7 - Utilization Management

Sierra Health & Life (SHL) defines Utilization Management as the process of evaluation and determination for appropriateness of health care services. Listed below are just a few of the functions performed by our Utilization Management System:

- Prior Authorization (Pre-service Determinations)
- Admission and Health Care Services/Telephone Advice Nurse (Patient and Provider Access Center)
- Concurrent Review
- Denials, and Appeals Process
- Retrospective Review (Post-service Determinations)

7.1 Prior Authorization (Pre-service Determinations)

**Definition:** Pre-service determinations involve cases or services that must be approved, in whole or part, in advance to member’s obtaining medical care or services. Prior authorization and precertification are pre-service claim determinations.

Prior authorization is the assessment and screening of requests for health care services from providers. The screening determines if the treatment is compatible with the diagnosis, if the member has benefits for services requested, and if the requested services are to be provided by a participating provider in an appropriate setting. This allows members’ access to cost-effective, specialized care, necessary for their medical conditions, through their primary care physician.

The Health Plan’s Prior Authorization Department is responsible for the processes of notification and prior authorization with Clinical Review for medical necessity and final determination of selected medical procedures, treatments, services or equipment.

7.2 Notification

Specialty-specific procedures, treatments and services must be processed through the Prior Authorization Department however; they do not require review by licensed personnel. The notification process includes checking eligibility, benefit coverage, and determination of appropriate site and provider. These requests are built into the computer system for provider payment purposes only. Services are to be done by designated providers and facilities. If not, prior authorization with clinical review by licensed personnel will be required.

7.3 Medical Necessity Determination

The Prior Authorization process includes checking member eligibility and benefit coverage, clinical review to determine medical necessity and determination of appropriate site and provider. Clinical review involves gathering all relevant clinical information that supports determinations of medical necessity of requests for medical treatment or services.

Nationally accepted guideline criteria, including, but not limited to; MCG, locally and nationally developed health plan criteria, and CMS and NCQA guidelines and regulations are applied based on the needs of individual members and the local delivery systems. The UM criteria
utilized in rendering a decision is available to providers on our web site at www.sierrahealthandlife.com/Provider or upon request by contacting the Prior Authorization Department at (702) 243-8499 or (800) 288-2264.

SHL also utilizes consultants from appropriate specialty areas. Consultants representing the specialties of cardiology, gastroenterology, hematology, infectious disease, nephrology, neurology, orthopedics, pediatrics, urology, etc. are used for review of individual cases when appropriate. All consultants are either board certified by one of the American Boards of Medical Specialties or other specialty certification appropriate to the practitioner’s discipline.

Prior authorization staff has the authority to approve all situations that meet criteria and to refer potential denials or questionable cases to the Medical Director for review. Only the Medical Director may issue a prior authorization denial based on medical necessity review. Notifications of denial with appeal rights are given to members in writing and to providers verbally as well as in writing.

The purpose of the prior authorization function is to ensure that every SHL member receives quality care delivered to promote wellness, through utilization of appropriate resources, in the most appropriate setting and in the most cost-effective manner. This is achieved through the evaluation and determination of the appropriateness of the member’s and practitioner’s use of medical resources prior to services being rendered and the provision of any needed assistance to health care providers and/or the member to ensure appropriate use of resources.

7.4 Services That Require Prior Authorization

Services that require prior authorization with clinical review include, but are not limited to:

- All non-plan provider services (except for physician consultations)
- Elective admissions to an Inpatient facility and extensions of stay in a Hospital or Skilled Nursing Facility
- Outpatient surgical procedures performed in a hospital or an ambulatory surgery facility
- Diagnostic and Therapeutic Services, including but not limited to: complex radiology such as CT, CTA, MRI, MRA, PET and SPECT scans; Intensity Modulated Radiation Therapy and Genetic testing
- Anesthesia Services: Anesthesia for dental procedures; pain management procedures
- Home Health Care Services including IV therapy
- Mental Health and Substance Abuse Services
- Prosthetic and Orthotic devices over $750
- Durable Medical Equipment purchases or rentals over $750
- Courses of treatment; which may include, but are not limited to: allergy testing or treatment, home health care, physiotherapy or manual manipulation, rehabilitation services (physical, speech or occupational therapies), cardiac rehabilitation and pulmonary rehabilitation

For a complete list of services that require prior authorization from SHL, please go to www.sierrahealthandlife.com/Provider and select “I Need Help With”, “Prior Authorization”. This list may be updated periodically, so please check the SHL website for the most current version.

Note: Prior authorization of urgently/emergently needed care is NOT required. However, notification of such services is expected.
The medical review process requires the member, providers and the SHL Plan to work together. All Network Providers have agreed to participate in the medical review process. SHL Plan has no agreement with Out-of-Network Providers.

A prior authorization request may be initiated by a licensed facility, physician, or other ordering provider, patient or responsible patient representative including a family member. Patient prior authorization requests should be submitted by the provider using the appropriate prior authorization request form.

### 7.5 Prior Authorization Timeframes

**Routine Requests:**

Routine requests are reviewed with a determination rendered within the timeframes required by the Department of Labor, Centers for Medicare and Medicaid Services (CMS) and Nevada Division of Healthcare Financing and Policy - Managed Care Division. If additional clinical information is needed to render a decision, the provider will be contacted by phone and/or fax to supply the necessary information.

The UM criteria that is utilized to render a decision is available to providers on our web site [www.sierrahealthandlife.com/Provider](http://www.sierrahealthandlife.com/Provider) or providers may request a copy by contacting the prior authorization department at **(702) 243-8499** or **(800) 288-2264**.

**Urgent (Expedited) Requests:**

Urgent (expedited) requests are for those services, which are related to urgent medical care conditions that have the potential to become an emergency in the absence of treatment.

Urgent (expedited) requests are reviewed with a determination rendered and provider notified within the requirements of the, the Centers for Medicare and Medicaid Services (CMS) and State Division of Healthcare Financing and Policy – Managed Care Division, which is 72 hours, although we do strive to provide the determination within one calendar day.

### 7.6 How to Obtain Prior Authorization for Services

We are committed to providing exceptional service to our members and providers. Our online provider center offers benefit and claim information, referral and prior auth submissions, and more!

All Health Plan of Nevada Inc, and Sierra Health and Life Insurance Company providers are required to submit all Routine prior authorization requests online using the [online](http://www.sierrahealthandlife.com/Provider) provider center. **STAT/Urgent (Expedited) Requests** can be submitted through the [online provider center](http://www.sierrahealthandlife.com/Provider) **Monday – Friday, 7am – 4pm PST ONLY**. Please continue to fax STAT requests on the weekends to the UM department at the numbers below.

Routine authorization requests submitted through the online provider center will be processed prior to routine fax and telephone requests and will receive a prompt turnaround.

- **Website:** via [the online provider center](http://www.sierrahealthandlife.com/Provider)
Fax:
Las Vegas area (702) 304-7411
(702) 838-8297
Toll free (800) 282-8845

Phone:
Las Vegas area (702) 243-8499
Toll free (800) 288-2264
(888) 224-4036

Note: UM Representatives are available Monday – Friday from 8:00 a.m. - 5:00 p.m. (Pacific Standard Time) to assist you.

Note: If your group is not currently set up with an online provider center Administrator account you may submit a request online via the online provider center website (www.myaysonline.com) by clicking on “Create an Account” and following the on screen instructions. The online provider center tutorials are located on the SHL website and Provider Services is available to answer any specific questions you may have regarding the application.

It is the responsibility of the requesting provider to provide pertinent case specific clinical information to support the request for medical services or treatment.

Hospital Admit Notifications and Utilization Review

Telephone Numbers (for Members in area):
Admit Notification (702) 242-7770
Concurrent Review (702) 797-2100
Toll Free (877) 487-6659

Fax Numbers (702) 667-4623
(800) 645-6941

Telephone Numbers (for Members out-of-area):
Admit Notification (800) 365-9687
Utilization Review (800) 216-7525

Fax Toll free (800) 278-8701

Business Hours: Monday – Friday, 8:00 a.m. – 5:00 p.m. Pacific Standard Time

For Hospital Admission Notification and Utilization review after hours and weekends contact the Access Center at:

Telephone Numbers:
Las Vegas area (702) 242-7770
Outside Las Vegas area (800) 288-2264

Fax (702) 242-7025
7.7 Patient and Provider Access Center
(After Hours Admission and Healthcare Services/Telephone Advice Nurse)

Understanding the importance of quick and accurate information, the SHL Admission and Healthcare Services and Telephone Advice Nurse line have joined together to develop a department specifically designed to assist members, physicians and all other providers with health care information and services.

This 24-hour information and care management system provides access to a “one-stop-shop” staffed with specially trained professionals who work to meet the service and care needs of members and providers. As liaisons, staff members are actively involved in coordinating care by assisting with admissions and healthcare services and health care triage advice to SHL members.

Staff will assist with urgent/emergent hospital admissions and after-hours prior authorization for urgent outpatient services, patient transfers and referrals for other health care services such as Home Health, Hospice, Case Management, Durable Medical Equipment and Infusion Therapy.

The Telephone Advice Nurse program provides quick, comprehensive solutions to member’s health concerns no matter what the time of day or night. Specially trained nurses are available 24 hours a day to offer simple, accurate advice regarding specific symptoms, illness or injury or simply answer member’s questions about a particular health concern. If a member does need to see a physician or visit an urgent care clinic, the nurse will direct the member to an urgent care clinic or assist scheduling an appointment.

For information and assistance from the Access Center:

**Telephone Numbers:**
- Las Vegas area: (702) 240-8775
- Toll free: (800) 288-2264
- Telephone Advice Nurse (TAN): (702) 242-7330

**Fax Numbers:**
- Las Vegas area: (702) 242 7025

**Note:** Prior authorization is **NOT** required for emergency procedures or services for screening and stabilization in cases where a prudent layperson, acting reasonably, based on presenting systems, would have believed that an emergency existed.

7.8 Inpatient Concurrent Review

At SHL, the Continuity of Care department provides initial and ongoing assessments of members receiving care in the inpatient setting in order to ensure that the member is receiving the appropriate level of care based on medical necessity. The Continuity of Care department accomplishes the assessment process with on-site and telephonic case managers who perform case reviews on all members hospitalized in an acute care facility, a rehabilitation facility or a sub acute or skilled facility. The functions of Case Management include review of medical status for appropriate length of stay and level of care, discharge planning, case management, and
referrals for ongoing post hospital care. Nationally accepted guidelines and criteria are used to make medical necessity determinations.

Only the Medical Director issues denials for continued stay. Notifications of denial with appeal rights are given to members in writing and to providers verbally as well as in writing.

SHL’s Continuity of Care Department is available 7 days a week from 8:00 a.m. – 5:00 p.m. (Pacific Standard Time) and can be reached at (702) 797-2100.

7.9 Denial and Appeal Process

Denial

A denial, or adverse determination, is the determination by a Plan Medical Director that the services requested are not medically necessary after review of the clinical information submitted with the request for services. Only a licensed physician can make utilization management denial decisions based on medical necessity. Prior authorization staff or Hospital Case Management staff communicates the denial verbally and through written correspondence to the requesting provider. The provider is informed at that time of their right to physician-to-physician communication regarding the impending denial, as well as the appeal process. During the physician to physician communication the requesting physician provides NEW or ADDITIONAL clinical information that was not originally submitted with the initial request.

No financial incentives or other types of compensation are given to UM decision-makers for the reduction or denial of services or care. Decision-making is based on appropriateness of care (medical necessity of the service, appropriateness of providers of care), eligibility of the member, benefit coverage for the service, the individual needs of the member and the availability of services within the local healthcare delivery network.

Appeal

A formal appeals process is set into action when requested by a member, his or her designee or his/her provider(s). These requests are evaluated by a Medical Director or a Physician Peer Reviewer. This physician will be in the same or similar specialty that usually provides the service being requested and will not have been involved in the initial decision to deny the requested service. On behalf of a member, a provider can appeal a denial for a specific procedure, treatment or service by contacting the Prior Authorization Department either by phone, mail or fax. Member requests to appeal a denial for a specific procedure, treatment or service are received in the Member Services Department.

For appeals, please call: (702) 243-8499 or (800) 288-2264. Additional directions will be outlined in the denial letter.

An expedited (immediate) appeal review by the health plan, for continued stay denials and denials for services that would threaten life or limb of the member if not received immediately can be requested by the member. Sierra Spectrum members also have the right for an immediate Quality Improvement Organization (QIO) review of a denial for continued hospital, skilled nursing facility or home nursing care stays.
7.10 Retrospective (Post-Service) Review

Retrospective (post-service) review is the process of assessing the appropriateness of the medical care, services, treatments and procedures, and the providers of that care, after the care has been rendered. It is normally conducted by review of the members’ medical record(s), including admitting diagnosis and presenting symptoms, as applicable.

Retrospective (post-service) review is required for:

- Emergency admissions to out-of-area or out-of-plan facilities,
- Outpatient and emergency room care received in non contracted facilities,
- Other care and services received by members when the provider of care will not cooperate with Health Plan review procedures and
- Other unauthorized care.

Medical Adjudication Department Nurses, who are a part of the Claims department, conduct all reviews using the MCG, Medicare or health plan protocols to review cases. This process can take up to 30 days. Only the Medical Director can issue denial decisions based on medical necessity of services.