Utilization Management

Utilization Management Program

Utilization Management is a set of activities performed by Driscoll Health Plan (DHP) to ensure that appropriate, medically necessary services are available to and coordinated for Members in an efficient and timely manner, at the appropriate level, and in the appropriate setting and to determine whether services are experimental or investigational in nature. The UM Program monitors over and under-utilization of both inpatient and outpatient services and provides feedback on performance to the health plan. It employs a combination of prospective, concurrent, and retrospective review of clinical data. Registered Nurses, Case Managers and Clinicians under the supervision of the Medical Director perform all Utilization Management activities.

Philosophy of Utilization Management

The goals of the Utilization Management Program are:

- Assure access to appropriate levels of care;
- Promote disease prevention and wellness;
- Provide high quality, cost-effective services for all Members; and
- Provide for Member and Provider satisfaction.

We strive to assure that the Member is receiving the appropriate care at the appropriate time and work proactively on the Member's behalf with the DHP network Providers, to ensure the Member is maintaining his/her optimal level of health and well-being.

Communication with Utilization Management

Access to Review Staff

Driscoll Health Plan (DHP) serves Texas counties in the Central Time Zone only. The CHIP/STAR/STAR Kids Utilization Management (UM) Department and STAR Kids Long Term Support Services (LTSS) Department are available Monday - Friday, 8 a.m. to 5 p.m. CST, excluding legal holidays, to respond to utilization review inquiries.

Review Service Communication and Time Frames

Hours to receive communications:

DHP receives communications from Providers and Members during both the business day and after business hours. Mechanisms for receipt of communications include telephone, facsimile, provider portal, and USPS mail. Providers can submit requests for inpatient or outpatient authorization 24 hours a day, seven days a week at the following numbers and website:

CHIP/STAR/STAR Kids UM

Fax:	**1-866-741-5650**
Inpatient Fax:	**1-833-808-2175**
Phone:	**1-877-455-1053**
Web:	**www.driscollhealthplan.com**

STAR Kids LTSS

Fax:	**1-844-381-5437**
Phone:	**1-844-376-5437**
Web:	**www.driscollhealthplan.com**

Calls received after business hours: An after-hours recording prompts the caller to select the option for nurse on call, who is available 24 hours a day, seven days a week, for calls received after hours.

Trained personnel staff the Mental and Emotional Health Services Hotline (Avail Solutions) 24 hours a day, seven days a week, toll-free throughout the service area.

Response to communications:
DHP responds to communications within one (1) business day, messages received after business hours on the next business day, and voice mail messages within one (1) business day.

Outgoing communications:
DHP conducts its outgoing communications related to UM during Providers' reasonable and normal business hours, unless otherwise mutually agreed.

Preauthorization

Overview

Driscoll Health Plan (DHP) requires preauthorization of certain services. DHP uses the preauthorization process to evaluate the medical necessity of a procedure or course of treatment, appropriate level of services, and the length of confinement prior to the delivery of services. The supporting clinical information provided aids in the medical review of the request. For a review of the services requiring preauthorization and the *Clinical Information and Documents to Support Medical Necessity* listing, visit the DHP Prior Authorization Requirement website: https://driscollhealthplan.com/priorauthcheck.

Providers must submit requests for services that require preauthorization to the health plan UM Department or Population Health (STAR Kids LTSS) Department prior to rendering services. Failure to obtain preauthorization may result in non-payment of claims.

The Medical Director will make any denial of preauthorization based on lack of medical necessity or documentation of such. Members and Providers receive written notification of all denials that are the result of lack of medical necessity. Denial notifications include the reason for the denial and instructions for requesting an appeal.

Clinical Review Criteria

DHP Medical Management will utilize InterQual review criteria in the process of managing utilization for prospective, concurrent, and retrospective review. Clinical peer reviewers may additionally utilize other criteria and evidence-based guidelines, such as The American College of Obstetrics and Gynecology (ACOG), The American Academy of Pediatrics (AAP), The American Medical Association (AMA), Texas Health and Human Services Commission (HHSC) and Driscoll Health Plan policy. DHP may develop its own clinical review criteria where the medical director determines existing clinical review criteria to be inadequate.

For LTSS Services, the STAR Kids Screening and Assessment Instrument (SAI) performed by the Service Coordinator will determine medical necessity for the LTSS services. Any DHP actions or intended actions will require a written notification to the member describing the action.

Results of Not Obtaining Preauthorization

When Providers do not obtain preauthorization for services that require preauthorization, these services are subject to denial.

Peer-to-Peer Conversation

Peer-to-Peer conversations related to non-certification decisions are available to Providers, pre and post determination, and are the most timely and direct process to facilitate exchange of information in support of the authorization process.

Peer Clinical Reviewers are available to discuss non-certification decisions with Attending Providers or other Ordering Providers via the toll-free UM line **at 1-877-455-1053 (CHIP/STAR/STAR Kids)** or **1-844-406-5437 (STAR Kids LTSS)** during normal business hours Monday - Friday from 8 a.m. to 5 p.m., except for legal holidays.

Peer-to-Peer Availability Prior to Decision
DHP affords the Provider with a reasonable opportunity to discuss the Member's treatment plan and the clinical basis of a non-certification decision with the original Peer Reviewer prior to issuing an adverse determination. The definition of reasonable opportunity timeframe is as follows:

- One (1) business day for a routine, prospective review;
- Five (5) business days for a retrospective review; and
- Prior to issuing, for a concurrent or post-stabilization review.

If the original Peer Reviewer cannot be available within one (1) business day, another Peer Reviewer will be available for the conversation.

Peer-to-Peer Post-Decision Conversation
When DHP decides to issue a non-certification decision, and no peer-to-peer conversation has occurred in connection with the case, DHP provides, within one (1) business day of a request by the Attending Provider or Requesting Provider, the opportunity to discuss the non-certification decision:

a. With the Clinical Peer Reviewer making the initial determination; or
b. With a different Clinical Peer Reviewer, if the original Clinical Peer Reviewer cannot be available within one (1) business day.

For CHIP, STAR and STAR Kids non-certification decisions, the *Peer-to-Peer Conversation Availability* form is sent via facsimile and/or the provider and/or facility receives notification via phone. Additionally, peer-to-peer offer for non-certification decisions is included in the *Notification of Authorization Status* facsimile.

For STAR and STAR Kids Members less than 21 years of age, the peer-to-peer offer is also included in the *Initial Request for Additional Information/Insufficient or Incomplete/Lack of Information* letter

If a peer-to-peer conversation or review of additional information does not result in an authorization (certification), DHP informs the Provider and Member of the right to initiate an appeal and the procedure to do so.

Appeals
Members may request reconsideration of determinations in accordance with the medical appeals process. For more information regarding how to appeal and the appeal process, contact Provider Services at the phone number below, or refer to "*STAR & STAR Kids, Section D, Appeals, Complaints, Peer-to-Peer Conversations, & State Fair Hearings"*, or *"CHIP, Section D, Appeals, Complaints, Peer-to-Peer Conversations, & IRO Processes"* in this manual.

Authorizations

Requesting an Authorization via the Internet
The preferred method of submission is via the Provider Portal on the internet through the Driscoll Health Plan (DHP) website: **www.driscollhealthplan.com**. Provider offices with internet access have received instruction on how to use the Provider Portal. Provider offices interested in additional information on entering web-based authorizations can call Provider Services at the phone number listed at the bottom of this page for detailed instructions on this process.

Requesting an Authorization via Phone or Fax
DHP also accepts authorization requests via phone or fax. DHP prefers providers to utilize the Texas Authorization and Referral Form (see **Appendix** of this manual) to request preauthorization for medically necessary services; however, any

Texas Medicaid Health Care Partnership Authorization Request Form will be accepted. All forms submitted must be complete. Providers may fax the request to the UM Department or STAR Kids LTSS Department.

Obtaining Authorization Forms

Forms are available online as well as from the Utilization Management Department.

Requesting an Authorization

The Provider (Primary Care Provider (PCP), Specialty Care Provider or Facility) initiates a preauthorization request via the Provider Portal on the internet, or via phone or fax. Authorizations to in-network Providers and Facilities are preferred when services are available within network.

Providers must include the following essential information listed below when submitting preauthorization requests for services to initiate the preauthorization:

- Member name;
- Member's birth date;
- Member's CHIP, STAR and STAR Kids Medicaid Identification Number;
- Requesting Provider name;
- Requesting Provider National Provider Identifier (NPI);
- Procedure codes (Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS));
- Quantity requested (number of visits or units requested); and
- Service start and end dates.

DHP will reject preauthorization requests missing essential information by faxing back the requesting Provider with a list of what is missing and the essential information to provide. Providers will need to resubmit the preauthorization request with all of the necessary essential information included.

To expedite processing of the preauthorization request, it is beneficial for Providers to include the Diagnoses and clinical information and documents to support medical necessity of the request with the essential information listed above (see the DHP Prior Authorization Requirement website: https://driscollhealthplan.com/priorauthcheck for the *Clinical Information and Documents to Support Medical Necessity* listing). DHP will initiate the Insufficient Lack of Information Process if it is determined clinical information or documents to support medical necessity are lacking.

DHP will review all requests for services. DHP will approve requests that meet clinical criteria and are determined medically necessary. An authorization number will be assigned. DHP will refer the request for services that fail to meet clinical criteria to the Peer Clinical Reviewer for review.

Authorization Procedure

Primary Care Provider (PCP) Authorizations to Specialty Care Providers

The Primary Care Provider (PCP) usually initiates a Member's authorization request during an office visit. Authorization requests usually include visits to the Specialty Care Provider, Ancillary Provider or Facility through the Member's enrollment period.

Prior to the visit to the Specialty Care Provider, Ancillary Provider or Facility (with the exception of Emergency Room and Behavioral Health initial evaluation), an authorization should be issued.

No preauthorization is required for requests from PCP to PCP or PCP to Specialty Care Provider for office visits (E&M codes) to in-network Providers.

PCPs must refer to in-network Providers if services are available. DHP will forward requests for services to an out-of-network Specialty Care Provider to the Peer Clinical Reviewer for review.

The following steps should be taken when an authorization to a Specialty Care Provider, Ancillary Provider or Facility is necessary:

- The PCP selects a Specialty Care Provider, Ancillary Provider or Facility from the DHP physician panel;
- The PCP arranges services with the Specialty Care Provider, Ancillary Provider or Facility in the usual manner including coordination of pertinent clinical information and then submits a preauthorization request for services; and
- The PCP submits a preauthorization request utilizing the Texas Authorization and Referral Form (TARF) (see **Appendix** of this manual) or online via the DHP Provider Portal on the internet.

Once the request is submitted to DHP and approved, both the Requesting and Referred Providers or Facility (the PCP, as well as the Specialty Care Provider, Ancillary Provider or Facility), will receive confirmation via fax that DHP has approved the request. The faxed *Notification of Authorization Status* document will contain the authorization number. (Authorization of services does not guarantee payment.)

The Specialty Care Provider, Ancillary Provider or Facility will examine and treat the Member (as requested by the PCP) and document recommendations and treatment. The Specialty Care Provider, Ancillary Provider or Facility should keep the PCP continually informed of findings and treatment plans.

The Specialty Care Provider, Ancillary Provider or Facility will submit a claim form, accompanied by the authorization number, to DHP. For further details regarding claim filing, please see "*VIII – Billing and Claims***"** in this manual.

If the Member requires additional services not directly associated with the requested services and diagnosis listed in the existing authorization, the Specialty Care Provider must then contact the UM Department or STAR Kids LTSS Department for preauthorization.

Members with Special Health Care Needs

Members with special health care needs may need several authorizations to meet their health care needs. These Members may need direct access to a Specialty Care Provider. Members with special health care needs may have a standing authorization to a Specialty Care Provider as approved by the Peer Clinical Reviewer/Medical Director.

Specialty Care Physician to Specialty Care Physician Authorizations

Specialty Care Providers may refer to another Specialty Care Provider if the Specialty Care Provider is in-network and the authorization is for the same diagnosis.

Specialty Care Providers may not refer to another Specialty Care Provider if the authorization is for a different diagnosis. When a Specialty Care Provider wishes to refer to another Specialty Care Provider for a different diagnosis, he/she must refer the Member back to the PCP to initiate the Physician-to-Physician authorization request.

Specialty Care Providers can refer patients for ancillary services that fall under the scope of their practice. (For example, an Orthopedic Specialty Care Provider can make an authorization for Physical Therapy or Occupational Therapy.) Specialty Care Providers should inform the PCP of the results of any examinations and any additional treatment recommended.

Self-Referral Services

Members may self-refer, without a Primary Care Provider (PCP) referral, for the following services:

- Emergency care;
- Routine vision Care;
- OB/GYN care;
- Behavioral Health Services;
- Texas Health Steps medical checkups;

- Family Planning (STAR Members only); and
- A network Ophthalmologist or therapeutic optometrist to provide eye Health care services, other than surgery.

Out-of-Network Authorizations
Request for services by non-participating, non-contracted providers, or out of area/out of network services require preauthorization by the UM Department or Population Health (STAR Kids LTSS) Department. The preauthorization will require that the requesting provider submit to DHP rationale for requesting services out-of-network.

Provider-Requested Second Opinions and Member-Requested Second Opinions
All members are entitled to a second opinion. Second opinions requested by either the Member or the Provider require preauthorization. For information regarding second opinion requests, contact the UM Department or STAR Kids LTSS Department.

Urgent or Emergent Acute Medical, Behavioral Health, or Substance Use Disorder Inpatient Admissions and Post-Stabilization Services Resulting in an Inpatient Admission
Facilities are required to notify DHP within one business day of the admission for all urgent, emergent, post-stabilization, or routine inpatient admissions, regardless of level of care, unless otherwise noted within this document or on the DHP Prior Authorization Requirement website: https://driscollhealthplan.com/priorauthcheck. Refer to the Prior Authorization Requirement website for additional requirements and guidance.

Eligibility Issues and Late Notification for Prior Authorization

Outpatient Services

DHP Member Coverage Unknown	Retro-Enrollment and assignment to DHP
Where prior authorization was required and DHP coverage is identified after services are rendered, authorization is required prior to claims submission. DHP will conduct retrospective review of medical necessity for the services rendered without penalty for late notification if the reason provided is substantiated in the request for authorization.	Where prior authorization was required and retro assignment to DHP is identified after services are rendered, authorization is required within 30 days of the retro assignment date and prior to claims submission. DHP will conduct retrospective review of medical necessity for the services rendered without penalty for late notification if indication of retro-assignment as reason for late notification is provided and substantiated in the request for authorization.

Inpatient Services

DHP Member Coverage Unknown	Retro-Enrollment and assignment to DHP
If DHP coverage was unknown upon admission, and identified during the stay, authorization is required. DHP will process the authorization request without penalty for late notification if the reason for late notification provided is substantiated in the request for authorization.	If retro-assignment to DHP is identified during the stay, authorization is required within 30 days of the retro-assignment date. DHP will process the authorization request without penalty for late notification during this timeframe. Indication of retro-assignment as reason for late notification must be provided with the authorization request.
If DHP coverage identified post discharge but prior to claim submission, authorization is required prior to claims submission. DHP will conduct retrospective	If retro assignment to DHP is identified after discharge and prior to claim submission, authorization is required within 30 days of the retro-assignment date

review of the stay without penalty for late notification if the reason for late notification provided is substantiated in the request for authorization.	and prior to claims submission. DHP will conduct retrospective review of the stay without penalty for late notification. Indication of retro-assignment as reason for late notification must be provided with the authorization request.

Providers may notify DHP of any above scenario in one of the following manners:

- Via the DHP Provider Portal on the internet through the Driscoll Health Plan (DHP) website: **www.driscollhealthplan.com**, by entering a note on the authorization;
- Via facsimile, by entering a comment on the cover sheet or authorization request form, toll free 1-866-741-5650; or
- Via telephone call to the DHP UM department, toll free 1-877-455-1053.

Providers are responsible for verifying members' eligibility. Eligibility can be verified via:

- DHP Provider Portal on the internet through the Driscoll Health Plan (DHP) website: **www.driscollhealthplan.com**;
- DHP's automated IVR system (1-877-324-3627); or
- Calling Customer Service and speaking with a Customer Service Representative (1-877-324-3627)

Prospective, Concurrent, and Retrospective Reviews and Determination Timeframes

Prospective and Concurrent Review Determinations

For prospective review and concurrent review, DHP bases review determinations solely on the medical information obtained by DHP at the time of the review.

Prior to elective hospital admissions or outpatient surgical procedures, Driscoll Health Plan (DHP) UM Case Manager and DHP Peer Clinical Reviewer perform pre-admission review and screening for appropriateness of admission and setting of care. The UM Case Managers are responsible for collecting data from the Providers' offices, Member, and/or Facility regarding anticipated length of stay and discharge planning needs.

To improve patient safety and reduce medical errors, DHP has implemented a mechanism to address potential safety and quality issues identified during prospective and concurrent review through to resolution. DHP screens authorization requests for potential safety and quality concerns including, but not limited to, contraindicated treatment, conservative treatment not addressed or ruled out, adverse drug reactions, and/or inappropriate treatment.

Prospective Review

Prospective review is the process of reviewing requests for health care services before the member's admission, stay, or other service or course of treatment. The functions of prospective review include:

a. Verification of eligibility and plan benefits;
b. Verification of medical necessity;
c. Determination of appropriate level and setting of care;
d. Determination of appropriate length of stay, if applicable;
e. Pre-certification of inpatient admissions;
f. Preauthorization of certain ambulatory services;
g. Initiation of Disease Management/Service Coordination, where applicable;
h. Authorization of specialty requests;

i. Identification of any aberrant practice patterns and submit to the CHIP/STAR/STAR Kids UM Manager or STAR Kids LTSS Manager; and
j. To ensure patient safety and report suspected issues as appropriate.

Concurrent Review
Concurrent review is the process of reviewing inpatient/observation health care services while rendered to ensure that:

a. Scheduled and unscheduled admissions are medically necessary and appropriate level and setting of care;
b. Continued stay is medically necessary;
c. Cases in which the admission is greater than twenty-one days are presented and reviewed at weekly Interdisciplinary Team (IDT) Meetings consisting of the Medical Director, Case Managers, Social Workers, and STAR Kids LTSS Service Coordination; and
d. To ensure patient safety and report suspected issues as appropriate.

In addition to the items listed above, other functions of concurrent reviews include:

a. Verify that care is coordinated among all disciplines;
b. Identify and refer problematic cases to Disease and Case management/Service Coordination;
c. Initiate timely discharge planning activities; and
d. Trigger referrals to Quality Management and Social Services.

Retrospective Review Determinations

Retrospective review is the process of reviewing appropriateness and medical necessity of health care services after delivery to the member. For retrospective review, DHP bases review determinations solely on the medical information available to the Attending Provider or Ordering Provider when he/she provided the medical care, including both inpatient and outpatient medical necessity reviews when a certification is required.

Retroactive Enrollments:
DHP will perform concurrent review of authorization requests for retroactively enrolled DHP members, if hospitalized, and remain admitted, at the time of the retroactive enrollment notification to DHP. Providers must provide written or electronic admission notification to DHP UM Department within 30 days of TMHP ADD date.

DHP will perform retrospective review of authorization requests for retroactively enrolled DHP members, if discharged at the time of the retroactive enrollment notification to DHP. Providers must provide written or electronic admission notification to DHP UM Department within 30 days of TMHP ADD date.

Time Frames for Initial Determinations

DHP shall issue a determination within the following timeframes (in compliance with state regulatory requirements) for each of the three general categories of utilization management review: prospective, concurrent, and retrospective.

Prospective Review Time Frames

- *Urgent Care*
  As soon as possible based on the clinical situation, but no later than 24 hours from receipt of a preauthorization request for a UM determination.

- *Routine/Non-Urgent*
  a. All CHIP requests submitted with complete supporting clinical information and documentation: Within two (2) business days (for approvals) and within three (3) business days (for adverse determinations) from the receipt of a preauthorization request for UM determination.

b. Non-emergent ambulance services requests for STAR/STAR Kids and all other STAR/STAR Kids requests submitted with complete supporting clinical information and documentation: Within three (3) business days from the receipt of a preauthorization request for a UM determination.
c. STAR and STAR Kids members of all ages lacking supporting clinical information and documentation: For a request for a UM determination that is lacking supporting clinical information and documentation, see the Insufficient Lack of Information Process below.

- *Life-threatening Conditions or Post-Stabilization Care*
  a. **Certification (authorization) is not required for Emergency Care.** "Emergency care" means health care services provided in a Hospital Emergency Facility or comparable Facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the Member's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:
     - Place the Member's health in serious jeopardy;
     - Result in serious impairment to bodily functions;
     - Result in serious dysfunction of a bodily organ or part;
     - Result in serious disfigurement; or
     - For a pregnant woman, result in serious jeopardy to the health of the fetus.
  b. Within one (1) hour from the receipt of a preauthorization request for a UM determination related to post-stabilization care subsequent to emergency treatment.
     - Post Stabilization: DHP will perform initial review and make a decision regarding post-stabilization care subsequent to emergency treatment within the time appropriate to the circumstances relating to the delivery of the services to the Member and the Member's condition. When denying post stabilization care subsequent to emergency treatment, DHP will provide the notice to the treating Provider or other Health Care Provider no later than one hour after the time of the preauthorization request.

Concurrent Review Time Frames

Inpatient and Observation Admissions:

Facilities are required to notify DHP within one business day of the admission for all urgent, emergent, post-stabilization, or routine inpatient admissions, regardless of level of care, unless otherwise noted within this document or on the DHP Prior Authorization Requirement website: https://driscollhealthplan.com/priorauthcheck. Refer to the Prior Authorization Requirement website for additional requirements and guidance.

DHP issues a determination of an authorization request for inpatient or observation level of care admission, with respect to a Member who is hospitalized at the time of the request, within one (1) business day of receipt of request (with all supporting documentation) or identification of a need to extend.

Requests to extend the current course of treatment:

DHP will issue a determination, if practicable, before the existing authorization expires. DHP allows for timely submission of continuation of service requests/renewal of an existing prior authorization up to 60 days before the current prior authorization expires. For some services, it is not practicable to prior authorize a new course of treatment 60 days prior to the end date of the current prior authorization period as these services may require documentation, to include assessments and provider or therapy progress notes, more recent than 60 days prior to the end date of the current prior authorization. When this occurs, DHP provides notification to the provider to resubmit the continuation of service/prior authorization recertification request, with supporting documentation, closer to the end date of the current prior authorization.

Per state regulatory requirements, when DHP receives preauthorization requests to extend a current course of treatment for cases involving urgent care at least 24 hours before the expiration of the currently certified period of treatment, DHP will issue a determination within 24 hours of receipt of the request for extension. When DHP receives preauthorization requests to extend a current course of treatment for cases involving urgent care less than 24 hours before the expiration of the currently certified period of treatment, DHP will issue a determination within one (1) business day or 72 hours (whichever is sooner).

Reductions or terminations of a previously approved course of treatment:

DHP issues the determination early enough to allow the Provider and Member to request a review and receive a decision before the reduction or termination occurs, but no longer than one (1) business day (with all supporting documentation). For termination, suspension, or reduction of a previously approved course of treatment, DHP sends notification via USPS mail and facsimile at least 15 calendar days prior to the termination, suspension, or reduction.

Retrospective Review Time Frames

DHP will issue a determination within 30 calendar days from the receipt of preauthorization request for a retrospective UM determination.

Frequency of Continued Reviews

DHP UM Case Managers or STAR Kids LTSS Service Coordinators shall conduct continued reviews for the extension of an initial determination with a frequency based solely on the severity and complexity of the patient's condition, or on necessary treatment and discharge planning activity. DHP UM Case Managers or STAR Kids LTSS Service Coordinators shall not routinely conduct such reviews on a daily basis. This applies to both inpatient and outpatient settings.

DHP reviews the clinical received from Providers or Facilities, makes a determination, and communicates to the Provider/Facility within the required determination timeframes for the type of review performed.

DHP requests Providers/Facilities report any change in admission status to DHP within one (1) business day of the status change.

Scope of Review Information

Information Utilized During Utilization Reviews

Driscoll Health Plan (DHP), when conducting routine prospective, concurrent, or retrospective review:

- Accepts information from any reasonably reliable source that will assist in the certification process including Members, Primary Care Providers (PCP), treating Providers, Consultants involved in care, or other Health Care Professionals and Facilities rendering care;
- Does not routinely request copies of all medical records on all patients reviewed;
- Requires only the section(s) of the medical record necessary in that specific case to certify medical necessity or appropriateness of the admission, length of stay or extension of stay, procedure or treatment, frequency or duration of service, or length of anticipated inability to return to work; and compliance with federal regulations specifying information required for utilization review; Documents may include, clinical and diagnostic testing, information regarding diagnoses, relevant medical history, the plan of treatment prescribed by the treating provider and the provider's justification for the plan of treatment (see the DHP Prior Authorization Requirement website: https://driscollhealthplan.com/priorauthcheck for the *Clinical Information and Documents to Support Medical Necessity* listing);
- Does not routinely require Providers or Facilities to numerically code diagnoses to be considered for certification, but may request such codes, if available;
- Administers a process to share all clinical and demographic information on individual patients among its various clinical and administrative departments that have a need to know, to avoid duplicate requests for information from Member or Provider;
- Protects Member and Provider confidentiality when obtaining or sharing medical information; and
- Requires elective services provided by non-participating providers, also known as "out-of-network" providers, be authorized in advance of the service by the UM Department or STAR Kids LTSS Department. DHP authorizes out-of-network authorizations on a limited basis. Services must be medically necessary and not available within

the network. DHP may approve services with out-of-network providers in situations where the member may have a long-standing relationship with a provider to ensure continuity of care.

Admission Notification and Clinical Submission

DHP requires admission notification within one (1) business day of admission. Facilities are required to submit clinical documentation supporting medical necessity within two (2) business days of the admission. Supporting documentation includes but is not limited to the physician's history and physical, progress notes, and orders. In some instances, vital signs, medication administration records, laboratory/imaging results, and other information may be required (see the DHP Prior Authorization Requirement website: https://driscollhealthplan.com/priorauthcheck for the *Clinical Information and Documents to Support Medical Necessity* listing).

If additional information is required related to a concurrent review or for continued stay, DHP will contact the facility. The due date of additional clinical is within one (1) business day of request. If additional information is required related to a retrospective review, facilities are required to submit requested information within three (3) business days of request.

Insufficient Lack of Information Policy and Procedures

If during the review of a preauthorization request for services, DHP determines there is no clinical information provided or the information provided with the request is insufficient, DHP shall contact the Attending Provider, Ordering Provider, or Facility rendering service via USPS letter and fax and/or phone to request needed information. The request will specify the information needed and the date the information is due to DHP. If DHP does not receive the requested information by the due date, this may result in an administrative denial for lack of information or non-certification based on lack of information.

The timeframe specified in that communication must be appropriate to the clinical circumstances of the review (that is, whether the review is prospective, concurrent, retrospective, urgent, non-urgent). Lack of information requests (excluding STAR/STAR Kids outpatient services with the exception of non-emergent ambulance services), which are prospective or concurrent routine requests, Providers are given one (1) business day to submit additional clinical information. Providers have three (3) business days to submit additional clinical information for retrospective reviews lacking clinical information.

Insufficient Lack of Information

If the preauthorization request is for a STAR or STAR Kids Member of any age, for an outpatient service (excluding non-emergent ambulance services) and is lacking information or insufficient information is provided to make a determination, the Insufficient Lack of Information Process may apply based on state regulations.

a. Within three business days from receipt of the prior authorization request, DHP sends the Requesting Provider the *Lack of Information Clinical Request Letter* describing specifically what clinical information or documentation to support medical necessity is lacking and needed in order to make a determination and provides the date when this information is due to DHP (three (3) business days from the date of the request by DHP). The Member and Rendering Provider receive a copy of this letter.
b. DHP forwards the preauthorization request to the Peer Clinical Reviewer for review of medical necessity if DHP received no information or insufficient information from the provider. This could result in a medical necessity denial due to lack of or insufficient information.
c. The Peer Clinical Reviewer will make a decision on the preauthorization request within two (2) business days from the date the request was forwarded to him/her;
d. If Peer Clinical review results in a non-certification of requested services, the Requesting and Rendering Provider receive faxed notification regarding peer-to-peer conversation reasonable opportunity. DHP allows for one (1) business day for the provider to request peer-to-peer conversation (see *Peer-to-Peer Conversation* section of this document listed above for further information related to peer-to-peer reasonable opportunity).
e. DHP enters a determination on the preauthorization, one (1) business day from the date of the Peer Clinical Reviewer decision, after completion of the peer-to-peer reasonable opportunity window.
f. For non-certification determinations, the Member will receive a written notification of non-certification letter based on state regulation requirements. Requesting Provider and Rendering Provider or Facility receive a copy of this letter.

g. The Insufficient Lack of Information Process will not exceed 10 business days/14 calendar days from date of receipt of the preauthorization request by DHP. DHP will adjust the timeline as necessary, if for example, a holiday closure will result in the preauthorization request and review process exceeding the 14-calendar daytime limit, so the preauthorization timeline does not exceed 14 calendar days.

If the Provider responds by providing more information or by communicating that there is no more information available, DHP will treat the case as though there was sufficient information upon which to base a certification decision, under the procedures outlined in this program description.

Per HHSC guidance, if DHP denies the preauthorization request for medical necessity due to lack of information, providers may either appeal the decision on the request or submit a new, complete preauthorization request.

Notifications and Letters

Notices of Initial Determinations

Certification (Authorization) Decision Notice and Tracking:

The UM Department or Population Health (STAR Kids LTSS) Department will notify the appropriate Provider(s) or Facility of certification determination (authorization) made during the utilization review process via auto-fax, direct fax, phone, and/or Provider Portal. The notification of certification will include the authorization number of the request for certification.

Driscoll Health Plan (DHP) notifies CHIP, STAR, and STAR Kids Members, or persons acting on behalf of the Member, via a mailed letter within one business day of a certification related to a preauthorization request. DHP also guides the Member to the DHP website to access this information. DHP advises all Members that they may call Customer Service at **1-877-220-6376** for CHIP/STAR, or **1-844-508-4672** (Nueces SA), or **1-844-508-4674** (Hidalgo SA) for STAR Kids for certification determination (authorization) status.

Upon request from the provider or member, the UM or Star Kids LTSS staff member issuing the notification will issue a written notification to the requesting party.

Continued Certification Decision Requirements

For continued hospitalization care or services, the certification (authorization) notification shall include the number of extended days or units of service, the next anticipated review point, the new total number of days or services approved, and the date of admission or onset of services via a fax to the Provider(s) and/or Facility.

Notice of Non-Certification Decisions

If the UM Department or Population Health (STAR Kids LTSS) Department is unable to issue a certification decision, staff will refer the case to an available Peer Clinical Reviewer. Only a Peer Clinical Reviewer may issue a non-certification (adverse determination) decision.

Adverse Determination: A determination by utilization review clinical staff that health care services provided or proposed health care services to a Member are not medically necessary or are experimental or investigational.

Written Notice of Non-Certification Decisions and Rationale

Where a Peer Clinical Reviewer issues a non-certification, he/she will assure that the specific principal reason for the non-certification is included in the written notice of non-certification. The Peer Clinical Reviewer also will document in the preauthorization the clinical rationale basis for his/her non-certification decision as well as a description of or the source of the screening criteria used.

DHP sends the written notification of non-certification letter to the Member with a copy to the Requesting Provider and Rendering Provider or Facility.

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

Driscoll Health Plan (DHP), Providers, and Facilities initiate discharge planning to facilitate the transition of the Member to the next phase of care through coordination with a multi-disciplinary team. DHP recognizes that discharge planning is a process, which requires multidisciplinary involvement to achieve the greatest success. Consequently, DHP seeks input from all Health Care Professionals such as Nurses, Physical Therapists, as well as any other ancillary staff. The DHP UM Case Managers or STAR Kids LTSS Service Coordinators work with the Attending Provider, the Member, the Member's family, and other Health Care Professionals to ensure continuity of care after discharge

The functions of discharge planning include:

a. Identifying discharge planning needs in anticipation of/or early in the hospital admission;
b. Coordinating discharge plans with multi-disciplinary team;
c. Informing and assisting the Primary Care Provider (PCP) in obtaining appropriate clinical information; and
d. Assistance in arranging implementation of post discharge service.

Providers should discuss anticipated discharge needs with the UM Department or STAR Kids LTSS Department prior to admission, or as early as possible in the admission. All admissions require authorization, with the exception of routine deliveries.
Providers and/or Facilities should call the DHP UM Department or STAR Kids LTSS Department to facilitate discharge planning for Members in the hospital. The UM Department Case Manager or LTSS Service Coordinator may help 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;
- Referrals to Community-Based Services as appropriate for STAR Kids Members; and
- For STAR Kids MDCP Members assess any change in condition and arrange for LTSS services as deemed medically necessary.

Providers and/or Facilities agree to work collaboratively with DHP's UM Department or STAR Kids LTSS Department as appropriate to communicate the members' discharge plans. Providers and/or Facilities should provide discharge plans as well as a copy of the discharge summary to DHP within two (2) business days of discharge.

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 admission required post-operatively for medical necessity or known risk factors or medical conditions requiring frequent monitoring by the nursing staff. Authorization for observation admissions is 48 hours.

In cases where a Member requires an observation admission beyond the initial 48-hour observation period, the Admitting Provider must contact the Driscoll Health Plan (DHP) UM Department for authorization for inpatient admission. If the decision to keep the patient beyond the 48-hour observation period occurs after 5 pm, the Attending Provider should contact DHP the next business day. There is a UM Department Case Manager on call available after hours if the Provider or Facility wishes to discuss the case further. Providers or Facilities can reach the Case Manager on call after 5 p.m., by calling the toll-free preauthorization number listed at the bottom of this page. The phone recording prompts direct the caller to the Case Manager/Registered Nurse on call.

Direct Urgent Admissions: Admissions that take place upon direct referral from a Provider's office or Provider directs Member to go to the hospital. The facility is required to notify DHP within 24 hours or next business day of the admission.

Emergency Admissions: 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 facility should contact the DHP's UM Department within 24 hours or next business day for authorization.

Vision Services

As of August 1, 2015, Envolve Vision of Texas (formerly OptiCare Managed Vision/AECC Total Vision Health of Texas, Inc.) administers both routine vision and medical eye care services for Driscoll Health Plan (DHP). These services are administered and payable directly by Envolve Vision of Texas.

IMPORTANT: Providers must submit claims for routine and medical eye care services performed on or after August 1, 2015, to Envolve Vision of Texas. For your convenience, plan specifics outlining the benefit information for Driscoll are located through Envolve Vision of Texas 24/7 Provider Portal, Eye Health Manager at:
https://visionbenefits.envolvehealth.com/logon.aspx

Extremely Low Birth Weight / Extreme Prematurity and Severe and/or Complex Conditions Newborn Guidelines for the Nueces Service Area

Newborns born at <29 weeks' gestation, who weigh 1000 grams or less at birth, who have congenital conditions, or who have severe and/or complex conditions are in the highest risk group and have the most specialized needs. Facilities must notify Driscoll Health Plan (DHP) UM Department within one (1) business day of the birth of an extremely low birth weight and/or extremely premature newborn, or a newborn with an obviously severe and/or complex condition.

Regional Facilities with the greatest depth of neonatal capabilities care for these newborns to provide for optimal care and outcome. The optimal time of transfer should be within the first 12 hours after birth or once stabilized but no more than three (3) days after birth. DHP may forward the following for Peer Clinical Review for exception of DHP policy:

- Stable newborns <1000 grams but equal to or >29 weeks with no co-morbid conditions such as Respiratory Distress Syndrome (RDS) requiring ventilation;
- Continuous infusions, such as vasoactive and sedative medications; or
- Severe and/or complex illnesses (congenital birth defects, deformities, grade 3 or 4 Intra-Ventricular Hemorrhage (IVH)).

CRITERIA:
A regional facility capable of caring for these newborns shall have the following capabilities:

- Ability to provide comprehensive care for extremely low birth weight infants or premature newborns with the most complex medical problems;
- Advanced respiratory support such as high-frequency ventilation and inhaled nitric oxide for as long as required;
- Continuously available, 24 hours a day, seven (7) days a week, board-certified or board eligible Neonatologists;
- A comprehensive range of Pediatric Medical Subspecialists and Pediatric Surgical Subspecialists will be immediately available to arrive on-site for face-to-face consultation and care for an urgent request within one (1) hour. These Subspecialists include but are not limited to:
    - Pediatric Surgical Subspecialist experienced in major surgeries such as ligation of patent ductus arteriosus and repair abdominal wall defects, necrotizing enterocolitis with bowel perforation, tracheoesophageal fistula and/or esophageal atresia, and myelomeningocele;
    - Neurologist;
    - Cardiologists;
    - Anesthesiologists;
    - Endocrinologists;
    - Neurosurgeons;
    - Urologists;
    - Orthopedists; and
    - Cardiothoracic surgeons
- Pediatric Radiologists who can perform advanced imaging with interpretation on urgent basis, including computed tomography, magnetic resonance imaging, and echocardiography;
- Perinatal Pathologists and related services available;
- Access to Ophthalmologists who are experienced in the diagnosis and treatment of retinopathy of prematurity and an organized program for the monitoring, treatment, and follow-up of retinopathy of prematurity;
- Respiratory Therapist with neonatal experience continuously on-site;
- A certified Lactation Consultant available for consultations;
- Perinatal education: A Registered Nurse with experience in neonatal care shall provide supervision and coordination of staff education; and
- Facilitate and provide Neonatal transport. Oscillatory ventilation is available when indicated for transport.

Until newborns are stable enough to transfer, there will be daily DHP Peer Clinical reviews.

Failure to transfer qualifying newborns after stabilization will result in authorization denial for subsequent days. DHP will not pay unauthorized days unless overturned upon appeal.

Therapy Guidelines

Providers can find guidelines for approval of therapy services (i.e., Physical Therapy, Occupational Therapy, and Speech Therapy) on the Driscoll Health Plan (DHP) website at https://driscollhealthplan.com/priorauthcheck/forms-and-checklists/.

Chiropractic Services

Chiropractic services are available for Members. Requests for Chiropractic services do not require a Provider referral but do require preauthorization. The services are limited to 12 visits for spinal subluxation only. Additional visits will require preauthorization. For preauthorization, contact the Driscoll Health Plan (DHP) UM Department via telephone or facsimile numbers listed at the bottom of this page or via the Provider Portal on the internet.

Transplant Services

Providers who are caring for Members who may be under consideration for transplant services must notify Driscoll Health Plan (DHP). DHP Case Management will become involved with this Member and follow them through the pre-transplant

and final transplantation process. DHP requires preauthorization for admission to any transplant facility. DHP will evaluate any nationally recognized facility for approval based on the medical necessity of services for the Member. For prior approval and notification of potential transplantation, contact the DHP UM Department at the phone number listed at the bottom of this page.