MASS ADVANTAGE
Plan to love your plan.

UTILIZATION MANAGEMENT

Utilization Management Program

The Utilization Management (UM) Program is a component of the Clinical Operations Department and monitors both access and quality of care using nationally recognized, evidence-based standards of care across the Medicare lines of business. The UM program facilitates optimal settings for delivery of care and educates physicians and facilities on the advantages of managing care in a medically appropriate and cost-effective manner. The UM structure is routinely evaluated such that appropriate utilization is continuously monitored and corresponding interventions initiated to improve health outcomes. The UM program maintains regulatory compliance and is annually reviewed by the Mass Advantage Utilization Management Committee (UMC) and annually approved by the Quality Improvement Committee (QIC). Information below outlines the obligations of providers for collaboration with the UM program including complying with coverage guidelines, providing information in a timely manner, completing necessary documentation, and responding to questions.

Coverage Requests (Prior Authorization)

The prior authorization process includes steps confirming the eligibility of the member, verifying coverage of services, assessing the medical necessity and appropriateness of care, and establishing the appropriate level of care.

Only a limited number of services, items, or Part B drugs require prior authorization, and a complete list can be found on our website at www.massadvantage.com. It is the responsibility of the ordering or admitting provider to obtain prior authorization before services are rendered. The Clinical Operations Department accepts coverage requests via phone or fax, by completing a Prior Authorization Request Form and submitting it to Mass Advantage's Clinical Operations Department. A copy of the Prior Authorization Request Form can be found on our website. All requests are assessed based on medical necessity and appropriateness of services using a hierarchy of medical evidence that includes nationally recognized criteria, such as MCG® Guidelines, the Centers for Medicare and Medicaid Services' (CMS) definition of medical necessity and CMS National and Local Coverage Determinations, and Magellan coverage guidelines, when authorizing the delivery of healthcare services to members.

MCG® Guidelines are used in conjunction with the member's benefit plan and the provider's recommendation to approve, append and/or deny services.

Providers must submit the appropriate supporting clinical documentation for review with the authorization request to avoid an adverse determination by the plan. Documentation should include:

- Medical records that describe the planned treatment, including the medical rationale for the services being requested, lab reports, radiology reports, consultants' notes, etc.
- All pertinent medical information supporting the requested treatment and/or procedure.

The Clinical Operations Department is committed to assuring prompt, efficient delivery of healthcare services. The Utilization Management Department can be contacted between the hours of 8:00 a.m. and 6:00 p.m. EST, Monday through Friday at 866-312-8467 or by fax at 888-656-7783. Providers calling before or after operating hours or on holidays are asked to leave a voicemail message and a Clinical Operations Representative will return the call the next business day. Providers with urgent requests or questions are directed to call 866-312-8467.

Expedited Reviews

The Utilization Management Department will process an expedited review for a member with a life-threatening condition, or for a member who is currently hospitalized and needs specialized services not covered under the hospitalization, or to authorize a treatment following stabilization of an emergency condition. You may also request an urgent review to authorize treatment of an acute injury or illness, if the provider determines that the condition is severe or painful enough to warrant an expedited or urgent review to prevent a serious deterioration of the patient's condition or health.

For expedited requests for services or items, the Utilization Management Department will make a decision to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires, but no later than 72 hours from the receipt of the request and written notification to the member and provider will be provided. The time frame to deciding for a Part B drug requested as expedited is 24 hours.

Standard Reviews

For standard prior authorization requests, the Utilization Management Department will decide to approve, deny or limit authorization of the service request as expeditiously as the member's health condition requires. Notification will be sent to the requesting provider and member in writing on all standard prior authorization determinations no later than 14 calendar days from the receipt of the request. The time frame to deciding for a Part B drug requested as standard is 72 hours. A 14-day extension may be granted to an expedited or standard coverage request if the member requests it or if we have a need for additional information and the extension of time benefits the member (for example, if additional medical records are needed in order to change a potential denial decision).

Inpatient Hospital Services Authorizations (Inpatient Prior Authorization)

All request for inpatient hospital services and/or admissions must include appropriate supporting medical documentation, such as treatment plans, test results, medical history, needed to determine medical necessity to issue the authorization. The supporting medical information will help the Utilization Management Department facilitate the authorization process.

Elective Hospital Admission – the primary care provider or specialist may request the admission. Prior authorization requests for a selected list of procedures must be submitted to Mass Advantage's Clinical Operations Department at a minimum of 14 days prior to the admission or service. A list of the selected procedures can be found on our website at www.massadvantage.com.

Emergency Admissions are reviewed retrospectively.

The following are examples of services requiring prior authorization before providing the following non-urgent or urgent care services. For a complete list of services/items/Part B drugs requiring prior authorization please our website at www.massadvantage.com for the Prior Authorization List or call the Mass Advantage Provider Services Department at: 844-918-0114 (HMO), 844-915-0234 (PPO) or TTY: 711.

- Certain elective Inpatient admissions
- Inpatient mental health services

- Skilled Nursing Facility (SNF) admissions
- Home health care services
- Prosthetics
- Wheelchairs and Scooters
- Out of Network Services
- Transplant evaluation and services
- Outpatient IV infusion or injectable medications
- Requests for non- covered services under traditional Medicare program

Medicare Outpatient Observation Notice (MOON)

The MOON is mandated by the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act), passed on August 6, 2015. This law amended Section 18669(a)(1) of the Social Security Act by adding new subparagraph (Y) that requires hospitals and critical access hospital (CAHs) to provide written notification and oral explanation of such notification to individuals receiving observation services as outpatients for more than 24 hours at the hospital or CAHS.

- The MOON is a form that must be delivered before the member received 24 hours of observation as an outpatient.
- If the member is transferred, discharged or admitted, the MOON still must be delivered no later than 36 hours following initiation of observation services.
- The start time of Medicare observation services is measured as the clock time observation services are initiated in accordance with a physician's order.
- The MOON notice is required to be delivered to psychiatric hospital patients.

Further information about the MOON can be found at the CMS site:
http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.html

Instructions on how to complete the MOON can be found at:
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf

Penalties for Not Obtaining Approval for Requested Services

Mass Advantage will not be responsible for paying a provider for a service if the provider has not complied with administrative requirements such as prior authorization and other UM policies. Under such a situation, the provider is also prohibited from charging the member for the service. If there are extenuating circumstances that delayed the authorization process, the provider should advise the Clinical Authorization Department when requesting an authorization.

Out of Network Authorization Requests (Out of Network Pre-Certifications)

Members of HMO plans may need to see a healthcare professional outside of Mass Advantage's provider network. When the need for out-of-plan services arises, the provider contact Mass Advantage's Clinical Operations Department to obtain an authorization. The Clinical Operations Department will review the request and arranges for the member to receive the necessary medical services with a specialty care provider in collaboration with the recommendations of the primary care provider. Best effort will be made to locate a healthcare professional within an accessible distance to the member.

Second Opinions

A member has the right to a second surgical/medical opinion in any instance when the member disagrees with his or her provider's opinion of the reasonableness or necessity of surgical procedures or is subject to a serious injury or illness.

The second surgical/medical opinion, if requested, is to come from a provider chosen by the Member who may select:

- A provider who is participating with Mass Advantage and not in practice with first opinion provider, or
- If a network provider is not available, a non-participating provider located in the same geographical service area of Mass Advantage, who has a Medicare ID.

If a non-participating provider is required, the referring provider must contact Mass Advantage for authorization. Any tests that are deemed necessary as part of the second surgical/medical opinion will be conducted by participating Mass Advantage providers.

Emergency Care and Services (ER)

Federal and state regulations prevent a plan from requiring members to contact a primary care provider, specialist or the plan prior to seeking emergency care. The decision by a member to seek emergency care is based upon "prudent layperson" standard. Per CMS guidelines: "An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Members are instructed to call 911 and/or go to the nearest emergency room for treatment if they believe that they are having a medical emergency. Medical emergencies include, but are not limited to: severe chest pain, shortness of breath, uncontrolled bleeding, broken bones, sprains, burns, poisoning, convulsions and extended fever.

Physicians, specialist and covering physician must provide advice, consultation, and access to care appropriate for each member's medical condition.

- All life-threatening conditions must be referred to the nearest emergency room.
- All providers must notify Clinical Operations of known emergency inpatient admissions.
- Providers directing members to an emergency room for treatment are encouraged to notify the emergency room of the pending member arrival.

Prior Authorization is NOT REQUIRED for emergency room visits and coverage CANNOT be denied retrospectively for emergency services satisfying CMS and Mass Advantage criteria for such covered services.

The facility providing emergency inpatient admissions must notify Mass Advantage of a member's emergency admission within 24 hours, or as soon as the member's condition has stabilized. The Clinical Operations department can receive fax admission notifications 24 hours/day, seven days/week by fax at 888-656-7783.

Service Denials

Mass Advantage may deny a prior authorization request for several reasons:

- Member is not eligible
- Service is not a covered benefit
- Member has exhausted his or her benefits
- Service is not deemed medically necessary based on medical necessity guidelines

Mass Advantage notifies both the provider and member in writing of any adverse decision (partial or complete) within required time frames. The notice will state the reasons for the decision and inform of the right to file an appeal.