CHAPTER 5: HEALTH CARE MANAGEMENT

UNIT 1: MEDICAL MANAGEMENT

IN THIS UNIT

TOPIC	SEE PAGE
Medical Necessity Criteria	2
• Medical Necessity Defined	2
Prior Authorization	4
• Requesting Prior Authorization	4
• Services Requiring Authorization	5
• Authorization Process	6
• Procedures Specific to Durable Medical Equipment	7
• Skilled Nursing Facility (SNF)	9
• Outpatient Therapy Services	9
• Acute Inpatient Rehabilitation Facility	9
• Home Infusion	9
• Hospice Services	10
• Behavioral Health Services	10
• Pharmacy Services	10
Home Health Care	11
Private Duty Nursing Services	13
Transitions from Hospital to Home	14
Medical Claims Review	15

5.1 MEDICAL NECESSITY CRITERIA

Overview

The function of an authorization is to confirm the eligibility of the member, verify coverage of services, assess the medical necessity and appropriateness of care, establish the appropriate site for care, and identify those members who would benefit from care management or disease management.

Medical Necessity defined

Health Options' Utilization Management Department assesses the medical appropriateness of services using McKesson's InterQual® Procedure Criteria, American Society of Addiction Medicine (ASAM) criteria, approval criteria based on a Medical Director's review of the latest medical literature and citations, and the Delaware Health and Social Services (DHSS) definition of medical necessity when authorizing the delivery of health care services to members. The definition of medical necessity is:

The essential need for medical care or services (all covered State Medicaid Plan services, subject to age and eligibility restrictions and/or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements for children up to the age of 21) which, when prescribed by the member's primary care physician care manager and delivered by or through authorized and qualified providers, will:

- Be directly related to the diagnosed medical condition or the effects of the condition of the member (the physical or mental functional deficits that characterize the member's condition), and be provided to the member only;
- Be appropriate and effective to the comprehensive profile (e.g., needs, aptitudes, abilities, and environment) of the member and the member's family;
- Be primarily directed to treat the diagnosed medical condition or the effects of the condition of the member, in all settings for normal activities of daily living, but will not be solely for the convenience of the member, the member's family, or the member's provider;
- Be timely, considering the nature and current state of the member's diagnosed condition and its effects, and will be expected to achieve the intended outcomes in a reasonable time;
- Be the least costly, appropriate, available health service alternative, and will represent an effective and appropriate use of program funds;
- Be the most appropriate care or service that can be safely and effectively provided to the member, and will not duplicate other services provided to the member;
- Be sufficient in amount, scope, and duration to reasonably achieve its purpose;

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5.1 MEDICAL NECESSITY CRITERIA, Continued

Medical Necessity defined (continued)

- Be recognized as either the treatment of choice (i.e., prevailing community or statewide standard) or common medical practice by the practitioner's peer group, or the functional equivalent of the other care and services that are commonly provided;
- Be rendered in response to a life-threatening condition or pain, or to treat an injury, illness, or other diagnosed condition, or to treat the effects of a diagnosed condition that has and will be reasonably determined to:
  - Diagnose, cure, correct, or ameliorate defects, physical and mental illnesses, and diagnosed conditions or the effects of such conditions; or
  - Prevent the worsening of conditions or effects of conditions that endanger life or cause pain, or result in illness or infirmity, or have caused or threaten to cause a physical or mental dysfunction, impairment, disability, or developmental delay; or
  - Effectively reduce the level of direct medical supervision required or reduce the level of medical care or services received in an institutional setting or other Medicaid program; or
  - Restore or improve physical or mental functionality, including developmental functioning, lost or delayed as the result of an illness, injury, or other diagnosed condition or the effects of the illness, injury, or condition; or
  - Provide assistance in gaining access to needed medical, social, educational, and other services required to diagnose, treat, or support a diagnosed condition or the effects of the condition, in order that the member might attain or retain independence, self-care, dignity, self-determination, personal safety, and integration into all natural family, community, and facility.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the member, the member's family/caretaker and the primary care practitioner, as well as any other providers, programs, agencies that have evaluated the member.

All such determinations must be made by qualified and trained health care providers. A health care provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

5.1 PRIOR AUTHORIZATION

Requesting prior authorization

The Utilization Management Department is committed to assuring prompt, efficient delivery of health care services and to monitor quality of care provided to Health Options members. The ordering provider can request a prior authorization either via fax using the *Health Options Prior Authorization Form*, or by phone. The Utilization Management Department can be contacted at 1-844-325-6254 between the hours of 8 a.m. and 5 p.m., Monday through Friday.

When calling before or after operating hours or on holidays, practitioners are asked to leave a voicemail message and a Utilization Management Representative will return the call the next business day. If the Health Options Utilization Management Department is closed and you are seeking an authorization for urgent requests, you may call 1-844-325-6254. A Health Options Medical Director is available for review of these requests when necessary. For urgent and emergency situations, Health Options requires that the practitioner notify the plan within forty-eight (48) hours or two (2) business days of rendering service.

Information needed when calling for authorization

The following information is needed to authorize a service. Please have this information available before placing a call to the Utilization Management Department:

1. Member Name
2. Member's 8-digit Health Options ID Number
3. Diagnosis (ICD Code or precise terminology)
4. Procedure Code (CPT-4, HCPCS, or MA Coding) or billing codes for durable medical equipment requests
5. Treatment Plan
6. Date of Service
7. Name of Admitting/Treating Practitioner
8. Name of the Practitioner/Provider requesting the authorized treatment
9. NPI
10. History of the current illness and treatments
11. Any other pertinent clinical information

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5.1 PRIOR AUTHORIZATION, Continued

Services requiring authorization

The services requiring authorization include, but may not be limited to, this list of services:

- Abortion,* Sterilization, Hysterectomy, Vasectomy
- Bariatric Surgery/Stapling
- Behavioral Health (inpatient, residential treatment facility, partial hospitalization, intensive outpatient)
- Blepharoplasty
- Bone Growth Stimulator
- Breast Reduction
- Cardiac and Pulmonary (lungs) Rehabilitation Therapy
- Carpal Tunnel Surgery
- Cochlear and Auditory Implants
- Durable Medical Equipment purchase and rentals $500 or greater
- Electroconvulsive Therapy (ECT)
- Enteral/Parental Therapy
- Experimental or Investigational Services
- Genetic Testing
- Genital Reconstruction
- Hearing Aids, Ear Molds, Dispensing Fees as well as Hearing Aid Repair Services
- Home Health Care
- Hospice
- Hospital Admissions (Medical, Behavioral Health, Rehabilitation)
- Injectable Medications – Botulinum Toxins, H.P. Acthar,® Intravenous Immune Globulin (IVIG), Xolair®
- Intensity Modulated Radiation Therapy (IMRT)
- Joint Replacement
- Non-Emergent Air Ambulance Transport
- Orthotics and Prosthetics (over $500)
- Panniculectomy
- Proton Beam
- Psychological Testing
- Radiology Services (Complex, Outpatient):
  - MRI (magnetic resonance imaging
  - MRA (magnetic resonance angiography)
  - CT (computerized axial tomography)
  - PET (positron-emission tomography)
  - Myocardial Perfusion Imaging/Nuclear Cardiology Services

**** Does not require authorization but consent form may be required.***

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5.1 PRIOR AUTHORIZATION, Continued

Services requiring authorization (continued)

- Removal of Breast Implant
- Rhinoplasty
- Septoplasty
- Skilled Nursing Facility Admissions (acute)
- Sleep Apnea Procedures and Surgeries
- Speech, Occupational, and Physical Therapies
- Spinal Neuro Stimulator Services
- Spine Surgeries
- Temporomandibular Joint (TMJ) Surgery
- Transplants/Implants
- Vagus Nerve Stimulation
- Vein Procedures
- Ventricular Assist Devices
- Wound Vac
- All services to be provided by an out-of-network practitioner/provider (including durable medical equipment and home health)
- Services without a code or fee on the Medicaid fee schedule (including medical equipment and supplies) or Not Otherwise Classified (NOC) procedure codes

Authorization process

Authorization is the responsibility of the admitting practitioner or ordering provider and can be obtained by calling the Health Options Utilization Management Department at 1-844-325-6254.

If a service requires authorization and is being requested by a participating specialist, the specialist's office must call Health Options to authorize the service. Hospitals may verify authorization by calling the Health Options Utilization Management Department.

When a call is received, the above information will be reviewed and the member's eligibility verified. However, since a member's eligibility may change prior to the anticipated date of service, eligibility must be verified on the date of service.

If an authorized service is not able to be approved as proposed by the practitioner, alternate programs such as home health care, rehabilitation, or additional outpatient services may be suggested to the practitioner by the Utilization Management staff. If an agreement cannot be reached between the practitioner and the Utilization Management staff, the case will be referred to a Health Options Medical Director for review. A practitioner may appeal the decision within ninety (90) days of the date of the notice of action.

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5.1 PRIOR AUTHORIZATION, Continued

Authorization process (continued)

Please refer to Chapter 5, Unit 3: *Complaints, Grievances, and Appeals* for the process to appeal a decision.

Procedures specific to durable medical equipment

Health Options members are eligible to receive any covered and medically necessary durable medical equipment needed. When ordering durable medical equipment, these procedures are followed:

- If the cost of a single item or multiple quantities of a single item is $500 or greater as reimbursed by Medicaid, the ordering practitioner/provider must obtain authorization from the Utilization Management Department. A written prescription and Health Options authorization are necessary to obtain them.
- Rental equipment must be authorized if the monthly rental cost is $500 or greater.
- Covered items under $500 can be obtained from a participating durable medical equipment provider with a prescription from the ordering practitioner/provider. Provider Services can direct practitioners to a contracted vendor to supply durable medical equipment. Durable medical equipment vendors are also listed in the *Health Options Specialty Care Practitioner Directory*. A written prescription is required to obtain the item.
- Any item without an established Medicaid fee requires authorization by the Utilization Management Department.
- Regardless of price, when a miscellaneous code is requested, an authorization from Health Options Utilization Management Department is required.
- Due to potential interruptions of Medicaid coverage, Health Options strongly recommends that all providers verify eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.
- All medical supplies, including wound care, ostomy, enteral products, diapers (for age 4 and older), and incontinence products, must be obtained through a contracted durable medical equipment vendor as opposed to a participating pharmacy.
- Oral enterals must be obtained through a participating durable medical equipment provider. Based on the cost of the product ordered, an authorization from Health Options Utilization Management Department may be necessary if the product is $500 or greater. Please do not direct members to retail pharmacies for these services.

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5.1 PRIOR AUTHORIZATION, Continued

Procedures specific to durable medical equipment (continued)

- Health Options will accept the request for durable medical equipment directly from the durable medical equipment supplier. If the practitioner is requesting the authorization, please contact a participating durable medical equipment provider to receive the appropriate billing code(s) before calling the Health Options Utilization Management Department. Please call your Health Options' Provider Services Department at 1-844-325-6252 if you need an updated list of participating providers.
- Services provided by non-participating durable medical equipment providers require an authorization from the Health Options Utilization Management Department.
- Incontinence items will be covered by Health Options without requesting an Explanation of Benefits from any other plan; however, if the billed charge is $500 or greater, and/or a miscellaneous code is used to request the supply, a Utilization Management authorization will be required according to plan guidelines. Any services provided by non-participating providers always require authorization.

Information needed when ordering durable medical equipment

The following information will provide assistance to offices when ordering durable medical equipment services:

1. Patient Name, Health Options ID Number, Prior Authorization Number (if applicable)
2. Durable Medical Equipment Vendor/Provider NPI number
3. Ordering Practitioner/Provider, including NPI number
4. Diagnosis
5. Name of Requested Equipment, Medical Assistance Fee Schedule Code, Cost
6. Is this a Purchase or a Rental request?
7. Amount of items requested and over what period of time (if requesting rental)
8. Clinical information to support the request

To request a precertification for durable medical equipment, please call the Health Options Utilization Management Department at 1-844-325-6254.

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5.1 PRIOR AUTHORIZATION, Continued

Skilled nursing facility (SNF)

Should a member be in need of admission to a skilled nursing facility, the primary care practitioner, attending practitioner, hospital Utilization Review Department, or the nursing facility should contact the Health Options Utilization Management Department at 1-844-325-6254 for new requests.

Health Options will coordinate the necessary arrangements between the primary care practitioner and the nursing facility to provide the member with continuity and coordination of care.

At the time the skilled nursing facility services are approved, the Health Options Utilization Management reviewer will provide the name, phone number, and fax number of the primary care practitioner in order to fax any discharge instructions to ensure coordination of discharge services.

Outpatient therapy services

All outpatient therapy services -- including physical therapy, occupational therapy, speech therapy, cardiac and pulmonary rehab – require an authorization from the Health Options Utilization Management Department.

The outpatient therapist or the ordering provider of the therapy must contact the Health Options Utilization Management Department to request a precertification by calling 1-844-325-6254. The therapy provider will be asked to fax the current progress notes, plan of treatment, and goals, which support the medical necessity of the therapy services.

Acute inpatient rehabilitation facility

Should a member be in need of admission to an acute inpatient rehabilitation facility, the primary care practitioner, attending practitioner, hospital Utilization Review Department, or the rehabilitation facility should contact the Health Options Utilization Management Department at 1-844-325-6254 for new requests.

For ongoing reviews, please contact your assigned reviewer.

Home infusion

Nursing visits and supplies related to home infusion services do not require an authorization. Refer to the formulary regarding authorization requirements for infusion drugs.

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5.1 PRIOR AUTHORIZATION, Continued

Hospice services

Should a member be in need of hospice services – including home hospice, inpatient hospice, continuous care, and respite – the primary care practitioner, attending physician, or hospice agency should contact the Health Options Utilization Management Department. Health Options will coordinate the necessary arrangements between the primary care practitioner and the hospice provider in order to assure continuity and coordination of care.

Due to interruptions of Medicaid coverage, Health Options strongly recommends verification of eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.

Behavioral health services

For information about authorization for behavioral health services, please see the Chapter 3, Unit 2 of this manual.

Pharmacy services

Health Options allows access to all non-formulary drugs, other than those excluded by the Department of Public Welfare's Fee-For-Service Program, through the exception review process. If changing to a formulary medication is not medically advisable for a member, a practitioner must initiate a Request for Medicaid Drug Exception.

The *Request for Medicaid Drug Exception Form* should be faxed to 1-888-245-2049 during normal business hours. Requests during off-hours and weekends should be made by calling 1-844-325-6251. Practitioners should assure that all information on the form is available when calling.

The *Request for Medicaid Drug Exception Form* can also be found in Health Options Drug Formulary or on the Health Options website. The form may be photocopied. You can also request a copy of the form by calling 1-844-325-6253.

All requests for exception will receive a response within twenty-four (24) hours. The pharmacy has the ability to dispense a 72-hour supply of prior authorization medications of the pharmacist feels the member is in emergency need of medication.

5.1 HOME HEALTH CARE

Overview

Health Options encourages the use of home-based services as an alternative to hospitalization when medically appropriate in order to:

- Allow for timely and appropriate discharge from the hospital.
- Avoid unnecessary admissions of members who could effectively be treated at home.
- Permit members to receive care in greater comfort due to familiar surroundings.

Home-based services may include, but are not limited to, the following type of services:

- Skilled Nursing
- Speech Therapy
- Hospice
- Home Health Aide
- Physical Therapy
- Infant Care (after initial postpartum visits)
- Occupational Therapy
- High-Risk Pregnancy
- Social Services

Authorization requests

The Health Options Utilization Management Department coordinates medically necessary non-private duty home health care needs with the ordering practitioner and the home health care provider. Please call the Health Options Utilization Management Department at 1-844-325-6254.

Authorization is required for all home-based services. Health Options will accept the request for home health services directly from the home health provider.

Due to interruptions of Medicaid coverage, Health Options strongly recommends verification of eligibility if the need for an item or service extends beyond the calendar month in which the authorization was given.

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5.1 HOME HEALTH CARE, Continued

Billing for home health services

Billing for home health services must be on a UB-04 form or 837I electronic transaction. Include a HCPCS procedure code along with the appropriate revenue code as listed below:

HCPCS CODE	DESCRIPTION	REVENUE CODE	DESCRIPTION
G0151	Services of physical therapist in home health setting, each 15 minutes	0422	Physical therapy, hourly charge
G0152	Services of occupational therapist in home health setting, each 15 minutes	0432	Occupational therapy hourly charge
G0153	Services of speech and language pathologist in home health setting, each 15 minutes	0442	Speech/language pathology, hourly charge
G0154	Services of skilled nurse in home health setting, each 15 minutes. **Note:** This code shall be used for **all** nursing services including nursing services provided to Assisted Living Waiver clients and early postpartum discharge in-home assessment.	0552	Skilled nursing, hourly charge
G0156	Services of home health aide in home health setting, each 15 minutes. **Note:** This code shall be used for **all** home health aide services including home health aide provided to Assisted Living Waiver clients.	0572	Home health aide (Home Health), hourly charge

5.1 PRIVATE DUTY NURSING SERVICES

Overview

Health Options Care Management Department coordinates medically necessary private duty nursing services with the ordering practitioner and the home health care provider. The Care Management Department can be reached by calling 1-844-325-6255. The Care Management Department can be contacted between the hours of 8 a.m. and 5 p.m., Monday through Friday.

Ordering private duty nursing services

Should a member be in need of private duty services, the member's primary care practitioner or a specialist rendering care to the member may submit a letter of medical necessity to the Health Options Care Management Department.

The following information will provide assistance to physicians when ordering private duty nursing:

1. Specify the level of care being requested.
2. Specify hours per day being requested and schedule.
3. Outline care the member requires assistance with during hours services are being requested.
4. Summary of the member's past medical history, including review of current conditions driving need for private duty services, along with prognosis and treatment plan.
5. Outline of all caregivers supporting the member's care.
6. If caregiver's ability to render care is limited, detail and provide documentation.
7. If a caregiver's availability to render care is limited, detail and provide documentation.

5.1 TRANSITIONS FROM HOSPITAL TO HOME

Overview

Seeing a patient in the office following an admission can be a challenging experience for both your office and the patient. Health Options is dedicated to making that transition less confusing for you and your patients.

The initial contact with members is attempted while they are still in the acute care setting and interventions are focused in six areas:

1. Medication reconciliation
2. Making and keeping follow-up appointments
3. Assessing and arranging home health care needs
4. Assessing and coordinating durable medical equipment needs
5. Discussing transportation options and resources to appointments
6. Coordination to have gaps in care and preventive screening needs addressed

Health Options offers assistance to members

The Health Options team works with members related to these activities:

1. Keeping the discharge instruction and bringing them to the appointment.
2. Understanding and adhering to their medications, both dosing and frequency.
3. Keeping a current list of all medicines and sharing that with the physician and members of their care team.
4. Making and keeping follow-up appointments with their primary care practitioner and specialists.
5. Making sure there is transportation to appointment by coordinating with transportation programs if needed.

Referring a member for transition coordination

If you have a patient who you feel would benefit from coordination during a transition, please contact the Care Management Department at 1-844-325-6255, Monday through Friday from 8 a.m. to 5 p.m.

5.1 MEDICAL CLAIMS REVIEW

Requesting a claim review

Claims rejected for services that did not have medical records attached or the appropriate authorizations are subject to a Medical Management Review. All claim records should be sent to Health Options. When submitting a written request for a claim review, please provide the following:

- A copy of the Health Options Remittance Advice
- The member's name and Health Options ID Number
- The reason the review is requested and include as much supporting documentation as possible to allow for a complete and comprehensive review
- Date(s) of service in question
- A copy of the medical record for the service(s) in question, if applicable

Mailing address

Claim inquiries for administrative/medical review should be mailed to:

Health Options
Attention: Claims Review Department
P.O. Box 22218
Pittsburgh, PA 15222-0218

Review process

In the event that the claim cannot be reprocessed administratively, a medical necessity review is undertaken. The records will be reviewed by a Medical Review Nurse. If the Medical Review Nurse cannot approve the services, a Health Options Medical Director makes the final decision to approve or deny the claim. A final decision is made within thirty (30) days from receipt of the inquiry.

If the Medical Director does not approve the services, a denial letter is sent to the practitioner. If the practitioner is not satisfied with the results of the medical necessity review, a written complaint can be submitted which will be treated as an appeal.

For more information on this process, please see Chapter 5, Unit 3 of this manual.