MedStar Family Choice DISTRICT OF COLUMBIA		
ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**115.DC**	
Subject:	**Utilization Management (UM) Criteria**	
Section:	**Clinical Operations**	
Initial Effective Date:	**10/01/2020**	
Revision Effective Date(s):	**07/21, 07/22, 07/23**	
Review Effective Date(s):	**02/21**	
Responsible Parties:	**Manager Utilization Management**	
Responsible Department(s):	**Clinical Operations – Utilization Management**	
Regulatory References:	**NCQA 2023: UM 7A, UM 11E** **District of Columbia Contract: Section C.5.28.15, C.5.30.4**	
Approved:	**Sharon Henry, RN** **Director, Clinical Operations**	**Raymond K. Tu, MD** **Sr. Chief Medical Officer (CMO)**

Purpose: **This policy describes criteria utilized to facilitate consistency in Utilization Management (UM) decision making.**

Scope: **MedStar Family Choice District of Columbia (MFC-DC)**

Policy: **MFC-DC follows documented UM criteria to facilitate consistency in UM decision making. All criteria utilized in utilization management are available upon request. The request can be made independent of a specific case. Reviewers and Medical Directors are also available to discuss any and all utilization management decisions, questions or issues. To request specific utilization management criteria or to speak with a Medical Director, please contact us by phone during our normal business hours, 8:00 AM to 5:30 PM, Monday through Friday at 1-(855)-798-4244. Messages received outside of normal business hours will be addressed the following business day.**

UM decision making is based only on appropriateness of care and service and existence of coverage. MFC-DC does not specifically reward practitioners or other individuals for issuing denials of coverage. In addition, there are no financial incentives for UM decision makers that would encourage decisions that result in underutilization.

MFC-DC may provide the treating practitioner with the opportunity to discuss a nonbehavioral and /or behavioral authorization request pending medical necessity denial with a UM reviewer and/or Medical Director prior to the denial.

Procedure:

The following criteria and processes, as documented on MFC-DC web site, are utilized for UM decision making:

A. Pre-Service (Prior Authorization), Retrospective Review, Requests for Continuation of Outpatient Services:

1. MFC-DC follows a basic prior-authorization process: An Enrollee's practitioner forwards clinical information and requests for services to MFC-DC most often by eFax. Requests for service can also be accepted via telephone, secure email, or mail. Telephones are manned on business days from 8:00am-5:30pm at 1-(855)-798-4244 or (202)-363-4348. Our fax numbers are 202-243-6258 (pharmacy requests), 202-243-6307 (non-pharmacy requests), 202-243-6320 (behavior health). Faxes are received 24 hours/day, 7 days/week. Faxes and voice messages received after hours will be addressed the next business day. The message also contains the telephone number for MFC-DC representative who is on call after hours, weekends and holidays to process emergent UM requests in a timely manner.

2. All appropriate ICD-10/CPT/HCPCS codes along with supporting clinical information must be included in requests for prior authorization. Requests for authorization can be submitted on MFC-DC Prior Authorization Form or a Uniform Consultation Referral Form with clinical information attached. Our experienced clinical staff reviews all requests. MFC-DC prior-authorization decisions are based on the following criteria:
    a. MFC-DC Protocols
    b. MFC-DC Pharmacy Policies and Procedures
    c. InterQual
    d. American Society of Addiction Medicine (ASAM)
    e. Medicare and Medicaid Guidelines
    f. Department of Healthcare Finance (DHCF) Contract, Transmittals and Policies
    g. MFC-DC Managed Care Organization (MCO) benefit coverage
    h. Food and Drug Administration (FDA) Approval
    i. District of Columbia Medicaid Fee Schedule
    j. Availability of services within the MFC network
    k. MFC-DC Continuity of Care Policy
    l. Pain Management Contracts
    m. UM Criteria Policy
    n. National and International Professional Medical Society Guidelines, including but not limited to:
        i. National Comprehensive Cancer Network (NCCN)
        ii. NCCN Biomarkers Compendium
        iii. National Institutes of Health
        iv. National Cancer Institute
    o. U.S. Preventive Services Task Force (USPSTF)

p. In the absence of guidelines, we use prevailing medical literature from studies and journals.

3. A limited number of services require authorization from MFC-DC Utilization Management before the patient receives care. The list is included in the MFC-DC Provider Manual and on the Quick Authorization Guide, which can be found on the MFC-DC website.

4. MFC-DC reserves the right to direct services to participating providers and facilities. Services outside the network may need prior authorization. Approval will be based on the availability of services in the network and issues of continuity of care.

5. MFC-DC's utilization management decision making is based on the medical necessity of the service and the existence of MCO enrollment and coverage.

6. Prior authorization requests will be processed, and a decision made as expeditiously as the clinical situation warrants. The decision cannot take longer than fourteen (14) days for a standard prior authorization or seventy-two (72) hours for a concurrent/ urgent prior authorization request whether or not all clinical information has been received, unless an extension is approved.

7. All covered outpatient pre-service pharmacy and concurrent pharmacy drug authorization requests will be acknowledged within twenty-four (24) hours of receipt. (See Policy 110.DC UM Process for details on decision and notification timelines). All decisions and notifications shall be determined within twenty-four (24) hours of the prior authorization request. An extension of up to fourteen (14) days can occur if the Enrollee requests an extension or MFC-DC justifies to the DHCF a need for additional information and how the extension is in the Enrollee's best interest. A seventy-two (72) hour supply of a covered outpatient drug shall be dispensed in an emergency situation. If the service requested is denied, the practitioner may contact our Utilization Management Department to discuss the decision with the appropriate Medical Director.

8. Retrospective requests are reviewed against the above specified criteria and are not guaranteed for approval. Retrospective services that could have been provided within the network are not likely to be retrospectively approved unless, upon review, the care was urgent/emergent or there was a continuity of care issue.

9. Services carved out to another agency of the District of Columbia (e.g., DHCF, the Department of Behavioral Health, and others) including but are not limited to some behavioral health care (mental health and substance use disorder), antiretroviral medications, Emergency Medicaid services for DC Healthcare Alliance Enrollees, and others are subject to administrative denial since they are not the liability of MFC-DC.

10. Request for payment of services where the claim does not match the clinical provided will be subject to denial.

11. Upon review for medical necessity, requests for ongoing services or treatment that have not demonstrated improvement in condition or benefit to the Enrollee will be subject to denial as not medically necessary.

B. Pharmacy:
    1. MFC-DC includes multiple classes of medications for coverage in our drug formulary. If a practitioner feels it medically necessary to prescribe a medication not on the formulary, the practitioner may submit a request for a non-formulary medication to MFC-DC. Such a request must include clinical documentation that supports the medical need for that specific medication and any prior use of available formulary medications, when applicable. All non-formulary requests are reviewed by the Health Plan Pharmacist or a Medical Director. The Health Plan Pharmacist or Medical Director will decide based on pharmacy policies and procedures and current regulations. (See 110.DC UM Process Policy for details for decision and notification timelines). MFC-DC does not guarantee coverage of medications that do not meet medical necessity, Policies & Procedures, or regulatory guidelines. Practitioners may call MFC-DC at 1(855)-798-4244 or (202)-363-4348, or fax (202)-243-6258 to make a prior authorization request.

    2. Requests for Synagis (palivizumab) require a completed Statement of Medical Necessity form and authorization is based on criteria set forth by the American Academy of Pediatrics Policy Statement and published in the Red Book. The Statement of Medical Necessity form may be found on the MFC-DC web site.

    3. Requests for Hepatitis C medications require a completed "Hepatitis C Therapy Prior-Authorization Form and Prescription." This form may be found on the MFC-DC website.

    4. Medications covered by DHCF, or AIDS Drug Assistance Program (ADAP) are not covered by the MFC-DC MCO. These requests are subject to administrative denial since they are not the liability of the MCO.

    5. Requests for medications that are on prior authorization can be submitted on the MFC-DC Prior Authorization form. The form and guidance for each drug can be found on the MFC-DC website in the Pharmacy section.

C. Concurrent Review:
    1. MFC-DC utilizes the following criteria to make concurrent review decisions:
        a. InterQual®
        b. ASAM
        c. Medicare and Medicaid Guidelines
        d. Department of Healthcare Finance Contract
        e. MFC-DC benefit coverage and limitations for DC Healthy Families and Alliance
        f. Availability of services within the MFC-DC network

    2. MFC-DC reviews clinical documentation for timeliness of care and appropriate level of care. Submit requests for inpatient authorization via fax to 202-243-6256, 202-243-6257 or 202-243-6320 (behavior health)

3. Clinical denial determinations may be issued by our Medical Directors when a delay in care or delay in discharge planning creates an inpatient day that could have been avoided if service had been provided timely. While MFC-DC UM Nurses and Case Managers are available to assist with discharge planning, it is the responsibility of the inpatient facility to provide timely and appropriate discharge planning. Inpatient days that do not meet medical necessity as outlined in above criteria are the responsibility of the inpatient facility.

4. Services that are carved out to the District of Columbia agencies per the Contract which include but are not limited to behavioral health care for Alliance (mental health and substance use disorder) and some substance use disorder services for DC Healthy Families, are subject to administrative denial since they are not the liability of MFC-DC.

D. Emergency Care:
   1. In accordance with the Emergency Medical Treatment & Labor Act (EMTALA), MFC-DC will pay claims for all medical screening examinations (MSE) when the request is made for examination or treatment for an emergency medical condition (EMC), including active labor. MFC-DC does not consider a nurse exam or triage information as evidence of a medical screening exam. (This will exclude qualifying Emergency Medicaid services for DC Healthcare Alliance Enrollees which are the liability of the DHCF and will also exclude coverage outside of the District of Columbia as outlined in the DC contract.)

   2. In accordance with the Balanced Budget Act of 1997, MFC-DC pays for emergency services using a prudent layperson standard. An emergency medical condition is defined as:
      a. A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

E. Personal Care Services: (See Policy 1414.DC)

F. Request for Criteria:
   1. Providers may request the UM criteria for UM decision making by calling the MFC-DC Utilization Management Department at 1(855)-798-4244 or (202)-363-4348 or fax (202)-243-6307 to make a request.

Summary of Changes:	**07/23:**
	• Regulatory Reference: Updated NCQA to 2023
	• Procedure:
	  ○ A-1: Updated fax numbers
	  ○ A-2: Updated the criteria on which prior authorization decisions are made

	• Grammatical and formatting changes throughout the document **07/22:** • Responsible Parties: Removed associates' names; added titles • Regulatory References: Updated to reflect NCQA 2022 • Approver: Removed Dr. Patryce Toye, added Dr. Raymond K. Tu • Removed the email mailbox as requests via email are no longer being monitored due to automated fax process via the new clinical software system. • Procedure: • A-1; Clarified the Pre-Service request process along with the Source • A-6; Updated the prior authorization • A-7; Updated the pre-service pharmacy and concurrent pharmacy drug authorization requests decisions and notifications timeframes from "in 72 hours" to within "24 hours" • B-1; Under Pharmacy: o Revised "MFC-DC pays for a wide variety of medications" to state "MFC-DC includes multiple classes of medications for coverage in our drug formulary." o Revised "the practitioner may submit this request to MFC-DC" to "the practitioner may submit a request for a non-formulary medication to MFC-DC. o Added "All non-formulary requests are reviewed by the Health Plan Pharmacist" and "the Health Plan Pharmacist will make a determination based on pharmacy policies and procedures" in addition to the Medical Director. • D-3; Removed bullet that "MFC-DC requires and fully reviews emergency department clinical documentation" under Emergency Care **07/21:** • Updated regulatory reference to reflect NCQA 2021. • D3 -Added "DC" to MFC. **02/21** • No changes. **10/20:** • New policy.