

Medical Management Overview

Our medical management philosophy and approach focus on providing high quality and cost-effective healthcare services to our members. Our Medical Management Program is designed to align our goals of member service, effective medical management, and member and provider satisfaction.

WellChoice is committed to providing access for the delivery of quality medical care and services to its members. The Medical Management department shares the commitment by

- making utilization management decisions based only on the appropriateness of care and service, the existence of coverage, the provider of these services and the setting in which the services will be delivered.
- not rewarding our medical staff—or other people who perform medical management functions—for denials of coverage for medical care and services.
- taking steps to guard against the inappropriate restriction of care by specifically acknowledging the risk of underutilization that can result from overly aggressive utilization management decisions.
- having no financial incentives to encourage decisions that could result in underutilization.

Precertification and Notification Guidelines

For HMO members, WellChoice's Medical Management Program must be called by the PCP or provider prior to rendering certain services.

For PPO members, the member must call Medical Management to precertify.

The following services may require precertification:

- Any nonemergency care from a nonparticipating doctor or hospital (HMO members only)
- All inpatient admissions to hospitals and facilities including hospice services,

rehabilitation facilities and skilled nursing facilities (2 weeks in advance)

- Emergency admissions (within 24 hours)
- Air ambulance (HMO members only)
- Ambulatory surgery (only medically necessary cosmetic/reconstructive surgery procedures, outpatient transplants and ophthalmologic procedures*)
- Behavioral health and substance abuse†
- Durable medical equipment, prosthetic and orthotics (ancillary vendor is responsible for obtaining precertification)
- Home care and home infusion therapy
- Private duty nursing (if covered)
- Infertility services
- Maternity care, except routine deliveries
- Detained newborns
- MRIs/MRAs
- PET/CAT Scans and nuclear cardiology
- Nutritional counseling
- Physical/occupational/speech/vision therapies
- Cardiac Rehabilitation

* Call OptiCare at 1-800-840-7032 Monday – Friday, 8:30 a.m. – 5:30 p.m. for precertification.

† Call Magellan Behavioral Health at 1-800-635-6626 (HMO) or 1-800-626-3643 (PPO), 24 hours a day, 7 days a week, for precertification.

Availability of certain services and precertification terms are subject to the member's benefit contract. Other services may require precertification. Call Provider Services at 1-888-476-7245 Monday – Friday, 8:30 a.m. – 5:00 p.m. to verify benefits.

Please remember the following:

- PCPs (for HMO) or members (for PPO) must call Medical Management, in advance, to precertify those services subject to precertification under the member's benefit contract.

- Specialists (for HMO only) with a valid referral from the PCP must call Medical Management in advance to precertify services subject to precertification under the member's benefit contract (refer to Precertification Guide in this section).
- For mental health or alcohol/substance abuse care, prior approval must come from the Behavioral Health Care Management Program.
- Medical Management must be notified within 24 hours of an emergency admission by the admitting physician, PCP or member.
- coexisting behavioral/mental health diagnosis so that all of the member's care needs can be coordinated with the behavioral health vendor.

Please note: WellChoice requires notification of all inpatient emergency admissions per the terms of your contract, typically within 24 hours of the admission. After-hours calls are handled through our 24-hour Nurse Call Center. If a PCP, treating practitioner or hospital calls Medical Management during nonbusiness hours, an option for notification of emergency admissions will be provided.

HMO Members cannot be billed for any services requiring precertification if payment is denied or reduced for failure to obtain the required precertification from WellChoice's Medical Management Program.

To precertify, you may call:

HMO: 1-800-441-2411

PPO: 1-800-982-8089

Monday – Friday, 8:30 a.m. to 5:00 p.m.

You also have the option to complete the Fax Authorization Request Form (see Section Nine: Sample Forms of this *Sourcebook*) and fax it to Medical Management.

When calling Medical Management, please have the following information ready:

- Physician's name, ID number, address and phone number
- Patient's name, ID number and date of birth
- What service is being precertified (refer to list above)
- Diagnosis with CPT-4 and/or ICD-9 codes
- Quantitative clinical information

In addition, for hospital admissions you will need to know the

- admitting physician's name, address and site number.
- facility's name, address, and phone number.
- diagnosis and procedure with CPT-4 and/or ICD-9 codes.

For HMO patients admitted to a participating facility, Medical Management will conduct a medical review only from the date of the notification forward, if the patient is still in the hospital. The claim will be subject to decreased payment for the days prior to notification. If the HMO patient has already been discharged at the time of notification, Medical Management will not review the admission and the claim may be subject to decreased payment for lack of notification.

For PPO patients admitted to a participating facility, if Medical Management is not notified within the required time frames, WellChoice will review the days prior to the notification, and may reduce payments for the days of service prior to the date of notice for the medically necessary condition.

The facility will be provided with grievance rights and information for any claims denials or reductions for lack of notification.

Behavioral Health Care Management

Magellan Behavioral Health is our behavioral health and substance abuse utilization review agent. Magellan ensures that members receive appropriate treatment in the most suitable setting. Once you have determined that your patient is a WellChoice member and in need of behavioral health treatment, please call the number listed on the back of the member's identification card for precertification. A Magellan representative is available 24 hours a day, 7 days a week.

Our Behavioral HealthCare Management Program, not the Medical Management Program, should be contacted for precertification of behavioral healthcare services. The program coordinates the following case management functions:

- paper referrals
- fax authorization for outpatient treatment requests

For inpatient mental healthcare, partial hospital programs, outpatient mental healthcare, inpatient alcohol and substance abuse care, and outpatient substance abuse care, our program manages the following:

- precertification
- concurrent review
- retrospective review
- discharge planning

You are responsible for contacting the Behavioral HealthCare Management Program if the patient is an HMO member. If the patient is a PPO Member, he/she is responsible for calling.

Call Magellan Behavioral Health at 1-800-626-3643, 24 hours a day, 7 days a week.

In emergency situations, you (on behalf of the HMO members) or your PPO patient must call the program within 24 hours or as soon as reasonably possible after an admission.

Medical Management Review Process

A Medical Management registered nurse will review each request for medical appropriateness of services and setting. This review is conducted according to evidence-based medical policy and medical necessity criteria.

If the criteria are met, our nurse will document the clinical data on our Medical Management system and authorize the requested covered service. Precertification approval letters are mailed to the facility, the member, the PCP and the attending physician.

If our nurse determines that criteria are not met, or there is insufficient information to complete a review, the requested service will be referred to one of our Medical Directors. A Medical Director will review the information and the attending physician may be contacted to obtain more clinical data on the case.

If the Medical Director does not approve the prospective admission, the facility, the member, the PCP and/or the attending physician are notified via telephone and in writing of the denial.

Medical Necessity Criteria

Medical Management nurses use both nationally recognized criteria and evidence-based medical policy to assess the medical necessity and appropriateness of care and services. Copies of these criteria are made available to providers on a case-by-case basis. You may call Medical Management at 1-800-441-2411 (for HMO) and 1-800-982-8089 (for PPO) Monday – Friday, 8:30 a.m. to 5:00 p.m. for specific information on how to obtain criteria or order copies through criteria vendors for your own reference.

Medical Director Availability

WellChoice's medical directors are available to discuss medical necessity denial decisions with physicians. To speak to a medical director, please refer to the denial notification. It includes the medical director's name and telephone number.

Concurrent Review

Once WellChoice has approved an initial length of stay, you must contact Medical Management for approval of any additional days. It is your responsibility to provide all information according to the time frame. A WellChoice nurse may call your Utilization Review Department and/or PCP or attending physician upon reviewing the case to request additional clinical information. Our nurse's goal is to support a treatment plan that provides appropriate care in a cost-effective manner and results in discharge from the hospital at the appropriate point in the patient's treatment.

It is also your responsibility to provide access to your Utilization Review Department to accept our calls for requests of clinical information. Utilization Review Departments that have hours extended beyond the normal business day should notify us so that they may be contacted during those extended hours.

authorization for such services, except where there was a material misrepresentation or fraud in connection with the prior authorization request or the patient was not a member at the time of service.

Inpatient Care

A person receives inpatient care while spending the night in a hospital or other facility as a registered patient. For full coverage, the patient must meet the following conditions:

- The care is medically necessary and is a covered service under the member's benefit contract.
- For HMO members, a network facility must deliver the care. The only exceptions are in an emergency or if the attending physician decides that care in a hospital outside our network is more appropriate and prior approval from Medical Management has been obtained. PPO members may receive care from a network hospital provider, or for a higher out-of-pocket cost (in nonemergencies) by an out-of-network hospital provider.
- For HMO members, the facility or the physician must precertify the member's admission in advance through the Medical Management Program, except in an emergency. For PPO members, the precertification may be handled by the members/patients themselves, unless they have authorized the Provider to do so.
- The facility (or other network provider) coordinates the patient's care while he/she is hospitalized.

Retrospective Review of Services Rendered

A retrospective review is an evaluation done after services are completed. WellChoice's Medical Management Program reviews care retrospectively in certain situations where medical necessity must be established to approve the payment of the benefit. We will not retroactively deny reimbursement for services that were provided based on our prior