POLICY AND PROCEDURE

DEPARTMENT: Medical Management	**DOCUMENT NAME:** Clinical Decision Criteria and Application
PAGE: 1 of 6	**REPLACES:** CC.MEDM.UM.07 Utilization Mgmt Decisions (3/05)
APPROVED DATE: 3/16/06	**RETIRED:**
EFFECTIVE DATE: 3/16/06	**REVIEWED/REVISED:** 8/13; 12/13; 09/14; 08/15; 08/2016
PRODUCT TYPE: Medicaid and HIM	**REFERENCE NUMBER:** CC.UM.02

SCOPE:
Centene Corporate and Plan Medical Management Departments

PURPOSE:
To ensure clinical decisions are made and documented using all relevant clinical information and are based on written, nationally recognized clinical decision support criteria.

POLICY:
Centene plans and delegated vendors (as applicable) use written clinical support criteria to evaluate medical necessity, level of care, and/or clinical appropriateness of select services including inpatient hospitalization and outpatient referrals. They will work collaboratively to ensure members have timely access to high quality healthcare and appropriate healthcare resources. The Utilization Management (UM) criteria and the procedures for applying them will be reviewed annually and updated as appropriate.

PROCEDURE:

I. Clinical Criteria

A. Evidence-based, nationally recognized clinical support tools:

Plan UM staff consult the following criteria sets when determining medical necessity, level of care, and appropriateness of physical health care. Refer to CP.MP.68 – *Medical Necessity Criteria* for appropriate hierarchy in selecting criteria.

- Centene clinical policies include medical, behavioral health, medical pharmacy benefits, durable medical equipment and devices and are developed based on current scientific research and clinical thinking. Centene's Clinical Policy Committee (CPC) reviews and approves clinical policy related to new and emerging technologies and new uses for existing technologies. Clinical policies are available to all health plan staff and external providers on the provider portal or upon request. (See CP.CPC.01 *Clinical Policy Committee*)
- Most recently available written/electronic version of McKesson's *InterQual* Level of Care and Care Planning Criteria for Acute Adult, Acute Pediatric, Long-Term Acute Care, Rehabilitation, Subacute/SNF, Home Care, Outpatient Rehabilitation and

Chiropractic, Durable Medical Equipment, Imaging, Procedures, Molecular Diagnostics and also available BH criteria including Geriatric Psychiatry, Adult Psychiatry, Adolescent Psychiatry, Child Psychiatry, Substance Use Disorders & Dual Diagnosis and Residential & Community-Based Treatment

- Plan's Medical Management Guidelines for therapies and rehabilitation
- Local state and/or regulatory guidelines, where applicable, may also be used in making UM decisions.
- While *clinical practice guidelines* <u>*are not*</u> used as criteria for medical necessity determinations, the plan's Medical Director and UM staff will ensure that UM decisions are consistent with guidelines distributed to network providers. Such guidelines will include, but not be limited to, preventive health (adult and child), asthma, prenatal care, diabetes, and synagis.
- Other nationally recognized support and reference tools such as Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, Agency for Healthcare Research and Quality (AHRQ), etc., are available to Medical Director(s).

B. Annual Review of Criteria

Updates and revisions to McKesson's InterQual Level of Care and Care Planning Criteria, along with any state specific clinical policies are reviewed annually by the Plan Utilization Management Committee (UMC) and/or Quality Improvement Committee (QIC). All clinical policies are reviewed, updated, and approved by the CPC on an annual basis. At this time, local practitioners with professional knowledge or clinical expertise in the area being reviewed have an opportunity to give advice or comment on adoption of UM criteria and on instructions for applying the criteria.

C. Availability of Criteria:

Providers are notified through provider orientation, the Provider Manual, and Provider Newsletters of the criteria utilized by Centene for medical necessity determinations. The Provider Manual, Newsletters, and other provider information are also available on the Plan web site. These communications include notification that treating providers may, at any time, request UM criteria pertinent to a specific authorization by

contacting the Medical Management Department or may discuss the UM decision with the Plan Medical Director.

II. Clinical Criteria Application

A. Levels of Clinical Review

Clinical criteria are applied to determine medical necessity and/or appropriate level of care for the service being requested. Two levels of UM clinical review are available for all authorization requests (UM.02.01 - *Medical Necessity Review*)

a. **Level I** review is conducted by a clinical UM designee (Prior Authorization Nurse, Care manager, etc.) who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. A Level I review is conducted utilizing McKesson's InterQual **or other applicable** criteria or clinical policy, while taking into consideration the individual member needs and complications at the time of the request, in addition to the local delivery system available for care. Other factors that must be considered when applying criteria to a given individual situation includes the member's age, co-morbidities, complications, progress of treatment, psychosocial situation and home environment, when applicable. At no time shall a Level I review result in a reduction, denial or termination of a service. Adverse determinations can only be made by a Medical Director, or qualified designee, during a Level II review.

b. **Level II** review is conducted by an appropriately licensed practitioner or other health care professional. If the request is for behavioral health service, a qualified behavioral health practitioner will be consulted during the review. If the request is for dental services, a qualified dental practitioner will conduct the Level II review. All Level II reviews shall be conducted utilizing McKesson's InterQual or other applicable criteria or policy with consideration given to continuity of care, individual member needs at the time of the request and the local delivery system available for care. A board-certified consultant may also be used in making a medical necessity determination.

B. Consistency in Applying Criteria:

Annual Interrater Reliability (IRR) testing is performed on all staff involved in UM decision making to ensure consistency in determinations and documentation is being attained. (Refer to *UM.02.05 – Interrater Reliability.)*

- All current InterQual users will be tested at least yearly. This includes all Medical Directors, Registered Nurses, Licensed Practical Nurses, and Licensed Clinical Social Workers who use InterQual.
- All new employees must be tested after training but before the end of the 90 day orientation regardless of any pre-employment test. If this testing coincides with the annual testing, it may be used for both. If there are more than 30 days separating the new employee and annual testing, it must be repeated.
- Temporary staff required to use InterQual must be tested prior to working in the live authorization system. Temporary employees who do not pass the applicable IRR testing are ineligible for assignment.
- Staff will be kept updated related to any changes of the InterQual system as needed based on when changes occur.

III. Oversight of Delegated Activities

A. Centene health plans may, at their discretion, delegate UM activities, including adoption or development of utilization decision criteria, to qualified subcontracted vendors. For example, plans may delegate management of behavioral health care benefits to Cenpatico Behavioral Health or high tech outpatient radiology services to National Imaging Associates (NIA).

B. The plan is accountable for delegated UM services and monitors performance of these services. Initial monitoring occurs through the approval of the delegate's UM program and UM policies and procedures (or the delegated portions of the program). Subsequent performance reviews are achieved through routine reporting and at least annual evaluation. The evaluation criteria include NCQA and/or plan/state standards. The Plan also retains the right to reclaim the responsibility for performance of this function should standards not be maintained.

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REFERENCES:
UM.01 – *UM Program Description*
UM.02.01 – *Medical Necessity Review*
UM.02.05 – *Interrater Reliability*
UM.04 - *Appropriate UM Professionals*
CP.CPC.01 - *Clinical Policy Committee*
CP.MP.68 – *Medical Necessity Criteria*
Current NCQA Health Plan Standards and Guidelines

ATTACHMENTS: N/A

DEFINITIONS:
Medical Director: As used in this policy is a collective term for the Chief Medical Officer, Chief Medical Director or Associate Medical Director(s).
UM Designee: Member of the UM department who has been appropriately trained in the principles, procedures, and standards of utilization and medical necessity review. See *UM.04 Appropriate UM Professionals* for UM department staff titles, qualifications and reporting structure.

REVISION	**DATE**
Annual review; Updated approver titles; Updated references (added *CP.CPC.01 Clinical Policy Committee;* updated NCQA for current year); Updated InterQual product names for current year; Deleted reference to policies being available within McKesson InterQual Products under Specialty Referral; Updated "B. Annual Review of Criteria"; Minor grammatical changes; Removed "These policies are also available within the McKesson InterQual Products under Specialty Referral." within "A. Evidence-based, nationally recognized clinical support tools:"; Removed several definitions related to Medicare; Updated approver titles.	08/13
Updated "A" "Clinical policies are available to all" and added reference tools; Updated "B" "Clinical policies are approved by CPC"; Under "II.A." removed reference to CC.UM.02.02 and CC.UM.02.03 and added CC.UM.02.01; Removed reference to CPC making modifications to criteria in "B."; Updated NCQA in references for 2014	12/9/13
Annual Review; Updated "Product Type: from "All" to "Medicaid and HIM; Updated "I.A." to reflect reference to CP.MP.68; Added IN.UM.23 to reference section; Added "Molecular Diagnostics" criteria, added bullet for MCG guidelines and clarification for NCD and LCD; Minor grammatical updates; Removed last bullet under "B." as same info is documented in CC.UM.02.05; Updated NCQA reference to 2015; Updated approver titles; Removed revision history prior to 2011.	9/04/14

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Annual Review; Updated NCQA to 2016; Changed "case manager" to "care manager"; no substantive changes; Removed revision history prior to 2012	08/15
Annual review: NCQA updated to reflect current; removed revision history prior to 2013; removed reference to MCG guidelines used by Indiana under "Procedures"; updated approver titles.	08/2016

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Director, Medical Management: Approval on File
Manager, Medical Management: Approval on File