Utilization Management, Case Management and Disease Management

The purpose of HNE’s Utilization Management (UM)

The purpose of HNE’s UM program is to confirm member eligibility, assess medical necessity, enable and encourage use of contracted providers and facilitate claims payment. This involves collaborating with practitioners, members, facility staff and other providers to ensure timely and appropriate discharge plans and to understand and/or resolve barriers to discharge. This is accomplished through:

1. Pre-Service Review
   Review of a case or service that must be approved, in whole or in part, in advance of the member obtaining behavioral health, medical care, or services. Prior authorization and pre-certification are defined as pre-service review. HNE requires pre-service review for the following:
   a. All admissions/procedures/services with an Out-of-Plan or Out-of-Network facility for HMO plans
   b. All admissions to a skilled nursing facility or inpatient rehabilitation facility for HMO plans
   c. Human organ transplants
   d. Selected elective outpatient/ambulatory procedures or services
   e. Selected durable medical equipment (for specific plan requirements, refer to the individual member’s benefit materials)
   f. Services that represent new or emerging technologies, unusually wide variation in use, or are prone to abusive high utilization

Pre-service review also includes confirmation of member eligibility, coverage and assessment of medical necessity. **It is the responsibility of the provider to submit complete and accurate information to HNE prior to the treatment or facility stay. Failure to submit the information in a timely manner may result in non-payment for administrative reasons.**

2. Concurrent Review
   Review includes admission certification of urgent/emergent admissions and elective admissions that were not prior approved, the ongoing review of a member’s inpatient stay, and the review for extension of previously approved ongoing courses of treatment over a period of time or number of treatments. Any request to extend the member’s length of stay or treatment beyond the initial authorization must be reviewed and approved by HNE. **It is the responsibility of the provider to submit complete and accurate information to HNE by the last day of authorized treatment or facility stay. Failure to submit the information in a timely manner may result in non-payment for administrative reasons.**

3. Post-Service Review
   This includes review for care or services that have already been received (i.e., retrospective review).

There may be times when a service is not approved. A utilization management denial may be made only on the basis of whether it is medically necessary or appropriate or if it is not a covered service under the member’s plan.

Affirmative Statement Regarding Incentives

- HNE makes utilization decisions based on appropriateness of care and service and existence of coverage.
- There are no specific rewards to practitioners or other individuals conducting utilization review for denials of coverage or service care.
- HNE does not provide financial incentives for UM decision-makers that encourage or result in under-utilization.
- Practitioners are ensured independence and impartiality in making referral decisions that will not influence: hiring, compensation, termination, promotion, or any other similar matters.
This statement covers any practitioner, provider, staff member, or delegate who is subject to financial incentives for UM decisions.

This statement appears at minimum in the HNE Provider Manual, HNE Intranet and in ALL editions of ALL HNE member newsletters.

**UM Review and Decision Process**

All UM decisions are made in accordance with the terms of the member plan document. UM decisions shall be made in a fair and consistent manner. When making a determination of coverage based on medical necessity or appropriateness, HNE will render the decision in accordance with defined UM criteria and will evaluate all relevant clinical information, including the individual member’s particular health care needs and the capability of the local delivery system. Written criteria govern all decision-making.

The HNE UM Decisions policy sets forth the timeframes for UM decision-making and the process for notification of UM decisions. It is HNE’s policy to meet both state and federal regulatory requirements as well as to meet or exceed NCQA standards and requirements. At a minimum, this policy is updated on a bi-annual basis. HNE will notify providers in writing of changes or modifications to the UM program that have a substantial impact on the rights or responsibilities of the providers and the effective date of such modifications. If providers would like a copy of HNE’s most recent UM Decisions policy, providers may request a copy by calling Provider Relations at (413) 233-3313 or (800) 842-4464, extension 5000.

**Physician Reviewers**

The Chief Medical Officer and/or appropriate specialists and clinical practitioners are consulted for cases that do not meet medical criteria. Program staff may not make denial of service determinations for medical necessity. The Chief Medical Officer, Medical Director, Associate Medical Director, Associate Medical Director for Behavioral Health or an HNE pharmacist is the final decision-maker for any denial based on medical necessity.

**UM Decisions, Criteria and Definition of Medical Necessity**

Consistent with generally accepted principles of professional medical practice and in consultation with the member, the physician treating a member makes all clinical decisions regarding medical treatment to be provided to the member, including the provision of durable medical equipment and hospital lengths of stay. Nothing in this section shall be construed as altering, affecting or modifying either the obligations of any third party or the terms and conditions of any agreement or contract between either the treating physician or the member and any third party.

In reviewing requests for prior approval, HNE may consider whether the service:

- Is a covered benefit or service
- Is medically necessary
- Is being provided in the appropriate setting
- Follows generally accepted medical practice
- Is available within the HNE network
- Meets HNE’s clinical criteria for coverage

HNE utilizes commercially purchased criteria sets to assist with making level of care determinations. HNE’s commercially purchased criteria sets are licensed criteria sets, which are the PROPRIETARY and CONFIDENTIAL property of the licensing company. HNE has a contractual obligation to protect the confidentiality of these licensed criteria. HNE makes available to the treating provider and the member the specific portion of the criteria used where required by law or by applicable accreditation requirements.

HNE also has developed internal criteria that are used as a guideline when applying the standard of medical necessity for select procedures, treatments, and services. Providers who would like a copy of the HNE-developed clinical criteria that are used to make UM determinations should contact Health Services at (413) 787-4000 or (800) 842-4464, extension 5027.
The medical necessity guidelines utilized by HNE in making coverage determinations are:

- Developed with input from practicing physicians in HNE’s service area
- Evidence-based and developed in accordance with the standards adopted by national accreditation organizations
- Updated annually or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice.

In applying such guidelines, HNE considers the individual health care needs of the member. In addition, HNE will notify members and providers 60 days prior to the effective date of any material changes to HNE’s criteria.

With respect to a member enrolled in a health benefit plan under which HNE only provides administrative services (i.e., for members enrolled in a Self-Funded plan), the payer may reserve the right to decide certain appeals of benefit denials. If so, HNE’s role with respect to payment is limited to the benefit coverage recommendation of the payor.

HNE defines “medically necessary” as follows. Health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:

- The service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual.
- The service is known to be effective, based on scientific evidence, professional standards, and expert opinion in improving health outcomes.
- The service is based on scientific evidence for services and interventions not in widespread use.

Inquiring about the Status of a UM Decision
Practitioners have direct access to UM staff regarding specific cases and discussion of UM decisions. In general, if a provider requests a service that requires HNE’s prior approval and would like to know its status or outcome, the provider should contact Health Services at (413) 787-4000 or (800) 842-4464, extension 5027, between 8:00 a.m. and 5:00 p.m., Monday through Friday.

Practitioners may also call HNE UM Departments or delegated entities directly as follows:

- High Cost Radiology and Imaging - eviCore healthcare at (888) 693-3211
- Chiropractic Services - OptumHealth at (888) 676-7768
- Pharmacy Issues - OptumRx at (800) 282-3232
- Medical injectable drug program - MagellanRx Management at (800) 424-8325

Submitting Additional Information in the Case of an Adverse Determination
When a requesting physician or PCP has received an adverse determination and has additional information that may influence the decision, the office may fax the additional information to the Health Services Department at (413) 233-2700 within 10 business days of the denial notification for reconsideration. The office may also request a peer review during this time frame.

Reconsideration of Adverse Determinations
If a decision is based on medical necessity and appropriateness, the physician may request a reconsideration from a clinical peer reviewer. As required by Massachusetts law, a provider who is treating a member has the right to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. This reconsideration process shall be initiated within one business day of the receipt of the request. It will be conducted between the provider and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if said reviewer cannot be available. If the adverse determination is not reversed by the reconsideration process, the member or the provider on behalf of the member, may pursue the grievance process established pursuant to Massachusetts General Laws chapter 176O. The reconsideration process allowed herein shall not be a prerequisite to the formal internal grievance process or an expedited appeal required by Massachusetts General Laws chapter 176O.
**Arranging a Telephone Conference for a Case Discussion or Reconsideration**

To arrange a telephone conference time for a reconsideration, the requesting physician should call Health Services at (413) 233-4000, extension 3470, or (800) 842-4464, extension 3470. Health Services will obtain the relevant plan information for the case and arrange a teleconference between the requesting physician and the HNE physician reviewer or clinical peer reviewer.

**Case Management**

HNE’s Case Management Program is designed to support individuals with more complex care needs associated with severe illness, injury or other conditions. Participants are identified for our case management programs through a combination of claims data, physician referrals and self referrals. Members are identified as High, Medium or Low based on the claims review and the intensity of outreach needs based on the claims review. Once the member meets criteria for case management, the case manager’s outreach begins to offer specialized one on one support. All of the programs are opt in programs and once the member agrees to participate, a letter is sent to notify the provider of the case management involvement. This case manager will follow the member through the continuum of care, providing the member and provider with one direct contact at HNE for medical concerns. This design allows case managers to build trusting relationships with HNE members and providers.

In general, members who would benefit from coordination of care are those:
1. Experiencing high cost/catastrophic events
2. Experiencing sub-optimal ambulatory management
3. Who could be managed at a less intensive level of care
4. Receiving care outside of the network
5. Whose physicians have sought case management assistance for high-risk members
6. Identified as priority cases

The case management process involves case identification, assessment, planning, coordination, monitoring and evaluation. HNE provides an After Hours On-Call Program. An HNE case manager is available to providers and members to assist in care coordination needs that are identified or planned to occur outside of HNE’s usual business hours. The After Hours On-Call Program functions include:
1. Avoiding acute inpatient admissions when another level of care is appropriate
2. Assisting providers in transitioning members from one level of care to another appropriate level of care
3. Assisting in disposition planning for hospitalized members on weekends or holidays where delays may otherwise be experienced
4. Being available to members/families and providers during transitions in care to answer case management or HNE system specific questions

HNE provides ambulatory or hospital case management. Ambulatory case management includes the management of care for members with complex illnesses or who require complex coordinated care in the ambulatory setting (physician office, ECF, home care and outpatient care). Hospital case management includes the management of care for members with complex illnesses or who require complex coordinated care while admitted to an acute care facility.

Providers may refer a member to receive Case Management Services by calling the HNE Health Services Case Management queue at (413) 787-4000, extension 5027, or (800) 842-4464, extension 5027.

**High Risk Member Case Management**

High-risk members are those who are likely to become hospitalized or require multiple health care services. This is a proactive approach to managing HNE’s high-risk members, with the goal being to improve the member’s functional status, reduce hospital admissions, and reduce medical costs. If providers have questions or would like to refer a member to this program, providers may contact Health Services by calling (413) 787-4000, extension 5027, or (800) 842-4464, extension 5027.
Disease Management

HNE is committed to helping our members with chronic health conditions live healthy lives. As part of this commitment, we offer Disease Management (DM) programs for members with diabetes, asthma, coronary artery disease, and high-risk pregnancy. Through our DM programs, HNE partners with physicians in support of the plan of care. The overall goal of this collaborative effort is to help members achieve and maintain control of their condition by improving self-management skills. Self-management skills impact clinical outcomes and are important in delaying and preventing exacerbations and complications of chronic disease. HNE DM programs provide members with education and support to help improve their ability to manage their health condition on a day-to-day basis.

Claims and encounter data are reviewed to identify members with chronic conditions and stratify them into low-, medium-, and high-risk categories based on the level of disease control. HNE provides DM interventions based on a member’s stratification level. Interventions include: educational materials sent by mail, questionnaires, peak flow meters, health diaries, tracking tools, asthma action plans, smoking cessation reimbursement, and telephonic assessment performed by a case manager.

If providers have questions or would like to refer a member to disease management, contact Health Services at (800) 842-4464 or (413) 787-4000, extension 5553 or extension 5027. More information is available at http://healthnewengland.org/care-management.

Health Information Line (or Nurse Line)

The Health Information Line provides health information and resources to HNE members 24-hours a day. Also known as the Nurse Line, it is not intended to replace or question the diagnosis of a physician or health care provider, nor provide specific follow-up care for treatments prescribed. For triage situations, the nurse directs the member to the type of care most appropriate based on the symptoms and situation conveyed by the member. The health information line vendor notifies HNE about member activity on a daily basis for quality and utilization purposes. The Nurse Line is accessible by calling (866) 389-7613.

Behavioral Health (BH)

HNE follows the provisions of its UM Program and the UM Decisions Policy for review of behavioral health services. HNE covers mental health and substance abuse services that are medically necessary or according to the member’s plan. All determinations of medical necessity are based upon the most current edition of the InterQual Level of Care Criteria or HNE’s Clinical Review Criteria. A telephonic review of single criteria may be conducted by contacting the Health Services Department at (413) 787-4000, extension 5027, or (800) 842-4464, extension 5027.

HNE covers behavioral health treatments according to the member’s individual benefit package and may include inpatient, community-based acute residential and partial hospitalization services. Direction of care is provided by hospital-based Emergency Service Providers. The BH Department conducts concurrent reviews of ongoing behavioral health hospitalization services to ensure continued medical necessity.

HNE covers substance abuse treatments according to the member’s individual benefit package. Covered benefits may include: inpatient detox, inpatient rehabilitation, community stabilization services and intensive outpatient program services. Direction of care may be provided by hospital-based Emergency Service Providers or Emergency Departments. The BH Department conducts concurrent reviews of ongoing substance abuse services to ensure continued medical necessity.

Please note: For specific benefit information, providers may contact Member Services at (413) 787-4004 or (800) 842-4464, extension 5025.

Inpatient Hospitalization Services

HNE covers inpatient hospitalization services. HNE requires notification following admission. HNE recommends screening by a Crisis Team prior to admission however this is not a requirement. The Health
Services Department conducts concurrent reviews of ongoing hospitalization services to ensure continued medical necessity.

What is not covered:
Services that are not covered under the mental health/substance abuse benefit include:
- Educational services or testing, except services covered under the benefit for Early Intervention Services
- Services for problems of school performance
- Faith-based counseling
- Social work for non-mental health care
- Christian Science practitioner and sanitarium stays
- Services required by a third party or court-ordered residential/custodial services (including residential treatment programs and halfway houses)

Radiology Management Program
eviCore healthcare performs utilization management services for outpatient imaging services. Certain radiological services require prior approval. This prior approval policy affects outpatient services only; emergency room, observation and inpatient imaging procedures do not require prior approval. Failure to obtain prior approval may result in denial of payment. This policy is applicable to all HNE products.

Procedures That Require Prior Approval
- CT Scan
- MRI/MRA
- PET Scan
- Nuclear Cardiology (in office only)
- Virtual Colonoscopy

Prior Approval Process
- The ordering physician is responsible for obtaining the prior approval from eviCore healthcare for the study requested. Patient symptoms, past clinical history and prior treatment information will be requested and should be available at the time of the call. eviCore healthcare also has the ability to receive your requests online via a secure web application at https://www.evicore.com/.

- The HNE facility providing radiological services is responsible for ensuring that approval has been obtained prior to rendering service. Facility providers may confirm authorizations by visiting eviCore healthcare’s website at https://www.evicore.com/.

- Call center hours of operation are Monday through Friday, 8 a.m. to 9 p.m. EST. Providers may obtain prior approval by calling (888) 693-3211. (Studies ordered after normal business hours or on weekends should be conducted by the rendering facility as requested by the ordering physician. However, the ordering physician must contact eviCore healthcare within 48 hours of the next business day to obtain proper approval for the studies, which will still be subject to medical necessity review.)

Important Notes:
- If the ordering provider is not satisfied with eviCore healthcare’s decision, which may include the result of a case discussion with the original reviewer, the provider may request a reconsideration of the pre-service denial. The reconsideration will be conducted by a clinical peer reviewer who was not involved in the initial decision. The provider may request a reconsideration by contacting eviCore healthcare at (888) 693-3211. The reconsideration will be conducted within one working day of the request. If the provider is still not satisfied with the outcome after a reconsideration, the provider
may initiate a member appeal on behalf of the member by contacting HNE’s Member Services Department at (413) 787-4004 or (800) 842-4464, extension 5025. The member must consent to the initiation of the member appeal. The provider may submit a provider appeal for post-service denials.

**Accreditation Requirements for Advanced Diagnostic Imaging Facilities**

Suppliers of the technical component of advanced diagnostic imaging services must be accredited.

For all lines of business, HNE follows the Centers for Medicare and Medicaid Services (CMS) accreditation requirements for suppliers that provide the technical component of advanced diagnostic imaging. CMS defines advanced diagnostic imaging procedures as including magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine imaging such as positron emission tomography (PET). This requirement only applies to the suppliers that furnish the technical component (TC) of advanced diagnostic imaging services, not to the physicians interpreting them. Providers subject to this requirement include physicians, non-physician practitioners, and Independent Testing Facilities. Hospitals are excluded from this requirement.

**Provisional Credentialing of Advanced Diagnostic Imaging (ADI) Facilities**

Diagnostic Imaging Technical Component Provisional credentialing will be granted to new locations and/or to enrolled suppliers who wish to purchase additional ADI equipment or expand its services by location or modality for a timeframe of 120 days from the date the new location opened and/or the ADI equipment was first utilized to receive an additional accreditation decision with respect to that particular location or modality.

**Clinical Transition Program**

HNE has established a Clinical Transition Program to ensure the continuity of care for:

- new members to HNE;
- members who have reached their benefit maximum for coverage;
- continuation of coverage following provider disenrollment; and
- departing members without new coverage.

If providers have questions concerning program requirements and transitional coverage available, providers should contact Health Services by calling (413) 787-4000, extension 5027, or (800) 842-4464, extension 5027.

**Appropriateness of Care Statement**

It is the policy of HNE that decisions regarding patient care are made based upon medical necessity, the appropriateness of care, and the services rendered. If a service is not medically necessary or is not a covered benefit, coverage may be denied. In cases where services are covered but are not being provided, such as preventive care services and prenatal care, it is HNE’s policy to encourage appropriate treatment.

**Affirmative Statement Regarding Incentives**

- HNE makes utilization decisions based on the appropriateness of care and service and the existence of coverage.
- There are no specific rewards to practitioners or other individuals conducting utilization review for denials of coverage or service care.
- HNE does not provide financial incentives for UM decision-makers that encourage or result in underutilization.
- Practitioners are ensured independence and impartiality in making referral decisions that will not influence: hiring, compensation, termination, promotion, or any other similar matters.
• This statement covers any practitioner, provider, staff member, or delegate who is subject to financial incentives for UM decisions.
• This statement appears at a minimum in the HNE Provider Manual, HNE Intranet and in ALL editions of ALL HNE member newsletters.

Medical Technology Assessment Program

HNE has established the Medical Technology Assessment Program to ensure that members have equitable access to safe and effective care through the evaluation of developments in new technology and new applications of existing technology. This process involves review by HNE’s internal Medical Technology Assessment Committee (MTAC) of all available scientific evidence and determinations from regulatory bodies. This information, coupled with input from local physicians through the HNE Clinical Care Assessment Committee (CCAC), form the basis for decision making regarding new medical technology.

Technology evaluation criteria, in general terms, include the following:
• Approval from appropriate regulatory bodies
• Scientific evidence must permit conclusions concerning the effect of the technology on health outcomes
• The technology must improve the net health outcomes
• The technology must be beneficial as an established alternative
• The improvement must be attainable outside investigational settings

If providers have questions about this program or would like HNE to consider coverage for a new or existing technology, they should contact HNE’s Process Coordinator, at (413) 787-4000, extension 3457, or (800) 842-4464, extension 3457.

PCP Data

HNE keeps data regarding utilization of services, membership, and financial performance with respect to PCPs. This data is sorted by risk unit, provider group, and individual practitioner. This data is summarized and presented to physician unit leadership on a regular basis. Reports may contain data that is specific to individual physicians and may pertain to pharmacy utilization, adherence to clinical guidelines, performance within clinical initiatives or individual patterns of utilization. Case mix and efficiency scores also are reported on a regular basis.

It is the intent of HNE to monitor all data for possible under- or over-utilization of services. Such findings will be presented to practitioners in a manner appropriate to their importance. All measures are compared to peer benchmarks and confidentiality is maintained at all times.

HIPAA Privacy Requirements and Patient Information Needed for Utilization Management, Case Management and Care Coordination

HNE conducts utilization review, case management and care coordination activities for payment and health care operations purposes. In order to perform these activities, HNE often needs patient information such as office notes, diagnostic results, and treatment plans.

Some physicians have expressed concern about whether they may disclose medical record information to HNE in light of the Privacy Rule requirements of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA allows covered entities, which includes physicians and health plans to use or disclose protected health information (PHI) without an individual authorization from the patient for treatment, payment and some health care operation purposes, and for certain other specific purposes outlined by the HIPAA Privacy Rule [45 C.F.R. & 164.506(c)(4)].
Covered entities may disclose PHI to other covered entities for the other covered entity’s treatment, payment and limited health care operation purposes, as defined by the Privacy Rule, as long as the request relates to current or former patients or members [45 C.F.R. & 164.506(c)(4)].

HNE’s utilization review activities are included under payment and case management and care coordination activities are included within the limited health care operation. Therefore, the disclosure of health information by physician to HNE for these purposes is permissible without an individual authorization from the patient under the HIPAA Privacy Rule.

HNE recognizes that physicians are concerned with compliance with applicable privacy laws. We at HNE share those same concerns and will proceed only in a manner that is consistent with applicable laws, as outlined above. Providers should contact the HNE Privacy Office at (800) 842-4464 or (413) 787-4000, extension 3340, if they have additional questions or concerns.