HEALTH PLAN POLICY		
Policy Title: Medical Director Initial Review		**Number:** MUM14 **Revision:** F
Department: Medical Management	**Sub-Department:** Utilization Management	
Applicable Lines of Business: ☐ Children's Health Insurance Plan ☒ Medicare ☐ Commercial Insured ☐ Non Insured Business ☒ Health Insurance Exchange ☒ USFHP ☐ Medicaid		
Effective Date: 03/04/2016		
Revision Date(s): 06/01/2017, 09/20/2018, 04/29/2020, 04/14/2021, 03/29/2022, 12/08/2023		

PURPOSE:

The purpose of this policy is to describe the process for reviewing initial requests for authorization by the chief medical director who participates in the utilization management (UM) process on behalf of the health plan. The health plan employs a chief medical director who is responsible for ensuring the clinical accuracy of all coverage decisions made by the plan that involve medical necessity.

DEFINITIONS AND ACRONYMS:

- **Health Solutions Plus (HSP)** – The claims processing system used by CHRISTUS Health Plan.
- **Medical Necessity** – Defined by the Health Plan as a determination that has been made by a licensed physician and/or qualified clinican for services that clinical documentation supports to be justified as reasonable, necessary, and appropriate, based on evidence based guidelines criteria and accepted clinical standards of practice.
- **Medical Necessity – (Applicable to USFHP only)** A collective term for determinations based on medical necessity, appropriate level of care, custodial care (as these terms are defined in 32 CFR 199.2) or other reason relative solely to reasonableness, necessity or appropriateness. Determinations relating to mental health benefits under 32 CFR 199.4 are considered medical necessity determinations. For pharmacy claims, a determination regarding pharmaceuticals prescribed outside the guidelines issued by the DoD Pharmacy and Therapeutics Committee is not considered a medical necessity determination, even when the determination is based on medical review. Such determination is a factual determination and should be processed in accordance with Section 5.
- **Medical Review –** The collection of information and clinical review of medical records to ensure that payment is made only for services that meet all coverage, coding, and medical necessity requirements.
- **Organization Determination** – A health plan's response to a request for coverage (payment or provision) of an item or service – including auto-adjudicated claims, service authorizations which include prior-authorization (authorization that is issued prior to the services being rendered), concurrent authorization (authorization that is issued at the time the service is being rendered), and requests to continue previously authorized ongoing courses of treatment. It includes organizational determination and reconsideration requests submitted by contract providers on behalf of the enrollee and requests from non-contract providers. It does not include claims for payment or appeals from contract providers that are governed by the contractual arrangement between the MAO and its contract providers.
- **Peer-to-Peer Consultation** – A discussion between a requesting practitioner and a Chief medical director concerning a utilization issue. This discussion may address a potential request for services, requests under review, ongoing patient care, or a denial.

- **Reconsideration** – A member's first step in the appeal process after an adverse organization determination; a health plan or independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.
- **Representative –** An individual either appointed by an enrollee or authorized under State or other applicable law to act on behalf of the enrollee in filing a grievance, requesting a coverage determination or in dealing with any of the levels of the appeals process. Unless otherwise stated in part 423, subpart M of the Medicare Part D regulations, the representative has all of the rights and responsibilities of an enrollee in obtaining a coverage determination or in dealing with any of the levels of the appeals process, subject to the rules described in part 422, subpart M of the Medicare Part C regulations.
- **Waiver of Liability – (Applicable to USFHP only)** Subject to application of other TRICARE definitions and criteria, the principle of waiver of liability is summarized as follows: If the beneficiary did not know, or could not reasonably be expected to know, that certain services were potentially excludable from the TRICARE Basic Program by reason of being not medically necessary, not provided at an appropriate level, custodial care, or other reason relative to reasonableness, necessity or appropriateness (hereafter, all such services will be referred to as not medically necessary), then the beneficiary will not be held liable for such services and, under certain circumstances, payment may be made for the excludable services as if the exclusion for such services did not apply.
- **Utilization Management (UM)** – The process of assuring members receive the appropriate care in a cost-effective manner and with the highest quality clinical outcomes. Requests for clinical services are received either via phone or electronic/fax means and are reviewed for coverage, benefits, and medical necessity. Determinations must be made according to routine and expedited standards.

POLICY:

A. Each initial denial determination about services requested or provided by a licensed doctor of medicine or osteopathy or by a doctor of dentistry must be respectively reviewed by another professional of the same licensure, if the initial determination is based on lack of medical necessity or other reason relative to reasonableness, necessity or appropriateness.

B. Following an established process for escalation of a medical necessity review, Medical Management team members forward any issues that are of clinical concern to the chief medical director for review and determination.

C. When considering whether to certify a health care service requested by a provider or member, the chief medical director shall determine whether the requested health care service is covered by the health benefits plan and is medically necessary.

    a. Before denying a health care service requested by a provider or member on grounds of a lack of coverage, the chief medical director shall determine that there is no provision of the health benefits plan under which the requested health care service could be covered. If the chief medical director finds that the requested health care service is not covered by the health benefits plan, the chief medical director need not address the issue of medical necessity.

D. If the chief medical director finds that the requested health care service is covered by the health benefits plan, then when considering whether to certify a health care service requested by a provider or member, a physician, registered nurse, or other health care professional shall, within the timeframe required by the medical exigencies of the case, determine whether the requested health care service is medically necessary.

E. If an adverse determination is based on a lack of medical necessity, the chief medical director will clearly and completely explain why the requested health care service is not medically necessary.

F. If the adverse determination is based on a lack of coverage, the chief medical director will identify all health benefits plan provisions relied on in making the adverse determination, and clearly and completely explain why the requested health care service is not covered by any provision of the health benefits plan.

G. The chief medical director will include a description of the standard (i.e., policies and procedures, Local Coverage Determination, MCG Health Care Guidelines, TRICARE Operation Manual, etc.) that was used in denying or approving the services requested.

H. Provide a summary of the discussion which triggered the final determination. A statement that the health care service is not medically necessary will not be sufficient.

I. Determinations of medical necessity made in a concurrent or pre-procedure review should include discussions with the attending provider as to the current medical condition of the patient whenever possible.

J. The Health Plan will extend a peer-to-peer invitation to the attending, treating, or ordering physician.

K. In the event that a peer-to-peer discussion occurs, tthere must be a record that includes the date and time, person contacted, context of the conversation.

L. The chief medical director can make a positive determination regarding medical necessity without necessarily speaking with the treating provider if there is enough available information to make an appropriate medical decision.

M. The chief medical director must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the member and the discussion must include at minimum clinical basis for the adverse decision and the description of documentation or evidence, and if the provider has additional information, he should be given an opportunity to submit, which may lead to a different utilization review decision.

N. The notice of the initial determination shall include a caption identifying:

1. A summary of the issue or issues and shall be clear and concise. All issues shall be addressed; for example, a determination in all cases requiring preadmission authorization shall address the requirement for preadmission authorization of the care as well as whether the requirement was met.

2. A brief discuss of the provision of law, regulations, guidelines on which the determination was made. Include pertinent specific citations and quotations of applicable text (e.g., when citing cosmetic surgery policy, should quote only the procedure(s) applicable to the case under review).

3. Discuss the original and any added information relevant to the issue(s) clearly and concisely, and shall state the patient's condition, including symptoms. Include a discussion of any secondary issues which may have been discovered during the review process.

4. State the decision and whether the requested services or supplies are approved or denied in whole or in part, and clearly and concisely state the rationale for the decision; i.e., fully state the reasons that were the basis for the approval or denial of requested benefits. If applicable criteria must be met, the patient's medical condition must be related to each criterion and a finding made concerning whether each criterion is met.

5. All related case documentation and contacts will be documented in the Health Solutions Plus

(HSP) system.

6. Determination Letters will be sent according to the prior authorization guidelines. (24 hours for expedited request and 48 hours for standard request)

For USFHP, all statements above as well as the additional language below are applicable and true.

A. The chief medical director review shall be in accordance with the health plan best business practices. This process does not alter the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), or TRICARE Systems Manual (TSM) provisions covering active duty personnel or TRICARE For Life (TFL) beneficiaries.

B. Payment and liability for services or supplies retrospectively excluded by the chief medical director by reason of being not medically necessary, at an inappropriate level, custodial care, or other reason relative to reasonableness, necessity or appropriateness will require a "Waiver of Liability" determination.

C. Waiver of liability applies to retrospective determinations that services are not medically necessary (with the exception of services provided by network providers).

D. Waiver of liability should be applied when:

1. Member did not know, provider did not know care was excludable as not medically necessary (for specific dates of service).
2. Member did not know, provider knew care was excludable as not medically necessary (for specific dates of service).
3. Member knew, provider knew care was excludable as not medically necessary (for specific dates of service).
4. Member knew, provider did not know care was excludable as not medically necessary (for specific dates of service).

REFERENCES:

- Medicare Managed Care Manual Chapter 6, Chapter 11, 42 CFR, 422.562(a)(4) and 423.562(a)(5).
- 13.10.17.2 NMAC - Rp, 13.10.17.2 NMAC, 5-3-04; A, 2-1-08; A, 5-15-12
- Insurance Code Title 14. Utilization Review and Independent Review
- TRICARE Operations Manual 6010.56-M, February 1, 2008, Chapter 12, Section 4 - Referrals/Preauthorizations/Authorizations
- TRICARE Operations Manual 6010.56-M, February 1, 2008, Chapter 8, Section 5 - Appeals Hearing
- TRICARE Policy Manual 6010.57-M, February 1, 2008 Chapter 1, Section 4.1- Waiver of Liability
- Texas Administrative Code Title 28, Part 1, Chapter 19, Subchapter R

RELATED DOCUMENTS:

None

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REVISION HISTORY:

Revision	Date	Description of Change	Committee
New	03/04/2016	Initial Release	Board of Directors
A	06/01/2017	Annual Review. Changed signatory from Anita Leal, Executive Director to Nancy Horstmann, CEO.	Board of Directors
B	09/20/2018	Annual review - product lines updated	Executive Leadership
C	04/29/2020	Annual review. Updated formatting.	Executive Leadership
D	04/14/2021	Annual review. No change to policy content.	Executive Leadership
E	03/29/2022	Annual review. No change to policy content.	Executive Leadership
F	12/08/2023	Annual review. Updated policy title, definitions, and details throughout for clarity.	Executive Leadership