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Overview

The Clinical Services – Utilization Management (UM) department is comprised of health care professionals whose objective is to support and facilitate the delivery of quality health care services to our Members. This is accomplished through several activities, including Preapproval/Precertification of elective health care services, medical review, facilitation of discharge plans, and case management. *All capitalized terms in this section shall have the meaning set forth in either your Professional Provider Agreement (Agreement) or the Member's benefits plan, as applicable.*

Utilization review process and criteria

Utilization review overview

Utilization review is the process of determining whether a given service is eligible for coverage or payment under the terms of a Member's benefits plan and/or a network Provider's contract.

In order for a service to be covered or payable, it must be listed as included in the benefits plan, it must not be specifically excluded from coverage, and it must be Medically Necessary. The vast majority of Independence benefits plans exclude coverage for services considered experimental/investigational and those considered primarily cosmetic in nature.

To assist us in making coverage determinations for certain requested health care services, we apply established Independence medical policies and medical guidelines based on clinical evidence to determine the Medical Necessity for the requested services. We also evaluate the appropriateness of the setting (e.g., office, inpatient, outpatient) for Covered Services requested by a Member's health care Provider that may be provided in alternate settings or sites. When a Covered Service can be administered in various settings, Providers should request Preapproval/Precertification, as required by the applicable benefits program, to provide the Covered Services in the most appropriate and cost-effective setting for the Member's current medical needs and condition, including any required monitoring. Independence's review for Preapproval/Precertification will be based on the clinical documentation from the requesting health care Provider supporting the requested setting.

It is not practical to verify Medical Necessity on all procedures for all occasions. Therefore, certain procedures may be determined by Independence to be Medically Necessary and automatically approved, based on the following:

- the generally accepted Medical Necessity of the procedure itself
- the diagnosis reported
- the agreement with the Provider performing the procedure

Utilization reviews generally include several processes depending on the timing of the review and the service for which a determination is requested.

- **Preapproval/Precertification.** When a review is required *before* a service is performed, it is a Preapproval/Precertification review.
- **Admission Review.** Initial review of the Medical Necessity of an Emergency admission.
- **Concurrent review.** Reviews occurring *during* a hospital stay or when services are already being provided are concurrent reviews.

- **Retrospective/Post-service review.** Those reviews occurring *after* services have been performed are either retrospective or post-service reviews. Independence follows applicable State and federal standards for the time frames in which such reviews are to be performed and for when coverage or payment determinations are issued and communicated.

Pennsylvania law requires that initial prospective, concurrent, and retrospective utilization review decisions of managed care plans be communicated verbally, as well as confirmed in writing, to the Member and the requesting health care Provider within specific time frames. We ask that our Participating Providers inform Members of our initial utilization review decisions upon their receipt of the communication from Independence. Providers should document that they gave this verbal notification. Independence provides written notification of determinations to both Providers and Members within the required time frames.

Note: For retrospective determinations, in situations where the Member is held harmless from financial responsibility for the service, Providers are not required to notify the Member.

Generally, when a requested service requires utilization review to determine Medical Necessity, nurses perform the initial case review and evaluation for coverage approval. Only a Medical Director may deny coverage for a service based on Medical Necessity.

The nurses review applicable policies and procedures in the benefits plan, taking into consideration the Member's condition and applying applicable policies and procedures to the request. Evidence-based clinical protocols are applied to specific procedures. When the clinical criteria are not met, the service request is referred to a Medical Director for further review and coverage or payment determination. Independent medical consultants, who are board certified in the relevant medical specialty as required by the particular case under review, may also be engaged to conduct a clinical review. If coverage for a service is denied based on lack of Medical Necessity, written notification is sent to the requesting Provider and Member notifying them of the denial and their appeal rights in accordance with applicable law.

Independence's utilization review program encourages peer-to-peer discussion regarding coverage decisions based on Medical Necessity by giving Providers direct access to Medical Directors to discuss coverage determinations. The nurses, Medical Directors, other professional Providers, and independent medical consultants who perform utilization review services are not compensated or given incentives based on their coverage review decisions. It is our policy that all utilization review decisions are based on the appropriateness of health care services and supplies, in accordance with the benefits available under the Member's coverage, our definition of Medical Necessity, and applicable medical policies.

Medical Directors and nurses are salaried; contracted external Providers and other professional consultants are compensated on the basis of the number of cases reviewed, regardless of the coverage determination. Independence does not specifically reward or provide financial incentives to individuals performing utilization review services for issuing denials of coverage. There are no financial incentives that would encourage utilization review decisions that result in under-utilization.

Selective medical review

In addition to the foregoing requirement, Independence reserves the right, under our Utilization and Quality Management Programs, to perform a medical review prior to, during, or following the performance of certain Covered Services (selective medical review) that are otherwise not subject to reviews as previously described. In addition, we reserve the right to waive medical review for certain Covered Services for certain Providers, if we determine that those Providers have an established record of meeting the utilization and/or quality management standards for these Covered Services.

Providers are notified in advance when we are planning on performing selective medical review, Members may not be penalized when required selective medical review results in a determination that a service is not Medically Necessary is not obtained by the Provider.

Delegation of utilization review activities and criteria

In certain instances, Independence has delegated utilization review activities to entities with expertise in medical management of a certain membership population or type of benefits (such as mental health/substance abuse [behavioral health], diagnostic imaging, and outpatient radiation therapy). A formal delegation and oversight process is established in accordance with applicable State and federal laws and with the National Committee for Quality Assurance (NCQA) accreditation standards. In such cases, the delegate's utilization review criteria are generally adopted by Independence for use by the delegated entity.

Utilization review and criteria for behavioral health services

Utilization review activities for behavioral health services have been delegated by Independence to a contracted behavioral health management company, Magellan Healthcare, Inc. (Magellan), an independent company. This company administers the behavioral health benefits for the majority of our Members.

Clinical criteria, guidelines, and other resources

The following clinical criteria, guidelines, and other resources are used to help make Medical Necessity and appropriateness coverage decisions:

- **InterQual®.** A product of Change Healthcare, an independent company, the InterQual clinical decision-support criteria model is based on the evaluation of intensity of service and severity of illness. Covered Services for which InterQual criteria may be applied include, but are not limited to, the following:
  - home health care
  - inpatient hospitalization admissions
    - An inpatient admission requires an overnight stay, which must be at least 24 hours. An overnight stay is defined as a period of at least 24 hours. Therefore, a patient presenting to the emergency department at 9:00 p.m. and leaving at 11:00 a.m. the following morning is *not* considered an inpatient admission.
  - inpatient rehabilitation
  - long-term, acute care facility admissions
  - observation
  - some elective surgery for inpatient and outpatient procedures

In addition, we apply acute-care guidelines, medical necessity/medical policy criteria, and medical judgement to evaluate appropriateness for Emergency admissions. Admissions that do not meet acute intensity of services and severity of illness are reviewed by a Medical Director, and coverage or payment may be denied if guidelines are not met. In addition, certain conditions requiring observation in the hospital outpatient department while diagnostic studies are performed or response to treatment is monitored, will have additional review by a Medical Director to determine whether payment for an inpatient admission at acute level of care is appropriate. These are typically conditions where there is a need to rule out serious medical illness that would require inpatient admission (e.g., abdominal or chest pain). Observation services do not require Preapproval/Precertification may be subject, at the discretion of

Independence, to review for Medical Necessity, and the Independence criteria, which requires that the treatment and/or procedures include at least eight hours of observation.*

Independence's policies for facility reporting of observation services supersede InterQual guidelines. In this instance, Independence's policies stating the treatment and/or procedures must* ***include at least eight hours of observation supersedes the InterQual standard of six hours.* *For more information on these policies, visit our Medical Policy Portal at www.ibx.com/medpolicy.*

Note that medical records may be required to complete a review to determine coverage or payment in many situations including, but not limited to, a Medical Necessity review or cosmetic review.

When submitting a written request for utilization review, be sure to attach the request or case identifier to the medical records and submit records electronically or as instructed. Medical records that arrive with a request or case identifier require less research and are rapidly forwarded to the appropriate team for review.

We may conduct focused evaluation of the Medical Necessity for the use of an inpatient setting for certain elective surgical procedures. Examples include, but are not limited to: cardiac catheterizations, laparoscopic cholecystectomies, tonsillectomies, adenoidectomies, hernia repairs, and battery and generator changes. Providers must submit clinical documentation for instances where it is believed that the outpatient setting would not be appropriate and inpatient admission is necessary.

In addition, Emergency admissions where these procedures are performed must also meet guidelines from InterQual regarding acute admission.

- **Centers for Medicare & Medicaid Services (CMS) guidelines.** CMS adopts and publishes a set of guidelines for coverage of services by Medicare (for Medicare Advantage HMO and PPO Members).
- **Independence medical policies.** Independence internally develops a set of policies that document the coverage and conditions for certain medical/surgical procedures and ancillary services that are considered Medically Necessary. Independence medical policies may be applied for Covered Services including, but not limited to, the following:
  - durable medical equipment (DME)
  - Skilled Nursing Facility (SNF)
  - infusion therapy
  - nonemergency ambulance transports
  - review of potential cosmetic procedures and obesity surgery
  - review of potential experimental or investigational services
- **Non-certification decisions.** The criteria used to make non-certification decisions are stated in the letters to the Members and Providers, along with instructions on how to request specific guidelines. Providers may request the specific guidelines or criteria used to make specific utilization management determinations by faxing a request to 215-761-9529 or submitting a request to:

  Request for InterQual Criteria
  Clinical Services – Utilization Management Department
  1901 Market Street, 30th Floor
  Philadelphia, PA 19103

Important definitions

"Medically Necessary" or "Medical Necessity"

"Medically Necessary" or "Medical Necessity" shall mean health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, or disease of its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and (c) not primarily for the convenience of the patient, Provider, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Provider Specialty Society recommendations, and the views of Providers practicing in relevant clinical areas and any other relevant factor.

Experimental/investigational

Experimental/investigational services: A drug, biological product, device, medical treatment, or procedure that meets any of the following criteria:

- is the subject of ongoing phase I or phase II clinical trials;
- is the research, experimental study, or investigational arm of ongoing phase III clinical trials, or is otherwise under a systematic, intensive investigation to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with a standard means of treatment or diagnosis;
- is not of proven benefit for the particular diagnosis or treatment of the covered person's particular condition;
- is not generally recognized by the medical community, as clearly demonstrated by Reliable Evidence*, as effective and appropriate for the particular diagnosis or treatment of a covered person's particular condition;
- is generally recognized by either the Reliable Evidence* or the medical community that additional study on its safety and efficacy for the particular diagnosis or treatment of a covered person's particular condition is recommended.

A drug is not considered experimental/investigational if it has received final approval by the U.S. Food and Drug Administration (FDA) to market for the particular diagnosis or condition. Any other approval granted as an interim step in the FDA regulatory process (e.g., an investigational new drug exemption — as defined by the FDA), is not sufficient. Once FDA approval has been granted for a particular diagnosis or condition, use of the drug for another diagnosis or condition shall require that one or more of the following established referenced compendia recognize the usage as appropriate medical treatment:

- American Hospital Formulary Service (AHFS) Drug Information
- Micromedex®

Any drug that the FDA has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered experimental/investigational.

A biological product, device, medical and/or behavioral health treatment, or procedure is not considered experimental/investigational if it meets all of the Reliable Evidence* criteria listed below:

- Reliable Evidence exists that the biological product, device, medical and/or behavioral health treatment, or procedure has a definite positive effect on health outcomes.
- Reliable Evidence exists that over time the biological product, device, medical and/or behavioral health treatment, or procedure leads to improvement in health outcomes (i.e., the beneficial effects outweigh any harmful effects).
- Reliable Evidence clearly demonstrates that the biological product, device, medical and/or behavioral health treatment, or procedure is at least as effective in improving health outcomes as established technology or is usable in appropriate clinical contexts in which established technology is not employable.
- Reliable Evidence clearly demonstrates that improvement in health outcomes, as defined above, is possible in standard conditions of medical practice, outside clinical investigative settings.
- Reliable Evidence shows that the prevailing opinion among experts, regarding the biological product, device, medical and/or behavioral health treatment or procedure, is that studies or clinical trials have determined its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment for a particular diagnosis.

**Reliable Evidence is defined as any of the following: Reports and articles in the authoritative medical and scientific literature; the written protocol used by the treating facility or the protocols of another facility studying substantially the same drug, biological product, device, medical and/or behavioral health treatment, or procedure; or the written, informed consent used by the treating facility or by another facility studying substantially the same drug, biological product, device, medical and/or behavioral health treatment, or procedure.*

Preapproval/Precertification review

All Participating Providers and facilities must use Practice Management (PM) on the Provider Engagement, Analytics & Reporting (PEAR) portal to initiate the following authorization types: ambulance (land) – non-emergent ambulance transportation (*Note:* Except for ambulance land requests from a facility as part of discharge planning.), AIS therapy, AIS chemotherapy, chemotherapy, durable medical equipment – purchase and rental, Emergency hospital admission notification, home health (dietician, home health aide, occupational therapy, physical therapy, skilled nursing, social work, speech therapy), home infusion, infusion therapy, and medical/surgical procedures, and specific outpatient physical therapy and occupational therapy services for Medicare Advantage Members*

Requests for medical/surgical procedures can be made up to six months in advance on PEAR PM. In most cases, requests for Medically Necessary care are authorized immediately; however, in some cases authorization requests may result in a pended status (e.g., when additional clinical information is needed or when requests may result in a duplication of services). PEAR PM submissions that result in a pended status can vary in the time it takes for completion. If an urgent request (i.e., procedure or admission for the same or next day) results in a pended status, please call 1-800-ASK-BLUE for assistance.

For non-urgent services requiring Preapproval/Precertification, Providers are strongly encouraged to contact Independence **at least ten business days** prior to the scheduled date of the procedure to ensure documentation of timely Preapproval/Precertification.

The UM department will evaluate your request and will notify your office once a decision has been reached for those cases that require clinical review. You will be provided with a Preapproval/Precertification reference number based on the determination of your request.

Failure to obtain Preapproval/Precertification may result in Provider penalties or denials of payment regardless of Medical Necessity.

Requests for Medicare Advantage Members (e.g., Keystone 65 HMO) must include all required information within ten days of the initial request to assure completion within the CMS-specified time frame of 14 days.

At the time of Preapproval/Precertification review, the following information will be requested:

- name, address, and phone number of the Subscriber
- relationship to the Subscriber
- Member ID number
- group number
- Physician name and phone number
- facility name
- diagnosis and planned procedure codes
- all pertinent clinical information including indications for admission: signs, symptoms, and results of diagnostic tests
- past treatment
- date of admission or service
- estimated length of stay (SNF and rehabilitation only)
- current functional level (SNF and rehabilitation only)
- short- and long-term goals (SNF and rehabilitation only)
- discharge plan (SNF and rehabilitation only)

Note: For potentially cosmetic procedures, photos and test results may be required.

Certain products have specialized Referral and Preapproval/Precertification requirements. Visit *www.ibx.com/preapproval* to view a list of current services that require Preapproval/Precertification. Please note that these requirements vary by benefits plan and are subject to change.

For your reference, we have published a list of medical services and codes that require Preapproval/Precertification, which can be found on our Medical Policy Portal. Select *Policy Bulletins* from the home page and then HYPERLINK "http://www.ibx.com/medpolicy" *w.ibx.com/medpolicy* *Services Requiring Precertification* from the left-hand navigation menu.

**This information does not apply to Providers contracted with Magellan. Magellan-contracted Providers should contact Magellan at 1-800-688-1911 to request an authorization.*

Medications

For *all drugs* covered under the medical benefit that require Preapproval/Precertification, Providers will be required to report Member demographics, such as height and weight.

Certain drugs that require adherence to Dosing and Frequency Guidelines will be reviewed during Preapproval/Precertification. Dosing and Frequency Guidelines are included in the medical policies for such drugs, which are available at *www.ibx.com/medpolicy.* Additional information about this program is available on the *Dosage and Frequency* page of our website.

Dosing and Frequency Guidelines help Independence verify that our Members' drug regimens are in accordance with national prescribing standards. These guidelines are based on current FDA approval, drug compendia (e.g., American Hospital Formulary Service Drug Information®, Micromedex®), industry-standard dosing templates, drug manufacturers' guidelines, published peer-reviewed literature, and pharmacy and medical consultant review. Requests for coverage outside these guidelines require documentation (i.e., published peer-reviewed literature) to support the request.

Note: Infusion drugs that are newly approved by the FDA during the term of a Provider contract are considered new technology and will be subject to Preapproval/Precertification requirements, pending notification by Independence.

Medicare Part B drug requests

In accordance with CMS, Independence must notify Members, as well as the requesting and servicing Provider, of its Precertification determinations in the following time frames:

- **Standard determinations** must be submitted no later than **72 hours** after receipt of the precertification request.
- **Expedited determinations** must be submitted no later than **24 hours** after receiving the request.

After submitting an authorization request through PEAR PM, Providers should immediately fax all pertinent supporting clinical information related to the request to 215-238-7956, Attn: Utilization Management.

Nonemergency ambulance transport

Nonemergency medical ambulance transport services, including hospital to hospital transfers, require Preapproval/Precertification when such a transport meets *all* of the following criteria:

- It is a benefit as outlined in the Member contract.
- It is a means to obtain Covered Services or treatment.
- It meets requirements associated with transport origin, destination, and Medical Necessity.

Non-emergency land ambulance requests, excluding hospital to hospital transfers, initiated by the ambulance Provider must be submitted through the Authorization Submission transaction on PEAR PM.

Non-emergency air ambulance requests initiated by the ambulance Provider must be called into the UM department. Providers are not able to initiate non-emergency air ambulance requests through PEAR PM at this time.

Visit *www.ibx.com/medpolicy* to view our policy on nonemergency ambulance transport services.

Obstetrical admissions

Preapproval/Precertification and prenotification for a maternity admission for a routine delivery are not required.

Out-of-network requests

HMO: In the rare event a given service is not available from Providers in the Independence network, and a Primary Care Physician (PCP) wishes to refer an HMO Member to an out-of-network Provider, the Referral must be Preapproved/Precertified; otherwise, the service may not be covered. All HMO out-of-network requests are referred to a Medical Director. The Member must meet the following guidelines:

- The Member must have first sought and received care from either a Participating Provider in the same American Board of Medical Specialties or an American Osteopathic Association-recognized specialty as the nonparticipating Provider that the Member has requested (a Referral from the Member's PCP is required).
- The Member must have been advised by the Participating Provider that there are no Participating Providers who can offer the requested Covered Services. Independence reserves the right to make the final determination of whether there is a Participating Provider who can provide the Covered Services. Applicable program terms including Medical Necessity, Referrals, and Preapproval/Precertification review by Independence, when required, will apply.

POS (Point of Service): PCP-referred requests are the same as for HMO Members. However, POS Members have the option to seek care from any Provider without a Referral, even when one is required, subject to our Deductible, Coinsurance, and Preapproval/Precertification review requirements.

PPO: PPO Preapproval/Precertification review requests for services performed by out-of-network Providers are the responsibility of the Member. Members with PPO coverage may obtain out-of-network Covered Services; however, these will be reimbursed at the out-of-network level of benefits.

Preapproval/Precertification through Carelon†

Independence has contracted with Carelon Medical Benefits Management (Carelon), an independent company, to manage Preapproval/Precertification requests for the following services:

- outpatient nonemergency diagnostic imaging services and certain high-technology radiology services for our managed care Members;
- non-emergency cardiovascular tests/diagnostic procedures and nonsurgical treatments for obstructive coronary artery disease that are part of the Cardiology Utilization Management Program for commercial and Medicare Advantage Members;
- non-emergency interventional pain management and musculoskeletal spine and joint procedures that are part of the Musculoskeletal Utilization Management Program for commercial and Medicare Advantage Members;
- sleep studies and continuous positive airway pressure (CPAP) titration studies in a facility setting for all commercial and Medicare Advantage Members.

For more detailed information on the Preapproval/Precertification requirements for these services, refer to the *Specialty Programs* section of this manual.

†Self-funded groups can elect not to include this utilization management program as part of their group health plan.

Preapproval/Precertification through eviCore†

Independence has contracted with eviCore healthcare (eviCore), an independent specialty benefit management company, to manage Preapproval/Precertification requests for the following services:

- nonemergency outpatient radiation therapy services for all commercial and Medicare Advantage Members;
- certain genetic/genomic tests for all commercial Members.

Note: Preapproval/Precertification is not required when radiation therapy is rendered in the inpatient hospital setting.

Independence's Radiation Treatment of Breast Carcinoma guidelines indicate that a hypofractionated regimen is the preferred treatment for patients with early stage (T1-2N0) breast carcinoma who meet certain criteria. For these patients, a request for Preapproval/Precertification of conventional fractionation will require a peer-to-peer call with an eviCore Radiation Oncologist.

In addition, eviCore manages prepayment review for all genetic/genomic tests, along with certain molecular analyses and cytogenetic tests, for all commercial and Medicare Advantage Members.

For more detailed information on eviCore and radiation therapy and genetic/genomic tests, refer to the *Specialty Programs* section of this manual.

†Self-funded groups can elect not to include this utilization management program as part of their group health plan.

Preapproval/Precertification through Tandigm

Independence has contracted with Tandigm Health (Tandigm), a population health services organization serving many primary care practices in the Philadelphia area, to manage Preapproval/Precertification requests for certain services.

The following services are delegated to Tandigm for Preapproval/Precertification and/or concurrent review for Members who have a Tandigm PCP:

- skilled nursing facility (SNF) admissions
- acute inpatient rehabilitation
- elective (nonemergency) ground, air, and sea ambulance transport
- all home health services, excluding infusion therapy
- out-of-network and out-of-capitation laboratory, radiology, and occupational and physical therapy

Requests for skilled nursing placement, acute rehabilitation, and LTAC admissions for Tandigm Members are managed by Tandigm. Impacted facilities (hospitals, SNFs, LTACs) can contact Tandigm directly by calling 1-844-TANDIGM, option 5, or by sending a fax to 215-238-2271. Independence discharge planning staff can also direct facilities to Tandigm when requesting placement for Tandigm Members. Continued stay/concurrent review for these admissions is managed by Tandigm.

Penalties for lack of Preapproval/Precertification

It is the network Provider's responsibility to obtain Preapproval/Precertification for the services listed at *www.ibx.com/preapproval*. If Preapproval/Precertification is not obtained where required under the Member's benefits, neither the Member nor Independence will be responsible for payment. Members are held harmless and may not be billed for the service that was not Preapproved/Precertified where required.

Standing Referrals and specialist used as a PCP

HMO Members with life-threatening, degenerative, or disabling diseases/conditions are permitted to receive a standing Referral to a specialist with clinical expertise in treating the disease or condition. This will be granted upon approval of the treatment plan by the UM department, the Member's PCP, and the specialist.

Members with life-threatening, degenerative, or disabling diseases/conditions are also permitted to have a specialist designated as their PCP to provide and coordinate their primary and

specialty care. This will occur only after the specialist has agreed to meet our requirements to function as a PCP and after the UM department has approved the treatment plan.

Customer Service can provide direction on how to initiate a request under these circumstances. A standardized form must be completed by the Member, the PCP, and the specialist, as appropriate, and must include the diagnosis and clinical plan. The form is sent to the UM department and reviewed by a Medical Director. If the request is denied, the Member, PCP, and specialist will be notified verbally and in writing of the denial and the clinical rationale for the denial. The Member will be directed on how to initiate an appeal.

All Members who request standing Referrals shall be evaluated for ongoing case management support and continued follow-up of their disease or condition.

Admission review

Admission review is the initial review of the circumstances surrounding an Emergency admission to determine whether coverage for inpatient services will be granted. The review examines the severity of the Member's condition based on patient presentation and diagnostic study results, as well as the treatment provided, and whether the patient's condition is such that its symptoms are unlikely to resolve within 24 hours. Admissions to rule out seriously acute conditions should be considered for observation level of care.

Concurrent review

Concurrent review is the review of continued stay in the hospital or skilled nursing facility after an admission is determined to be Medically Necessary. Our concurrent review program consists of both fax and telephone reviews, based on the Agreement with the individual hospital.

Keep the following in mind:

- Concurrent review is performed when the reimbursement is per-diem.
- If concurrent review is not obtained by the first uncovered day where required, neither the Member nor Independence will be responsible for payment. Members are held harmless and may not be billed for the days not reviewed, regardless of Medical Necessity.
- When payment is based on a per-case or diagnosis related group (DRG)-based arrangement, a determination is made whether the initial admission meets criteria guidelines, both in elective and Emergency scenarios, and no further concurrent review is performed.
- For elective admissions (surgical) that were Preapproved/Precertified, confirmation of the procedure performed will be required.

Discharge planning coordination

Discharge planning is the process by which Independence care coordinators, after consultation with the Member, his or her family, the treating Provider, and the hospital care manager, do the following:

- assess the Member's anticipated post-discharge problems and needs;
- assist with creating a plan to address those needs;
- coordinate the delivery of Member care.

Discharge planning may occur by telephone or fax at the hospital. All requests for placement in an alternative level-of-care setting/facility (such as acute or sub-acute rehab or SNF) will be

reviewed for Medical Necessity. Providers must supply the requested information to the UM department to determine whether placement is appropriate according to InterQual guidelines.

When appropriate, alternative services (such as home health care and outpatient physical therapy) will be discussed with the Member, his or her family, the attending Provider, and the hospital discharge planner or social worker.

Once alternative placement is authorized, the approval letter is sent to the Member, the hospital, and the attending Provider. If the request does not meet the criteria, the case is referred to a Medical Director for review and determination.

Business hours

Our business hours are Monday – Friday 8 a.m. to 5 p.m. On weekends and holidays, staff is available for urgent discharge planning requests such as placements in skilled nursing facilities between 9 a.m. and 5 p.m. After hours, requests for urgent discharge planning can be left with an answering service and will be responded to on the next calendar day.

Denial procedures

All cases that do not appear to satisfy the relevant Medical Necessity criteria are referred to and reviewed by a Medical Director for a determination. If the service is determined to be covered, Independence staff will inform the Provider who submitted the request.

If we determine that the information provided by the attending Provider is insufficient to determine Medical Necessity, the case will be pended. If clinical information is requested and not provided within 48 hours of the request, the request will be denied due to lack of information. Any information provided after the denial for lack of clinical information has been processed will be reviewed and the case will be reconsidered for approval.

For non-urgent (elective) care, the information must be submitted within 10 calendar days of the initial request or prior to the date of service, whichever comes first. If the information is not submitted in the applicable time frame, the request may be denied and the information regarding an appeal process will be included in the denial letter.

All determinations are communicated verbally, and written confirmation is sent to the attending Provider, hospital, PCP, and Member, as applicable. The clinical review criteria applied in rendering an adverse coverage or payment determination are available free of charge and will be furnished upon request. All adverse determination (denial) notifications include the contractual basis and the clinical rationale for the denial, as well as instructions for how to initiate an appeal.

For detailed information about the appeals process, refer to the *Appeals* section of this manual.

Observation status

Observation status is an outpatient service that does not require authorization. It should be considered if a patient does not meet InterQual acute inpatient criteria or one or more of the following apply:

- Diagnosis, treatment, stabilization, and discharge can be reasonably expected within 24 hours.
- Treatment and/or procedures will require more than eight hours of observation.*
- The clinical condition is changing.
- There is a psychiatric crisis intervention or stabilization with observation every 15 minutes.

Observation status does not require a physical "stay" in an observation unit and does not apply to ER observation of less than eight hours.*

Independence's policies for facility reporting of observation services supersede InterQual guidelines. In this instance, Independence's policies stating the treatment and/or procedures must* ***include at least eight hours of observation supersedes the InterQual standard of six hours.* *For more information on these policies, visit our Medical Policy Portal at www.ibx.com/medpolicy.*

Independence reserves the right to retrospectively audit claims where there has been billing for observation status to assure that appropriate guidelines have been met.

If a Member has received observation services and is subsequently admitted, the date of the admission becomes the date that observation began. Observation services that result in an admission are subject to utilization management review for Medical Necessity.

Reconsideration and review processes

Peer-to-Peer Reconsideration process

In the event that an adverse determination (denial) is issued without direct discussion between an attending/ordering Provider and a Medical Director, the requesting Provider (including attending/ordering Provider or hospital medical director) may request a Peer-to-Peer Reconsideration with a Medical Director. Peer-to-Peer Reconsideration is an optional, informal process designed to encourage dialogue between the requesting Provider and Medical Directors and may be requested by a Provider for a Preapproval/Precertification, concurrent, or post-service review denial based on Medical Necessity.

Medicare refers to any determination issued by a health plan where a Medicare beneficiary may be financially liable for receiving a service in the event the health plan denies the claim as an organization determination. This is typically applicable only for Preapproval/Precertification determinations. For Medicare Advantage plans, once Independence issues an adverse organization determination denying coverage, any change to the organization determination is considered a reconsideration and must be handled as an appeal. Medical Directors are still available to discuss the case and explain the clinical rationale for the utilization management determination, but any reconsideration must be initiated through the appeal process. If the adverse determination was not appealed and new information becomes available that could change the determination, the Medical Director may assist the treating Provider in accessing the appeal process and make this new information available in the appeal process.

Please note the following:

- For concurrent review denials, the Peer-to-Peer Reconsideration process should be initiated while the Member is in the hospital; however, hospitals have up to two business days from the date the Member is discharged to initiate the process.
- For Preapproval/Precertification denials, the Peer-to-Peer Reconsideration process should be initiated after the Provider has received notification of the denial but before the service is actually rendered.

- To initiate the Peer-to-Peer Reconsideration process, the attending Provider, ordering Provider, hospital Utilization Management department Providers, or their designated Provider representative (e.g., hospital medical director) may contact an Independence Medical Director by:
  - filling out the Peer-to-peer request form found at *www.ibx.com/providerforms*;
  - calling the Provider Referral Line at 1-888-814-2244, or at 215-241-0494 within Philadelphia. The Provider Referral Line is available Monday through Friday from 8:30 a.m. to 5 p.m.
- A Medical Director will initiate a call to the Provider within five business days from the time the request for a peer-to-peer reconsideration has been received. If the Provider cannot be reached, the Medical Director documents the attempt and renders a final determination. Whenever possible, the Medical Director Support Unit staff facilitates "warm call transfers" between Providers and Medical Directors and schedules telephone appointments between Medical Directors and Providers.
- A decision to overturn all or a portion of the initial adverse determination will be communicated in writing to the Provider.

Continuity of care

If a Provider's contract is discontinued, the Member has access to the primary or specialty care Provider or Provider group as applicable, for up to ninety (90) calendar days from which the Member is currently receiving an active course of treatment provided that the Provider agrees to continue to provide services to the Member under the terms and conditions of the Plan. A Member is undergoing an active course of treatment if the Member has regular visits with the Provider to monitor the status of an illness or disorder, provide direct treatment, prescribe medication or other treatment, or modify a treatment protocol. Active treatment does not include routine monitoring for a chronic condition (e.g., monitoring chronic asthma).

Pregnant women enrolled in an HMO, POS, or PPO plan may continue to receive treatment by a Provider who has terminated from the network, unless the termination was due to unsafe health care practices that jeopardize the health, welfare, or safety of the Members, through the completion of postpartum care.

The continuity-of-care period may be extended by Independence when clinically appropriate. Coverage of Covered Services provided during the continuity-of-care period is contingent upon the Provider's agreement to comply with the terms and conditions applicable to Independence Participating Providers, prior to providing services for this time period.

If Independence initiates termination of a Provider *with cause*, Independence is not responsible for coverage of health care services provided by the terminated Provider to the Member following the date of termination. Notification will be provided to our Members, and arrangements will be made to facilitate transfer to another Participating Provider.