MetroPlus Health Plan

Policy and Procedure

Title: Utilization Management Member Outreach	Division: Medical Management Department: Utilization Management
Approval Date: 2/8/19	LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP
Effective Date: 2/8/19	Policy Number: UM-MP244
Review Date:	Cross Reference Number:
Retired Date:	Page 1 of 3

1. POLICY DESCRIPTION:

Utilization Management Member Outreach

2. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3. DEFINITIONS:

4. POLICY:

Utilization review determinations for medical appropriateness are made by evaluating information from the requesting physician, the member's medical record, consultations and relevant laboratory and radiological information. All adverse determinations are made by a medical director.
Upon receipt of an authorization request, the Utilization management reviewer evaluates the prior approval request. If insufficient information is received for a determination, additional information is requested, in writing, from the member or provider.
Whenever applicable, the reviewing medical director will also request additional information from the member or provider.

Metroplus Utilization management personnel may call members for the following reasons:

1) To obtain additional information
2) To resolve an apparent incongruity between a request and
    a. Other requests
    b. Other data M+ has (e.g. we seem to have paid for one hysterectomy now there is a request for another one)
    c. The typical pattern of requests
3) To resolve an apparent incongruity between statements in the request and other information available to MetroPlus (for example, the medical records state that both ankles are unstable and the member needs two ankle braces; we have previously paid for a below the knee amputation)

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4) To clarify any request and any statement that is not clear which is included in the documentation submitted.
5) To coordinate MetroPlus services and offer care coordination support as appropriate.

The member or provider is afforded sufficient time (as per regulatory timeframes) within which to provide the specified information, or the Plan will deny the request for benefits as not medically necessary based on the information received, and the charges may be denied when claims are submitted without prior approval.

Once the information is sufficient for determination, the registered nurse reviewer approves requests that meet pre-established medical necessity criteria and are covered benefits. If medical necessity criteria are not met, the registered nurse reviewer refers the case to a Plan medical director for decision. The physician reviewer may request additional information or contact the requesting physician directly to discuss the case. Appropriate clinical information is collected and a decision formulated based on adherence to nationally accepted treatment guidelines and unique individual case features.

5. REFERENCES:

REVISION LOG:

REVISIONS	DATE
Creation date	

Approved: Date:	Approved: Date:
Bruce Sosler, MD **Clinical Medical Director**	**Talya Schwartz, MD** **Chief Medical Officer**

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Medical Guideline Disclaimer:

Property of Metro Plus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members.

All coding and website links are accurate at time of publication.

MetroPlus Health Plan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.