Health New England
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UTILIZATION MANAGEMENT

Effective Date 1/1/2021 | Revised Date 11/1/2023

The purpose of HNE's Utilization Management (UM) Program

The purpose of HNE's UM program is to assess medical necessity, enable and encourage use of contracted providers and facilitate claims payment. This involves collaborating with practitioners, members, facility staff and other providers to ensure timely and appropriate decision making and to understand and/or resolve barriers. This is accomplished through:

1. Pre-Service Review
   Review of a case or service that must be approved, in whole or in part, in advance of the member obtaining medical or behavioral health care or services. Prior authorization and pre-certification are defined as pre-service review. Pre-service review also includes confirmation of member eligibility, coverage and assessment of medical necessity. HNE will make an initial determination within two days of obtaining all information necessary to the determination. **It is the responsibility of the provider to submit complete and accurate information to HNE prior to the treatment or facility stay. Failure to submit the information in a timely manner may result in non-payment for administrative reasons.**

2. Concurrent Review
   This includes review of urgent/emergent admissions and elective admissions that were not prior approved; ongoing review of a member's inpatient stay; and review of requests for extension of the length or number of previously approved ongoing courses of treatment. Any request to extend the member's length of stay or treatment beyond the initial authorization must be reviewed and approved by HNE. HNE will make an initial determination within one day of obtaining all information necessary to the determination. **It is the responsibility of the provider to submit complete and accurate information to HNE by the last day of authorized treatment or facility stay. Failure to submit the information in a timely manner may result in non-payment for administrative reasons.**

3. Post-Service Review
   This includes review for care or services that have already been received (i.e., retrospective review). "Post-Service Review" is appropriate under defined circumstances, and we will consider when the request meets the following Health New England (HNE) retrospective review criteria.
   1. When the member has been added retrospectively to HNE after services have been provided or during a course of continuing treatment; or
   2. The member has been referred or received same day services; or
   3. The service was urgent or emergent in nature; and/or;
   4. Enrollment with HNE/eligibility and/or member benefit unable to be verified

   Otherwise, HNE will not perform a retrospective review when a claim processed for services is on file.

There may be times when a service is not approved. A denial may be due to failure to follow appropriate administrative procedures, lack of medical necessity or appropriateness, or benefit exclusion under the terms of the member's plan.

UM Review and Decision Process

All UM decisions are made in accordance with the terms of the member plan document and in a fair and consistent manner. When making a determination of coverage based on medical necessity or appropriateness, HNE will render the decision in accordance with defined UM criteria and will evaluate all relevant clinical information, including the individual member's particular health care needs and the capability of the local delivery system.

The HNE UM Decisions policies set forth the timeframes for UM decision-making and the process for notification of UM decisions. It is HNE's policy to meet both state and federal regulatory requirements as well as to meet or exceed NCQA standards and requirements. These policies are reviewed at least annually. HNE will notify providers in writing of changes or modifications to the UM program that have a substantial impact on the rights or responsibilities of the providers and the effective date of such modifications. To request a copy of HNE's UM Decisions policies, providers may call Provider Relations at (800) 842-4464, extension 5000.

Physician Reviewers

The Chief Medical Officer, Medical Director, Associate Medical Director, Associate Medical Director for Behavioral Health or an HNE pharmacist is the final decision-maker for any denial based on medical necessity or appropriateness.

UM Decisions, Criteria and Definition of Medical Necessity

The medical necessity criteria utilized by HNE in making coverage determinations are:

- Developed with input from practicing physicians national-wide or in HNE's service area
- Evidence-based and developed in accordance with the standards adopted by national accreditation organizations
- Updated annually or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice.

In applying such guidelines, HNE considers the individual health care needs of the member. HNE will notify members and providers 60 days prior to the effective date of any material changes to HNE's criteria.

Many of these medical necessity criteria sets are commercially purchased. These commercially purchased criteria sets are licensed and are the PROPRIETARY and CONFIDENTIAL property of the licensing company. HNE makes the specific portion of the criteria used available to the treating provider and the member where required by law or by applicable accreditation requirements.

HNE has also developed criteria sets for other select procedures, treatments, and services. These HNE-developed criteria are available at http://healthnewengland.org/Providers/Resources

Please note: Some HNE members are enrolled in a health benefit plan under which HNE only provides administrative services (i.e., a Self-Funded plan). In some instances, the plan sponsor/payer has reserved the right to decide certain appeals of benefit denials. In those cases, HNE must adhere to the benefit coverage determination of the plan sponsor/payer.

Appropriateness of Care Statement

It is the policy of HNE that decisions regarding patient care are made based upon medical necessity, the appropriateness of care, and the services rendered. If a service is not medically necessary or is not a covered benefit, coverage may be denied. In cases where services are covered but are not being provided, such as preventive care services and prenatal care, it is HNE's policy to encourage appropriate treatment.

Affirmative Statement Regarding Incentives

- HNE makes utilization decisions based on the appropriateness of care and service and the existence of coverage.
- There are no specific rewards to practitioners or other individuals conducting utilization review for denials of coverage or service care.
- HNE does not provide financial incentives for UM decision-makers that encourage or result in under-utilization.
- Practitioners are ensured independence and impartiality in making referral decisions that will not influence: hiring, compensation, termination, promotion, or any other similar matters.
- This statement covers any practitioner, provider, staff member, or delegate who is subject to financial incentives for UM decisions.
- This statement appears at a minimum in the HNE Provider Manual, HNE Intranet and in ALL editions of ALL HNE member newsletters.

Clinical Transition Program

HNE has established a Clinical Transition process to ensure the continuity of care for

- members new to HNE;

- members who have reached their benefit maximum for coverage;
- continuation of coverage following provider disenrollment; and
- departing members without new coverage.

If providers have questions concerning transitional coverage availability, contact Health Services by calling (413) 787-4000, extension 5027, or (800) 842-4464, extension 5027.

Inquiring about the Status of a UM Decision

Practitioners have direct access to UM staff regarding specific cases and discussion of UM decisions. In general, if a provider requests a service that requires HNE's prior authorization and would like to know its status or outcome, the provider should contact Member Services at (413) 787-4000 or (800) 842-4464, extension 5025, between 8:00 a.m. and 6:00 p.m., Monday through Friday.

Practitioners may also call HNE UM Department delegated entities directly as follows:

- High Cost Radiology and Imaging, Genetic Testing and Sleep Studies - **eviCore healthcare at (888) 693-3211**
- Chiropractic Services - **OptumHealth at (888) 676-7768**
- Pharmacy Issues - **OptumRx at (800) 282-3232**
- Medical injectable drug program - **MagellanRx Management at (800) 424-8325**
- **NICU – ProgenyHealth at (888) 832-2006**

Reconsideration of Adverse Determinations at Treating Provider's Request

A treating provider shall have an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. Said reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and the clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If the adverse determination is not reversed by the reconsideration process, the insured, or the provider on behalf of the insured, may pursue the grievance process established pursuant to MGL c. 176O. The reconsideration process allowed herein shall not be a prerequisite to the formal internal grievance process or an expedited appeal required by MGL c. 176O. Any request for a peer-to-peer discussion between the treating provider and the HNE clinical reviewer shall be treated as a request for reconsideration of an adverse determination under MGL c. 176O. HNE delegated entities shall provide such opportunity to seek reconsideration.

Arranging a Telephone Conference for a Reconsideration

To arrange a telephone conference time for a reconsideration by an HNE clinical reviewer, the requesting provider should call Health Services at (413) 233-4000, extension 3470, or (800) 842-4464, extension 3470. Health Services will obtain the relevant plan information for the case and arrange a teleconference between the requesting provider and the HNE clinical reviewer or designated clinical peer reviewer.

In-Office Denial for Medicare Members

Providers have an obligation to notify HNE of an in-office denial for Medicare Members. When a provider fully or partially denies a Medicare Advantage enrollee's referral or request, or if there is a reduction of a requested service for the enrollee, it is the responsibility of the provider to contact HNE so a written notification, including the member's appeal rights, can be sent to the enrollee.

If a Network provider furnishes a non-covered service, the enrollee must be clearly advised prior to furnishing the service of the enrollee's financial responsibility for the full cost of the service.

Medical Technology Assessment Program

The Medical Technology Assessment Committee (MTAC) is responsible for systematically evaluating new healthcare technologies, new applications of existing technologies, and new uses of existing healthcare diagnostic and therapeutic

technologies, pharmaceuticals, medical devices, and medical/surgical/behavioral health services and procedures. This process is intended to afford all members with access to safe, high quality, cost effective healthcare.

MTAC uses evidence-based information for reviews, which focus on recently developed technologies and evolving applications of established modalities, particularly those that are most relevant to the clinical care of our members. Technologies include diagnostic tests, procedures, treatments, and devices for both medical and behavioral health that have implications for patient coverage. Decisions are made by a majority vote of MTAC voting members. New technologies approved by MTAC are presented to the Clinical Care Assessment Committee (CCAC). CCAC makes the final determination on new technologies and policies.

Medical technology evaluation criteria, in general terms, include:

- Final approval from appropriate governmental regulatory bodies;
- Scientific evidence that permits conclusions concerning the beneficial effect of the technology on health outcomes;
- Evidence that the technology improves the net health outcomes while outweighing any harmful effects;
- Evidence that the technology is as beneficial and cost effective as any established alternatives that achieve a similar health outcome;
- That the improvement is attainable outside investigational settings (i.e. in a standard clinical setting) to a degree comparable in the published, scientifically derived and evidence-based investigations.

If providers have questions about this program or would like HNE to consider coverage for a new or existing technology, they should contact HNE's Process Supervisor, at (413) 787-4000, extension 3457, or (800) 842-4464, extension 3457.