

Section 8: Medical Management

Utilization Management Program

Utilization Management is a set of activities performed by DCHP to ensure that medically necessary services are provided to members in an efficient and timely manner and that appropriate health care services are always available to members. Utilization Management activities are retrospective, concurrent and prospective. All Utilization Management activities are performed by Registered Nurses and clinicians under the supervision of the DCHP Medical Director/Associate Medical Director. The DCHP Third Party Administrator, Valence Health, currently performs the utilization review and case and disease management activities for DCHP.

Philosophy of Medical Management

It is the goals of the Medical Management Program to:

- Assure access to appropriate levels of care
- Promote disease prevention and wellness;
- Provide high-quality, cost-effective services for all members
- Have satisfied members and providers

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We strive to assure the member is receiving the appropriate care at the appropriate time and work proactively on the member's behalf with the DCHP network providers to assure the member is maintaining his/her optimal level of health and well-being.

Utilization Review Criteria

The screening criteria used for medical necessity determination by Driscoll Children's Health Plan are Texas Medical Review Program Hospitalization Screening Criteria and other guidelines from recognizable resources, as necessary. These resources may be, but are not limited to, the National Lung and Blood Institute (NLBI), the Agency for Health Care Policy and Research (AHCPR), National Institute of Health (NIH), American Academy of Pediatrics (AAP), or internally developed guidelines. The screening criteria used are objective, clinically valid, compatible with established principles of health care, and are flexible enough to deviate from the normal, when justified, on a case-by-case basis. Each case will be reviewed individually, for special circumstances that may cause deviation from the normal.

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Prior Authorization and Referrals: 1-877-455-1053 (FAX 1-866-741-5650)

Case Management: 1-877-222-2759 (FAX 1-866-741-5650)

CHIP Member Services: 1-877-451-5598 STAR Member Services: 1-877-220-6376

Member Services FAX: 361-904-0187

Referrals

Requesting a Referral

The physician (PCP or Specialist) initiates a prior-authorization for referrals by calling DCHP or by faxing the Texas Authorization and Referral Form (located in Appendix A) to the Health Plan Medical Management Department and providing the following information. Referrals can also be initiated over the internet and all provider offices with internet access can be instructed in this procedure. Provider offices interested in additional information on entering web based referrals can call Provider Services..

The following information is required for referral authorizations:

- Member/patient name
- Member's birth date
- Member's CHIP or STAR Identification Number
- Admitting or requesting physician
- Phone number or Fax number of requesting physician
- Contact person for requesting physician
- PCP's name
- Referral to/for which physician or facility
- Phone number or Fax number of the REFER TO physician, provider or facility
- Admitting diagnosis
- ICD-9 code or CPT code (if known)
- Reason for referral
- Number of visits requested
- Clinical information

All requests for services will be reviewed. Requests that are determined to be medically necessary and meet clinical criteria will be approved and given an authorization number. Requests that fail to meet clinical criteria will be referred to the DCHP Medical Director / Associate Medical Director for review.

The Medical Management Department will issue an authorization number to both the PCP and specialist office. This authorization number will appear on a faxed report the day following the completion of the review.

Referral Procedure

When a referral to a DCHP Specialist, or ancillary facility is necessary, the following steps should be taken:

- The PCP selects a Specialist from the DCHP physician panel.

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- The PCP arranges for services with the Specialist in the usual manner including coordination of pertinent clinical information and then issues a referral. A referral is submitted by using the Referral Form in Appendix A of this manual.
- A member's referral is usually initiated during an office visit to the PCP.
- The Specialist will examine and treat the member (as requested by the PCP) and document recommendations and treatment. The Specialist should keep the PCP continually informed of findings and treatment plans.
- The Specialist will submit a claim form, accompanied by the referral number, to the Health Plan. For further details regarding claim filing, please see Section 9 section of this manual.
- If the member requires additional services not directly associated with the diagnosis in the referral, the Specialist must then contact the Medical Management Department for prior-authorization.

PCP Referrals to Specialists

PCPs follow the procedure outlined above when referring a patient to a specialist. Referrals usually include visits to the specialist through the member's enrollment period.

Referrals should be issued prior to the visit to the Specialist (with the exception of emergency room and behavioral health visits).

Specialist to Specialist Referrals

When a specialist wishes to refer to another specialist they need to refer the patient back to the PCP to initiate the physician to physician referral. Specialists can, however refer patients for ancillary services that fall under the scope of their practice. Specialists should assure that the PCPs are kept informed of the results of any examinations and any additional treatment recommended.

Prior Authorization

Overview

Driscoll Children's Health Plan requires that certain services have prior-authorization. The prior-authorization process is used to evaluate the medical necessity of a procedure or course of treatment, appropriate level of service and the length of confinement prior to the delivery of services. The clinical information you provide aids in the medical review throughout the treatment.

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DCHP, or the Administrative Service Organization (ASO), provides prospective, concurrent, and retrospective utilization review services. All services that require prior-authorization must be phoned or faxed to the Health Plan Medical Management Department utilizing the prior-authorization form included in Appendix A of this manual.

Failure to obtain prior-authorization may result in non-payment of claims and encounters.

Members may request reconsideration of benefit determinations in accordance with the medical appeals process. Physicians are responsible for making medical treatment decisions in consultation with their patients. Any denial of prior-authorization based on lack of medical necessity or documentation of such, will be made by the Driscoll Children's Health Plan Medical Director/Associate Medical Director.

All decisions made by the Medical Management Department are subject to appeal using the provider appeal process described in Section 10 of this Manual.

Protocols and procedure for obtaining Prior Authorization

The physician (PCP or Specialist) initiates a prior-authorization using the same procedure as requesting a referral, by calling or by faxing the Texas Authorization and Referral Form (see Appendix A) to the Health Plan Medical Management Department and providing the same demographic and clinical information as required for a referral as stated above. Prior Authorizations can also be initiated over the internet and all provider offices with internet access can be instructed in this procedure. Provider offices interested in additional information on entering web based requests can call Provider Services.

Definition of Admissions:

Elective Admission: Elective, or pre-planned, admissions generally include elective surgeries and admissions for elective treatment that requires an acute care setting for management.

Observation Admission: Observation admissions are intended for use when it is necessary for a member to have a longer observation post-operatively, or known risk factors or medical conditions requiring frequent monitoring by the nursing staff. Observation is authorized for 23 hours. In cases where a member requires an observation stay beyond the initial 23 hour observation period, the admitting physician must contact the Medical Management Department for authorization for inpatient admission. If the decision to keep the patient beyond what was authorized occurs after 5:00 p.m., the attending physician should contact the Health Plan the next business day. There is a nurse on call available after hours if the physician or hospital wishes to discuss the case further.

Direct Urgent Admissions: Urgent admissions are defined as those admissions that take place upon direct referral from a physician's office or when the member is directed by a physician to go to the hospital. In the case of a direct admission from a physician's office during normal office hours, the physician's office staff should call the Medical Management Department, prior

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to sending the patient to the hospital (except in cases of medical emergency). If the admission is not authorized by the Health Plan prior to admission, the hospitalization usually will not be considered for payment, and no additional payment is due from the patient.

Emergency Admissions: An emergency admission usually occurs directly from a hospital emergency facility following evaluation and stabilization of a medical condition of recent onset and severity. These admissions may occur after regular business hours. The attending physician should contact the Health Plan's Medical Management Department the next business day for authorization.

Services Requiring Prior Authorization

For Prior-Authorization contact the Medical Management Department.

Inpatient Admissions Requiring Prior-authorization

- All inpatient admissions (medical and behavioral health)
- Admission required prior to the day of surgery
- Admission to Skilled Nursing Facility
- Admission to a rehabilitation center
- Non-emergency requests for assistant surgeons
(In emergency situations where a surgical assistant is needed, the attending surgeon's office is required to notify the Health Plan within twenty-four (24) hours or the first business day following surgery.)

Please notify the Medical Management Department of the Health Plan at least three to five (3-5) working days prior to elective admission to complete authorization.

All elective surgeries are performed on the day of admission unless, based on medical necessity, the Medical Management Department has approved the admission the day prior to surgery.

Outpatient Services Requiring Prior-authorization

- Outpatient ambulatory / surgical procedures
- 23 hour observations
- Surgical assistants for outpatient / ambulatory surgery
- Rehabilitation therapy (physical, speech and occupational)
- Home health services (including home IV therapy)
- Hospice Care
- Bio-feedback
- Chronic pain medications/pain clinic

Diagnostic Services Requiring Prior-authorization

- Sleep studies / sleep labs
- Radiological procedures which require admission for observation

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- Pneumograms

Other Procedures or Services Requiring Prior-authorization

- Referral to a specialist for ONLY the following: Dermatology Procedure Codes, Ophthalmology, Plastic Surgery Procedure Codes
- Durable Medical Equipment (DME) that is >\$300 (\$20,000 limit for 12 month period for CHIP) -- DCHP reserves the right to make exceptions to this limit, and require prior authorization based on the previously approved screening criteria.
- Use of ambulance for medical transportation (not emergency transport)
- Request for services by non-contracted providers
- Out of area / out of network services
- Injectable drugs over \$300 not covered under the Vendor Drug Program
- Temporal Mandibular Joint (TMJ) treatments
- Tobacco Cessation Program (with \$100 limit)
- Podiatry care
- Chiropractic Care
- Orthotics
- Organ transplant evaluation or admission to a transplant facility for purposes of transplantation
- Other alternative medicine forms of treatment

Vision Services

Driscoll Children's Health Plan offers vision services through a contracted vendor. This vendor is OptiCare. The vision benefit includes a routine eye exam, and eyewear. Vision services that are for medical conditions of the eye require prior authorization for referral to an Ophthalmologist and are handled through the Medical Management Department of Driscoll Children's Health Plan. Questions regarding the routine vision benefit and services should be directed to OptiCare at **1-888-268-2334 (for CHIP) or 1-866-838-7614 (for STAR)**.

Chiropractic Services

Chiropractic services are available for CHIP members. They do not require a physician referral but do require a prior authorization. The services are limited to twelve (12) visits for spinal subluxation, only. Additional visits will require proof of medical necessity through the Medical Management Department. For prior authorization, telephone or fax to the numbers shown on this page.

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Transplant Services

Providers who are caring for members who may be under consideration for transplant services must notify Driscoll Children's Health Plan. Case Management will become involved with this member and follow them through the pre-transplant and final transplantation process. Driscoll Children's Health Plan requires prior authorization for admission to any transplant facility. DCHP is not contracted with a specific transplant facility. Any nationally recognized facility will be evaluated for approval based on the medical necessity of services for the Member. For prior approval and to notify of potential transplantation, contact the DCHP Medical Management Department.

Management of Utilization

Concurrent Review

Concurrent reviews are conducted to ensure that services rendered to the member are medically necessary, meet medically acceptable standards of care, and are provided in the appropriate environment, and that continuity of care is appropriately planned for discharge.

Determinations on appropriateness of care and of hospitalization are made by reviewing information in the medical record and through discussions with the attending physician. The following criteria must be met:

1. Documentation in the medical record must indicate that the medical condition requires continuous daily monitoring by the facility staff and by the provider.
2. The member's condition cannot be managed safely at another level of care (e.g., outpatient, home health care, etc.)
3. Continued stay criteria for both intensity of service and severity of illness must be present and documented in the medical record each day of confinement.

It is the responsibility of the attending / admitting physician to ensure that hospital admissions are certified and that authorized lengths of stay are extended, if indicated.

If medical criteria is not met, or transfer to an alternative level of care is medically appropriate, the Medical Director or Associate Medical Director reviews the information and, if necessary, discusses the case with the attending physician prior to making a determination of whether continued hospitalization is authorized.

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If Concurrent Review indicates a discharge and / or transfer of care:

- The Utilization Management nurse is available to assist the attending physician with arranging discharge and transfer of patients from acute care facilities to other facilities, such as rehabilitation, or home health care.
- Daily on-site or phone reviews are usually conducted for inpatient cases in acute care, rehabilitation, and short-term facilities. The frequency and intensity of the reviews are based on the severity of illness and care required by the patient.
- Discharge plans will be discussed with the attending physician.
- If the hospitalization is deemed not medically necessary, the member, the PCP, and the hospital will be notified regarding termination of benefits beyond a specified date.

Information regarding the expedited appeal process may be obtained by calling the Medical Management Department.

Retrospective Review

Retrospective reviews may be conducted on any claim without an authorization, partial hospitalizations, emergency room treatment, out of area treatment, admissions or member reimbursement. The reviews are conducted to ensure that services rendered to the patient are medically necessary, provided in the appropriate environment and contractually covered.

The process includes the following steps:

- When the claim in question is received, the provider is notified within fifteen (15) days that the claim has been received and that it is under review.
- Records are requested from the provider.
If records are not received with thirty (30) days, the claim is considered denied until the medical record is received. The provider is notified of the denial, the reason for the denial and the appeal process.

When records are received, a decision is made within thirty (30) days using the following criteria

- medical appropriateness and necessity
- established medical criteria
- plan benefits

Once a decision is made, the provider is notified of the results.

If the provider disagrees with the results, he / she may appeal according to appeals requirements included in Section 10 of this manual.

Discharge Planning

Discharge planning refers to all aspects of planning for post-hospital needs and ensuring the continuity of quality medical care in an efficient and cost-effective manner, and should begin

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prior to admission. Discharge planning activities include provisions for and/or referrals to services required in improving and maintaining the patient's health and welfare following discharge.

Discharge planners work with the attending physician, the member, the member's family, and other health care professionals to ensure continuity of care after discharge. It is recognized that discharge planning is a process which requires multidisciplinary involvement to achieve the greatest success. Consequently, input is sought from all healthcare professionals such as nurses, physical therapists, as well as any other ancillary staff and services.

Anticipated discharge needs should be discussed with the Medical Management Department prior to admission, or as early as possible in the admission. All admissions receive prior-authorization with an anticipated length of stay that indicates the anticipated discharge date.

To facilitate discharge planning for members in the hospital, call the Medical Management Department. The Utilization Management nurse may assist in:

- Arranging home health services and durable medical equipment (DME)
- Admissions / transfers to other facilities
- Coordinating medical transportation
- Questions on benefits or coverage
- Authorization and arrangement of transfer of out-of-area patients
- Information and referral to community resources

Self-Referral Services

Members are allowed to self refer, without a PCP authorization, for the following services:

- Emergency care
- Routine vision care
- OB/GYN care
- Behavioral Health Services
- THSteps examinations
- Family Planning (STAR members only)

Out-of-Network Referrals

Request for services by non-contracted providers, out of area / out of network services require **prior-authorization** by the Medical Management Department.

Non-participating Specialist care requires **prior-authorization** by the Medical Management Department.

Physician-requested Second Opinions and Member-requested Second Opinions

Second opinions requested by either the member or the physician require prior authorization. For information regarding second opinion request, contact the Medical Management Department.

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Results of Not Obtaining Prior Authorization

Cases that require prior authorization and it was not obtained are subject to denial for lack of or late notification. Providers can initiate an appeal by following the Appeal process and explaining in detail any rationale of why DCHP was contacted regarding the request. Appeal information is located in Section 10 of this manual.

Appealing Non-Payment for Lack of Referral

See information on how to appeal in Section 10 of this manual.

Online Referrals and Authorization Processes

Any referral or prior authorization can be initiated on line. Contact member services at the number below for detailed instructions on this process.

Faxing Paper Referrals and Authorization Requests

Providers may fax the Texas Authorization and Referral Form (in Appendix A) to the Medical Management Department.

Obtaining Referral and Authorization Forms

Forms are available on line as well as from the Medical Management Department..

Pregnancy Notification Requirements

Pregnant CHIP Member

If a provider identifies a CHIP member as being pregnant, he/she should notify DCHP Provider Services.

Because of other CHIP program eligibility changes that were effective September 1, 2003, most pregnant CHIP teenagers and their newborns, up to age one year, will qualify for Medicaid. Since the Medicaid Program now provides a much more comprehensive scope of services for both the pregnant teen and their newborn, it is in the best interest of the pregnant teen to receive Medicaid coverage as early as possible. For this reason, it is critical that providers notify Driscoll Children's Health Plan immediately upon learning about a CHIP Teen's pregnancy. Driscoll Children's Health Plan will notify the CHIP hotline that the CHIP member is pregnant. Pregnant CHIP teens who are Medicaid eligible will be transferred from CHIP to Medicaid as soon as possible.

On occasion it will become necessary for Driscoll Children's Health Plan to cover the costs of the delivery; however, the provider must immediately notify Driscoll Children's Health Plan about the delivery. Upon notification by the provider, Driscoll Children's Health Plan will refer

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the newborn to Medicaid to determine eligibility. Newborns deemed not eligible for Medicaid, will be enrolled in CHIP as determined by HHSC.

Pregnant STAR/Medicaid Members

DCHP Medical Management department should be notified as soon as the member is determined to be pregnant, as well as advised of any high risk factors. This will allow the case managers to work collaboratively with the physician and provide proactive case management in order to assist in maintaining a healthy full term pregnancy.

Obtaining Pregnancy Notification Forms

Supplies of Pregnancy notification forms are available to provider's offices. Contact Provider Services for information regarding these forms.

Case Management Program

Case Management is a concurrent review activity undertaken on catastrophic medical cases or for specific types of health care services. The focus of case management is to ensure the appropriate level of care and the right time and in the right place. Case management activities are performed by Registered Nurses under the supervision of DCHP Medical Director. The Case Manager, along with the Member's PCP, evaluates the Member's medical history. The Case Manager works closely with the Member's PCP to monitor the Member's progress by tracking and reviewing the Member's utilization trends as far as admissions rates, days of care rates, as well as outpatient visit rates. Patients may be referred to the Case Management program by:

A child's family/self referral	PCP/ Provider Referral
Member Services Referral	Community/ External Agency Referral
Behavioral Health Referral	Analysis of claims utilization reports
Member Satisfaction Surveys	Administrator Contract for any
State developed Assessment tool	governmental program

Any of the following diagnoses or conditions, as well as others not listed, may trigger Case Management intervention:

AIDS	Paralysis	LOS exceeding 14 days
Congenital heart disease	Renal failure	Spinal cord injury
Diabetes	Asthma	Amputation of extremity

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Malignancies	High risk newborns	Cystic fibrosis
Multiple fractures	High risk pregnancy	

The Health Plan's case management program involves the member, family or significant others, physicians, social services, community resources and facility team members, all of whom contribute to decisions regarding care.

When appropriate, the Case Manager refers the member and family to public health resources. A partial listing of these resources may include the following:

- Texas Department of Health
- Food stamp program
- Women, Infants, and Children Program (WIC)
- Early Childhood Intervention Program
- Department of Mental Health and Mental Retardation
- Corpus Christi Independent School District, or other School District as appropriate
- Texas Information and Referral Network
- Texas Commission for the Blind (TCB)
- Other child serving civic and religious organizations and consumer and advocacy groups, such as Cerebral Palsy.
- March of Dimes
- American Heart Association
- American Lung Association

The Case Manager arranges multi-disciplinary conferences in the facility, arranges social services, community services and other services as needed, including DME.

For more information regarding the DCHP case management program or additional information on the community agencies, contact Cases Management.

Disease Management Programs

Disease Management Programs are largely retrospective oversight of high risk medical conditions. Disease management is designed to prevent exacerbation of symptoms that might result in hospitalization. Disease management is also designed to help members with specific illnesses deal more effectively with their disease or condition to as to improve their quality of life. DCHP Disease Management programs are under the supervision of the DCHP Medical Director.

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Currently, DCHP offers Disease Management Programs in Pediatric Asthma, Diabetes, COPD and CHF .

If you encounter a member that you feel would benefit from one of these programs designed to increase patient education regarding their health and or disease process, nutrition, medication and compliance issues, or community based resources available to them, please contact the Medical Management Department. We will be available to assist in facilitating the physician based treatment plan in a collaborative effort with the member's various healthcare providers to assist in improving or maintaining the well being of the member.

Practice Guidelines

Driscoll Children's Health Plan utilizes the American Academy of Pediatrics Practice Guidelines, as guidelines for care for the CHIP Members. DCHP recognized nationally recognized guidelines as published by the various specialty medical societies and the AMA. Copies of these guidelines are available at the various websites via the internet. Questions regarding practice guidelines may be directed to the DCHP Medical Management Department.

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