Section 8

Medical Management

- Managed Care Appropriateness Protocol (MCAP)
- Adverse Determination (Denial) and Appeals
- Case and Disease Management

Medical Management

Purpose

Neighborhood believes its members deserve to receive the best care at the right time in the right place. With this basic premise the Medical Management Department is designed into different functional arms.

The first is ***Utilization and Clinical Medical Policy***. The purpose of this area is to determine that the services received are benefits under the terms of the member's coverage and that the services are medically necessary according to approved clinical protocols and guidelines.

The ***Case Management*** area works with members and providers to ensure that services meet the members' needs. This is done through a process of assessment, planning, facilitating advocating and coordinating with members and their providers as well as other medical management team members.

The ***Health and Wellness*** area provides Disease and Condition management programs to enable and empower members to live healthy lives

The ***Clinical Quality and Health Outcomes*** area is part of the continuum between Case/Disease Management and Health and Wellness. The shared goal is to expand existing programs (asthma, diabetes, high-risk prenatal) and to build new programs (adolescent wellness and pediatric weight management initiatives) while focusing on how to set appropriate actionable, trendable outcomes.

Utilization and Clinical Medical Policy

A Neighborhood team comprised of physicians, nurses, social workers and other clinical staff works in collaboration with the member's practitioner(s) to ensure that the services requested are medically necessary and also not over- or under-utilized. On an annual basis, the physicians and nurses evaluate clinical criteria used for decision making, and through training and consultation with external clinical specialists, ensure the clinical criteria available is appropriate and specific for our membership. The Neighborhood team also works with the member's practitioners to facilitate coordination of services and identifies "high risk" members that may benefit from case management. The team members are not compensated for denying covered services.

Authorizations

We believe it is important that the member's care is coordinated by their primary care practitioner (PCP). Although the need for authorizations varies between Neighborhood's lines of business and affiliated benefit packages, we work directly with the member's practitioners to complete this process. Refer to Section 5, "Authorization Process".

Medical Necessity Review

The Medical Management program includes utilization review for medical necessity for inpatient services, some specialty services, and pharmacy. Utilization review activities for Mental Health and Behavioral Health are delegated to Beacon Health Strategies, LLC. Below is a brief description of each of the different types of reviews:

- A review before service is provided is a prospective or pre-service review. An example is custom equipment requested for the member.
- Review during the same time as the service is given is concurrent review. An example is an inpatient stay in a facility.
- When the request for authorization occurs after the service has been given, a retrospective or post-service review is required.

The Neighborhood team works with our providers to determine medical necessity and coverage of services. Services are not denied based on cost although members may be directed to alternative cost-efficient treatments, providers or settings of care. (Refer to Medical Review Process and Adverse Determination and Appeals.)

Medical Necessity Decision Criteria

Neighborhood utilizes Managed Care Appropriateness Protocol (MCAP) as the review criteria for services. Clinical Medical Policies (CMP) are the review criteria utilized for conditional benefit determinations.

Neighborhood uses the above-established criteria as a guideline when reviewing medical service necessity, but clinical judgment is always used when determining the appropriate level of care. Neighborhood considers its' ultimate goal to be the provision of clinically necessary services at the appropriate level of care for the appropriate duration. Medical Review criteria may not be appropriately applicable to all members in all circumstances. Neighborhood's clinical staff ensures that individual consideration is given when necessary.

The Medical Directors of each of the sixteen (16) Rhode Island hospitals review the MCAP criteria annually and are provided with an opportunity to comment. All comments are recorded and included in revisions of the criteria. A copy of the criteria is available at the Rhode Island Medical Society Office.

The use of the MCAP criteria are reviewed and approved annually by Neighborhood's Clinical Management Committee (CMC).

Neighborhood's Clinical Medical Policies are developed and/or revised following thorough review of current medical literature and standards of practice. To the extent possible, Neighborhood's CMPs are developed according to evidence-based outcomes, and are presented to CAC annually for further input and approval. Please refer to the Neighborhood website to view current CMPs.

Procedure for Requesting MCAP Criteria

All Neighborhood practitioners have the right to view the MCAP criteria applied to acute inpatient stays. Practitioners may request a copy of the MCAP criteria fact sheet by contacting the Medical Management Department Staff at 1-800-963-1001. The MCAP criteria are proprietary and copyrighted and therefore, cannot be distributed in their entirety. Practitioners are welcome to view the complete criteria at Neighborhood Health Plan of Rhode Island, 910 Douglas Pike, Smithfield, RI 02917. Practitioners may also request excerpts from the criteria which can be mailed or faxed to the practitioner's office. If upon review, you have any questions about MCAP criteria, one of Neighborhood's certified Medical Review Nurses or Associate Medical Director will be happy to assist you.

Medical Review Process

Medical review is conducted to confirm the medical necessity of treatments or services rendered, as well as the appropriateness of the care setting. Medical review requires evaluation of specific clinical information on-site, over the telephone, or via written communication. Medical Review Nurses compile all pertinent clinical information gathered from the treating practitioners/staff, review against the Neighborhood medical necessity decision criteria and consider individual patient needs. Once complete, the Medical Review Nurse confirms medical necessity, the appropriateness of the

care setting, and authorizes the requested service. When the Medical Review Nurse is not able to confirm the medical necessity and appropriateness of care setting, the case is referred to a Neighborhood physician reviewer for a final decision.

Adverse Determination (Denial) and Appeals

Adverse Determination (Denials)

Medical necessity denials are decisions not to certify or authorize a covered medical benefit. Decisions that care or services are not medically necessary are made only by one of Neighborhood's physician reviewers who is a similarly licensed practitioner as the ordering practitioner.
In order to accommodate the clinical urgency of each medical situation, medical review decisions are determined in a timely manner once all medical information is collected. Written notification of the decision is communicated to the practitioner and the member and includes the total number of days or services denied, the denial reason, the medical necessity decision criteria utilized, the availability of physician reviewers to further discuss the decision with the ordering practitioner, and the availability of hard copies. The notification also includes a description of the appeal rights.

Decisions are made according to the following timelines:

- Pre-service requests (non-urgent) are made within 15 calendar days from the receipt of the request, and prior to the date of service.
- Pre-service requests (urgent) are made within 72 hours of receipt of the request and prior to the date of service.
- Concurrent (hospital inpatient) requests are made prior to the end of the certified period, or within 24 hours of request, whichever comes first.
- Post-service requests are made within thirty (30) calendar days from receipt of the request.

The ordering practitioners may contact a physician or pharmacist reviewer to discuss denial decisions. ***Medical Management: 1-401-459-6060 or 1-800-963-1001.***

Appeals

Member and providers have the right to file an appeal to change or reconsider an adverse medical necessity decision previously made by Neighborhood. A written description of the member's rights and the appeal process is included in both the written denial notification and the Neighborhood Member Handbook. A Neighborhood representative is available to assist in the initiation of the appeal request. An expedited appeal process exists for members requiring a review determination for urgent situations.

All members and providers are entitled to two levels of internal appeal. A licensed practitioner from the same or similar specialty as the ordering physician reviews first and second level clinical appeals. No reviewer involved in prior reviews/direct care may participate in subsequent reviews.

RIte Care members have the right to a hearing with the Department of Human Services.

Please direct formal appeals in writing to:

Customer Service: Complaints/Appeals
Neighborhood Health Plan of Rhode Island
910 Douglas Pike
Smithfield, RI 02917

An external appeal process is also available to members who disagree with a Level II decision. This level of appeal is reviewed by an external appeals agency with which Neighborhood holds a Memorandum of Understanding (MOU). A document entitled "Instructions for Members who Wish to Request an External Appeal" is included when a member receives a Level II denial decision letter.

RIte Care members who are not satisfied with the outcome of an appeal may, at any time during the appeal process, initiate a Fair Hearing with the DHS as well as file a complaint with the DOH. The member must contact DHS directly at 1-401-462-5300 (English or Spanish) or 1-401-462-3363 (TTY) and the Rhode Island Department of Health at 1-401-222-2231. Hearing impaired members may use the RI Relay Service by dialing 711 for assistance. Members may also contact Rhode Island Legal Services at 1-401-274-2652 at any point to help with an appeal.

Practitioners or members who have received notification from Neighborhood's Medical Management Department of an adverse determination may appeal in writing to the Appeals Coordinator within ninety (90) days from receipt of notification. Level I and Level II appeal decisions are made per the following guidelines:

- Pre-service requests (services not yet rendered) are processed within fifteen (15) calendar days from receipt of the request
- Post-service requests (after services rendered) are processed within fifteen (15) calendar days from receipt of the request

If the member is not satisfied with the decision of the first level appeal, the member may appeal again (Level II Appeal), within sixty (60) days. A different practitioner of the same or similar specialty as typically treats this type of condition will make the decision.

Case and Disease Management

In the effort to not only improve our members' quality of care, but also their quality of life, Neighborhood has developed comprehensive Case Management and Disease Management Programs to benefit eligible members.

What is Case Management?

Neighborhood's Case Management Program design focuses on evaluation and assistance in the coordination of members' care along the health care continuum. Members are identified and referred in a variety of ways, including self-referrals, referrals from family members, referrals from providers, Medical Review Nurses and other Case Management staff, providers, Customer Service staff and Disease Management and external agencies.

Individualized care coordination programs focus on wellness education, the removal of barriers that have been identified as preventing access to medically necessary health care services and the delivery of continuous and coordinated medically appropriate care. The Medical Management Department has multiple care coordination programs, including: Bright Start (pre-natal), Children with Special Health Care Needs (CSN), Substitute Care, SSI, Transplants, High Risk Outreach such as, Members with Emergency Room Visits, and Inpatient Readmissions.

Individualized case management programs focus on assisting members at risk or with complex needs in achieving and maintaining wellness, providing educational support, and improving quality of life including the coordination of service and supports. Each case management program has established policies and procedures, outcome measures, and program admission criteria that identify those members who may benefit from case management intervention in order to maximize positive outcomes and to provide quality, member-focused, cost effective care. Neighborhood Case Managers utilize the Case Management Society of America (CMSA) standards of practice along with the nursing process of assessment, planning, intervention and evaluation in conducting activities. Each program has defined practices and standards for member care planning and documentation as well as case closure criteria. The Medical Management Department has the following case management programs: Asthma Case Management, Diabetes Case Management, Pre-natal Case Management, Neonatal Case Management, Pediatric Case Management, Adult Case Management, Substitute Care Case Management, Children with Special Health Care Needs, Connect CARRE, Optima Care Management, Rhody Health Partners, and Complex Case Management.

To determine whether a member is eligible for one of Neighborhood's Case Management programs, providers are encouraged to contact the Department at 1-401-459-6060 or 1-800-963-1001, Monday through Friday 8:00AM – 5:00PM.

What is Disease Management?

Disease Management is a multi-disciplinary, continuum-based approach to health care delivery that focuses on the identification of populations with established medical conditions. Neighborhood recognizes the importance of Disease Management Programs to:

- Support the relationship between practitioners and their patients and reinforce the established plan of care.
- Emphasize the prevention of exacerbations and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management.
- Continuously evaluate clinical, humanistic, and economic outcomes with the goal of improving overall health.

Disease management programs that are currently offered at Neighborhood include asthma and diabetes. The Bright Start prenatal program is also included in this group of programs.

Disease Management resides within the Medical Management Department at Neighborhood.

Please contact the Manager of Clinical Programs at 1-401- 459-6127 for further information or questions about Neighborhood's Disease Management Programs.

Who are Neighborhood's Case and Disease Managers?

The Case Managers at Neighborhood are nurses, social workers and other health care professionals with experience and skills in related clinical areas. Neighborhood's Case Managers will work with our providers to:

- Support and reinforce members in their efforts to adhere to treatment interventions recommended by their health care providers.
- Advocate for members to obtain the most appropriate health care services available, through education, referral and negotiation.
- Act as a liaison between all providers to enhance communication.
- Educate members, families and health care providers regarding benefits, availability of services, community resources, entitlement programs, and health care alternatives.
- Reduce barriers relating to transportation, language, pharmacy and scheduling.