covered benefit
- If a prior authorization is required
- If any pre-service requirements apply
- If a medical necessity review will be performed after the service has been delivered
  - The clinical review criteria used to evaluate the request
  - Any required documentation

The notice advises that the pre-determination request is not a prior authorization and does not guarantee services will be covered.

<p><b>REFERENCES / ASSOCIATED PROCESSES</b></p> <p>WA.UM.01 - Utilization Management Program Description                  WA.UM.02 - Clinical Decision Criteria and Application                  WA.UM.04 - Appropriate UM Professionals                  WA.UM.05 - Timeliness of UM Decisions and Notifications                  WA.UM.07 - Adverse Determination (Denial) Letters                  WA.UM.04 – Appropriate UM Professionals                  CC.UM.02.02 – Inpatient Leveling of Care                  WAC 182-501-0160 ETR – Request for no covered health care services                  WSR 18-24-021 - <a href="http://lawfilesexternal.wa.gov/law/wsr/2018/24/18-24-021.htm">http://lawfilesexternal.wa.gov/law/wsr/2018/24/18-24-021.htm</a>                  NCQA Health Plan Standards and Guidelines</p>
<p><b>DEFINITIONS:</b></p> <p><b>Medical Director:</b> As used in this policy is a collective term for the Chief Medical Officer, Chief Medical Director or Medical Director.</p> <p><b>UM Designee:</b> Member of the UM department who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. See CC.UM.04 Appropriate UM Professionals for UM department staff titles, qualifications and reporting structure.</p> <p><b>Exception to Rule:</b> A request by a Member or a requesting provider for the Member to receive a non-covered health care service according to WAC 182-501-0160</p> <p><b>Limitation Extension:</b> A request by a Member or the Member’s health care provider to exceed the scope, amount, duration, and frequency of a covered health</p>

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care service. For the purposes of this section, health care services includes treatment, equipment, related supplies, and drugs.

**Service Authorization:** A member's initial or continuing request for the provision of a service including member requests made by their provider or the member's authorized representative.

<b>REVISION LOG</b>	<b>DATE</b>
Removed network steerage language, addressed in another policy. Added in language for ETR process for clarity around timeframes and process.	1/15
Added InterQual variance table	10/15
Add additional InterQual variances	1/16
Added Neulasta variance to variance table per clinical policy committee update	3/16
Added additional IQ variances for surgery, elective cardiac stenting, and post-surgical wound per CMD	7/16
Added additional Variance for palliative care	9/16
Updated ETR section to remove reference to previous CM process, added in ASAM criteria.	4/17
Updated to remove IQ variance for Wound Vacs for Post-Surgical wounds due to InterQual update to include these criteria.	4/17
Update Variance Table to include increase in units for Psychological Testing	6/17
Added BH reviewer language from FIMC contract	7/17
Added additional language to reflect coverage of services in lieu of per AHMC contract amendment	7/17
Added verbiage for completion of Advisor Decision and requirement for Level II review for >24 hour inpatient stay for OBS conversion appropriateness	3/18
Added variance for prior authorizations of elective inpatient surgical admissions	4/18
Added language for pre-determination request notices and processes.	4/18
Clarified in lieu of services covered language	10/18
Updated against contract language	1/19
Updated against contract language	3/19
Added reference to WA.UM.02.02	5/19
Added Optune language to review grid	6/19
Updated for 2020 contract language, added definition of service authorization; removed psych testing, PACT and neulasta from IQ variance table due to changes in PA and policy	2/20
Annual review. Clarified ACEs can impact members of any age. Added licensure requirements to 4. Updated acronyms related to Foster Care. Added instructions for HCA technical assistance with excluded services. Updated IQ variance table.	1/21

## POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Archer, Centene's P&P management software, is considered equivalent to a physical signature.

Coordinated Care Vice President Medical Management: Approval on File