2020 Utilization Management Program Overview

Introduction

Eon Health's mission is to ensure high quality health care in the right place, at the right time, in the most effective and efficient manner for our members and support them in making the best-informed decision-making process when managing their health.

Our vision is to be the best health plan, both locally and nationally, by helping our members become and stay healthy. We will achieve our vision by working with the business, government and medical communities to improve the health care experience for our members and ensure they receive the appropriate care and services.

The Utilization Management (UM) program services are designed to determine whether clinical guidelines/medical necessity criteria for coverage are met, including guidelines and criteria related to:

- the location and level of care,
- the appropriateness of the proposed treatment compared to UM criteria, and
- the requested length of stay for the course of treatment.

UM services help determine whether certain procedures and services meet the clinical guidelines and medical necessity criteria for coverage under your health plan. UM services can also help identity members for Care Management programs that may be available under their health plan.

Eon Health is committed to treating your information with care and respect and managing our utilization review program in a manner which is compliant with applicable State and Federal laws.

The Utilization Management Review Process

In most instances, the treating provider will be initiating this process. Review requests can be submitted to Eon Health by fax, mail or email. The member, the treating provider, or the facility rendering the services can call Eon Health's customer service number on the back of the insurance card for any assistance with the UM review process.

The Utilization review process includes:

- Collecting information about the member's condition from the provider. The type of information collected will depend on what is being requested. Information collected may consist of the provider's progress notes, radiology or laboratory test results, and any treatments (and the results) the member has tried that are related to the request.
- Reviewing the information provided against clinical criteria to decide of the medical necessity of services provided or requested
- Notifying all parties involved: the member (or the member's designee), the treating provider, and the facility rendering the service of the outcome of the review

Types of Reviews Performed

Prior Authorization
The review of a medical request for services such as outpatient services, elective hospitalizations, and medical procedures.

Inpatient Certification
First review performed of a medical or surgical admission after the member has been admitted.

Concurrent Review
Process of evaluating admissions and continued stay requests when a member is hospitalized.

Retrospective Review
Occurs when a review of services occurs after the service or treatment has occurred. This type of reviews applies to both outpatient and inpatient services.

Utilization Management Timeliness - How long does the UM Process takes?

The length of time it takes to conduct a review may vary by the type of request.

Standard Request

UM department processes standard request within 14 calendar days for the date of receipt as mandated by state or federal requirements.

Expedited Request

Unless otherwise mandated by state or federal requirements, UM staff process pre-service expedited requests within 72 hours from the date and time of receipt.

Medical Necessity Determinations

Medical necessity determinations are made based on information received from many sources. All cases are treated independently since they are all different.
Information needed will often include the following:

- Patient name, age, gender
- Medical history
- Diagnosis
- Progress notes, inclusive of results of pertinent testing
- Treatment plans
- Referrals, if applicable

The UM program utilizes objective evidenced based Clinical Criteria/Guidelines for approving or denying care based on clinical evidence. They include the following:

- Centers for Medicare and Medicaid Services

- National Coverage Determination (NCD)[1]
- Local Coverage Determinations (LCD)[2]

- State Medicaid Benefits (for dual-eligible members)
- MCG® Guidelines
- Plan's benefits & medical policy guidelines and criteria
- Medical informatics on new and emerging health technology

Clinical guidelines are reviewed on an annual basis, or as needed, and updates are made with input from independent physician consultants of the appropriate medical specialties when new technologies or evidence-based medicine indicate the need for revisions. Clinical guidelines are available upon request.

Behavioral Health Services

Utilization functions for behavioral health services follow the same process as general medical inclusive of out of network providers.

Utilization Key Performance Indicators

The UM department employs systematic monitoring and evaluation of the utilization management processes and services against objective criteria and tools. Utilization operational activities are monitored on the individual, team and program level.

Medical Appeals, Denials and Reconsiderations

Appeals

Appeals can be requested after a denial has been issued for a requested service. Appeals can be requested within 180 days after a denial letter is received.

Standard Appeals are done for requests that are non-urgent, or for services/treatment that has already been provided, and can be requested in writing or verbally, depending on your plan. Unless state laws or other regulatory requirements make these different, the following describes the timeframe for completing appeals:

- Standard appeal is processed within 30 days from the date a written request for appeal is received.
- Expedited appeal is processed within 72 hours from the date a written request for appeal is received.

As part of the appeals process, the member, member's authorized representative, or provider acting on behalf of the member may submit written comments, documents, or medical records pertaining to the case for the reviewer to consider. The peer reviewer considers all documentation submitted without regard as to whether such information was submitted or considered as part of the initial consideration of the case.

The reviewer for an appeal is a physician or staff not involved in the original decision; nor is the reviewer, a subordinate to the original reviewer. The appeals staff is responsible for providing notification of the appeal decision, in writing, to the member and the provider.

Denials

Notification of denials of coverage (non-certification) is rendered in writing to both the member and providers/facility. The denial notification will clearly define the following:

- The principal reason for the determination to deny coverage.
- Reference to the benefit provision, guideline, protocol or criterion on which the decision is based
- The clinical rationale used to make the determination.
- Instructions on how to request a copy of the UM criteria used
- Instructions on how to initiate an appeal

Reconsiderations

The UM policies and procedures for authorization include consulting with the requesting provider when appropriate and policies and procedures for reconsideration in the event that an adverse determination is made without an attempt to discuss such determination with the referring provider. Determinations in such cases are made within the timeframes established for initial considerations.

External Reviews

External Reviews (also known as Independent Reviews) may be available after the internal appeal process has been completed. External Reviews can be requested within four months from the date that the final, internal appeal was completed and are sent to an Independent Review Organization (IRO) for review.