

HEALTH PLAN POLICY	
Policy Title: Medical Director Initial Review	Policy Number: MUM14 Revision: C
Department: Medical Management	Sub-Department: Utilization Management
Applies to Product Lines: <input type="checkbox"/> Medicaid <input checked="" type="checkbox"/> USFHP <input type="checkbox"/> Children’s Health Insurance Plan <input checked="" type="checkbox"/> Commercial Insured <input checked="" type="checkbox"/> Health Insurance Exchange <input checked="" type="checkbox"/> Non Insured Business <input checked="" type="checkbox"/> Medicare	
Origination/Effective Date: 03/04/2016	
Reviewed Date(s):	Revision Date(s): 06/01/2017, 09/20/2018, 04/29/2020

SCOPE:

The purpose of this policy is to describe the process for reviewing initial requests for authorization by medical directors who participate in the utilization management (UM) process on behalf of the health plan. The health plan employs a medical director who is responsible for ensuring the clinical accuracy of all coverage decisions made by the plan that involve medical necessity.

DEFINITIONS AND ACRONYMS:

- **Medical Necessity** – Is defined as accepted health care services and supplies provided by health care entities, appropriate to the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care.
- **Medical Necessity- (applicable to USFHP only)** A collective term for determinations based on medical necessity, appropriate level of care, custodial care (as these terms are defined in 32 CFR 199.2) or other reason relative solely to reasonableness, necessity or appropriateness. Determinations relating to mental health benefits under 32 CFR 199.4 are considered medical necessity determinations. For pharmacy claims, a determination regarding pharmaceuticals prescribed outside the guidelines issued by the DoD Pharmacy and Therapeutics Committee is not considered a medical necessity determination, even when the determination is based on medical review. Such determination is a factual determination and should be processed in accordance with Section 5.
- **Medical Review** - Is the collection of information and clinical review of medical records to ensure that payment is made only for services that meet all coverage, coding, and medical necessity requirements.
- **Organization Determination** - Any determination made by the health plan with respect to any of the following:
 - Payment for temporarily out of the area renal dialysis services, emergency services post stabilization care, or urgently needed services
 - Payment for any other health services furnished by a provider that the member believes are covered or should have been furnished, arranged for, or reimbursed by the health plan;
 - The health plan’s refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by the health plan;
 - Reduction, or premature discontinuation of a previously authorized ongoing course of treatment; or
 - Failure of the health plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse

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determination, such that a delay would adversely affect the health of the member.

- **Peer-to-Peer Consultation** - A peer-to-peer consultation is a discussion between a requesting practitioner and a medical director concerning a utilization issue. A peer-to-peer discussion may address a potential request for services, requests under review, ongoing patient care, or a denial.
- **Reconsideration** - A member's first step in the appeal process after an adverse organization determination; a health plan or independent review entity may re- evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
- **Reconsideration Medical Reviewer Qualifications** - If a reconsideration determination is based on lack of medical necessity or other reason relative to reasonableness, necessity or appropriateness, the reconsideration reviewer must be someone who is:
 - qualified to make an initial determination,
 - not the individual who made the initial denial determination.
- **Representative** - An individual appointed by a member or other party, or authorized under State or other applicable law, to act on behalf of an member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules.
- **Waiver of Liability- (applicable to USFHP only)** Subject to application of other TRICARE definitions and criteria, the principle of waiver of liability is summarized as follows: If the beneficiary did not know, or could not reasonably be expected to know, that certain services were potentially excludable from the TRICARE Basic Program by reason of being not medically necessary, not provided at an appropriate level, custodial care, or other reason relative to reasonableness, necessity or appropriateness (hereafter, all such services will be referred to as not medically necessary), then the beneficiary will not be held liable for such services and, under certain circumstances, payment may be made for the excludable services as if the exclusion for such services did not apply.

POLICY:

- A. Each person who makes an initial denial determination about services furnished or proposed to be furnished by a licensed doctor of medicine or osteopathy or by a doctor of dentistry must be respectively another licensed doctor of medicine or osteopathy, if the initial determination is based on lack of medical necessity or other reason relative to reasonableness, necessity or appropriateness.
- B. Following an established process for escalation of a medical necessity review, Medical Management team members forward any issues that are of clinical concern to the medical director for review and determination.
- C. When considering whether to certify a health care service requested by a provider or member, the medical director shall determine whether the requested health care service is covered by the health benefits plan.
- D. Before denying a health care service requested by a provider or member on grounds of a lack of coverage, the medical director shall determine that there is no provision of the health benefits plan under which the requested health care service could be covered. If the medical director finds that the requested health care service is not covered by the health benefits plan, the medical director need not address the issue of medical necessity.

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- E. If the medical director finds that the requested health care service is covered by the health benefits plan, then when considering whether to certify a health care service requested by a provider or member, a physician, registered nurse, or other health care professional shall, within the timeframe required by the medical exigencies of the case, determine whether the requested health care service is medically necessary.
- F. If an adverse determination is based on a lack of medical necessity, the medical director will clearly and completely explain why the requested health care service is not medically necessary.
- G. If the adverse determination is based on a lack of coverage, the medical director will identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan.
- H. The medical director review shall be in accordance with the health plan best business practices. This process does not alter the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), or TRICARE Systems Manual (TSM) provisions covering active duty personnel or TRICARE For Life (TFL) beneficiaries. **(Applicable to USFHP only)**
- I. The medical director will include a description of the standard (policies and procedures, Local Coverage Determination, TRICARE Operation Manual) that was used in denying or approving the services requested.
- J. Provide a summary of the discussion which triggered the final determination. A statement that the health care service is not medically necessary will not be sufficient.
- K. Payment and liability for services or supplies retrospectively excluded by the medical director by reason of being not medically necessary, at an inappropriate level, custodial care, or other reason relative to reasonableness, necessity or appropriateness will require a “Waiver of Liability” determination; **(Applicable to USFHP only)**
- L. Waiver of liability applies to retrospective determinations that services are not medically necessary (with the exception of services provided by network providers). **(Applicable to USFHP only)**
- M. Waiver of liability should be applied when: **(Applicable to USFHP only)**
 - 1. Member did not know, provider did not know care was excludable as not medically necessary (for specific dates of service).
 - 2. Member did not know, provider knew care was excludable as not medically necessary (for specific dates of service).
 - 3. Member knew, provider knew care was excludable as not medically necessary (for specific dates of service).
 - 4. Member knew, provider did not know care was excludable as not medically necessary (for specific dates of service).
- N. Determinations of medical necessity made in a concurrent or pre-procedure review should include discussions with the attending provider as to the current medical condition of the patient whenever possible.
- O. The medical director will initiate a peer to peer request by making a minimum of two best effort attempts to contact the attending, treating, or ordering physician.
- P. Record each successful and unsuccessful contact with a provider, each record must include the date and time, person contacted, context of the conversation.

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- Q. The medical director can make a positive determination regarding medical necessity without necessarily speaking with the treating provider if there is enough available information to make an appropriate medical decision.
- R. The medical director must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the member and the discussion must include at minimum clinical basis for the adverse decision and the description of documentation or evidence, and if the provider has additional information, he should be given an opportunity to submit, which may lead to a different utilization review decision.
- S. The medical director can make a positive determination regarding medical necessity without necessarily speaking with the treating provider if there is enough available information to make an appropriate medical decision.
- T. The notice of the initial determination shall include a caption identifying:
1. A summary of the issue or issues and shall be clear and concise. All issues shall be addressed; for example, a determination in all cases requiring preadmission authorization shall address the requirement for preadmission authorization of the care as well as whether the requirement was met.
 2. A brief discuss of the provision of law, regulations, guidelines on which the determination was made. Include pertinent specific citations and quotations of applicable text (e.g., when citing cosmetic surgery policy, should quote only the procedure(s) applicable to the case under review).
 3. Discuss the original and any added information relevant to the issue(s) clearly and concisely, and shall state the patient's condition, including symptoms. Include a discussion of any secondary issues which may have been discovered during the review process.
 4. State the decision and whether the requested services or supplies are approved or denied in whole or in part, and clearly and concisely state the rationale for the decision; i.e., fully state the reasons that were the basis for the approval or denial of requested benefits. If applicable criteria must be met, the patient's medical condition must be related to each criterion and a finding made concerning whether each criterion is met.
 5. All related case documentation and contacts will be documented in the Care Management system.
 6. Determination Letters will be sent according to the prior authorization guidelines. (24 hours for expedited request and 48 hours for standard request)

REFERENCES:

- Medicare Managed Care Manual Chapter 6, Chapter 11, 42 CFR, 422.562(a)(4) and 423.562(a)(5).
- 13.10.17.2 NMAC - Rp, 13.10.17.2 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12
- Insurance Code Title 14. Utilization Review and Independent Review
- TRICARE Operations Manual 6010.56-M, February 1, 2008, Chapter 12, Section 4 - Referrals/Preauthorizations/Authorizations
- TRICARE Operations Manual 6010.56-M, February 1, 2008, Chapter 8, Section 5 - Appeals Hearing
- TRICARE Policy Manual 6010.57-M, February 1, 2008 Chapter 1, Section 4.1- Waiver of Liability
- Texas Administrative Code Title 28, Part 1, Chapter 19, Subchapter R

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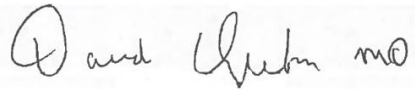
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RELATED DOCUMENTS:

None



Nancy Horstmann
Chief Executive Officer Health Plans



David Engleking, M.D.
Medical Director

REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	03/04/2016	Initial Release	Board of Directors
A	06/01/2017	Annual Review. Changed signatory from Anita Leal, Executive Director to Nancy Horstmann, CEO.	Board of Directors
B	09/20/2018	Annual review - product lines updated	Executive Leadership
C	04/29/2020	Annual review. Updated formatting.	Executive Leadership