

Function: Medical Management Program Policy		Policy No: FCHN.MM.11	Page 1 of 5
Subject: Clinical Review Determination - Certification			
Date Originated:	Review Date(s)	Revision Date(s)	Approved by MAC:
9/2002	9/2002, 1/2003, 3/2004, 8/2004, 3/2005, 3/2006, 2/2007, 3/2008, 5/2008, 3/2009, 3/2010, 3/2011, 2/2012	3/2005, 3/2006, 6/9/08, 3/31/10, 4/6/11, 9/22/11, 4/1/12	10/2002, 3/2003, 3/2004, 3/2005, 3/2006, 3/2007, 3/2008, 6/3/08, 3/17/09, 3/23/10, 3/15/11, 3/13/12

PURPOSE:

To provide a standard for First Choice Health (FCH) certification processes of prospective requests, to ensure that specific services provided to FCH participants are consistent with the Group’s Summary Plan document, and meet criteria for medical necessity and appropriateness of care.

DEFINITIONS:

See Medical Management Policy FCHN.MM.16 Definitions for definitions of terms used in this policy.

POLICY:

FCH has established standards for pre-certification by the FCH Medical Management staff in order to assure quality of care and appropriate utilization of healthcare services. From the FCH perspective, clinical review determination indicates the care was reviewed and certified by the staff of the Medical Management Department of FCH and meets either urgent care, prospective, concurrent care or retrospective review criteria for medical necessity and appropriateness of care. Participants and providers will be notified of all determinations.

Clinical review determinations are individually reviewed and numerically tracked based solely on the medical information obtained by FCH at the time of the review determination. For retrospective review, determinations are based solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

Clinical staff will be available, by telephone or in person, to discuss review determinations with attending physicians or other ordering providers. Clinical staff will utilize approved clinical review criteria as outlined in Medical Management policy FCHN.MM.09 Clinical Criteria.

Certification letters are sent to the participant and also when requested by the provider and facility, and in accordance with HIPAA privacy standards. Certification letters include the service requested and the certification reference number.

FCH does not reverse certification decisions unless it has received new information that is relevant to the certification and that was not available at the time of the original certification.

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PROCEDURE:

Initial service request:

1. Pre-certification information may be transmitted by telephone, fax, mail, email or on-line at www.fchn.com, within parameters defined for privacy standards as set forth by HIPAA, with the following information provided:
 - Patient Identification (identification number, patient and subscriber name, date of birth)
 - Provider Identification (primary care provider, PCP, referral provider, including phone number)
 - Payor/Group Identification (Payor and group name or number)
 - Diagnosis description(s) or codes
 - Procedure and/or visit description(s) or codes (if available)
 - Clinical information if available at time of request

2. The FCH Intake Coordinator will refer to the Groups’ Pre-certification Lists and Auth required Rules within the on-line authorization system (Bridge). Requests that do not meet the Group’s contract language are forwarded to the appropriate claims administrator.

3. Collected information will be entered into appropriate computer systems and at this time it is determined if the request is of an urgent nature. If urgent, the request is forwarded to clinical staff for immediate processing per established timelines.

4. To process the request, the clinical staff will review the member’s summary plan document, apply the appropriate clinical criteria and when necessary forward to the Medical Director for review. UM/CM RNs may approve a clinical request based on approved criteria (see policy FCHN.MM.09 Clinical Criteria)

5. When an initial service request is completed by either the Intake Coordinator or the Clinical Staff, this disclaimer is given for PPO line of business service: “Certification of this request is not a guarantee of payment. Please contact the insurance company to verify benefits and eligibility at the time of service. Do you need the telephone number?” For TPA lines of business, this disclaimer is given: “Certification of this request is not a guarantee of payment. Please contact your customer service department to verify eligibility and benefits now or at the time of service, may I transfer you?”

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- Notification of the decision to certify will be provided verbally to the requesting provider and in writing to the participant within the established timelines. Notification may be forwarded to the participant; the participant’s attending physician or other ordering provider, the facility rendering service, and/or the Payor.

Prospective Timelines

Urgent Prospective Review

A determination and verbal notification will be issued as soon as possible based on the clinical situation, but in no case later than 72 hours from the receipt of the initial request. Written notification will follow. (See letter for timelines)

Non-urgent Prospective Review

A determination and verbal notification will be issued as soon as possible based on the clinical situation, but no later than 5 calendar days of receipt of the initial request except when the review is sent for a peer – clinical review at an external review organization and it would be completed within 15 calendar days.

If Additional Information is required the member has up to 45 calendar days from the written receipt of notification of insufficient information to respond to request for additional information.

Note: FCHN policy does not allow a 15 calendar day extension for the initial review.

Concurrent

A determination and verbal notification will be issued within 24 hours of request when complete clinical information is received at least 24 hours before expiration of the currently certified period, or within 72 hours of the request if complete clinical information is received less than 24 hours before expiration of current certification period.

Verbal notification of the determination will include the date of admission, the number of extended days, the next review date, and the new total number of days approved. Written notification will not be forwarded.

Retrospective Review – UM Review

A determination and verbal notification will be issued based on the clinical situation, but in no case later than 30 calendar days of the receipt of request.

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Note: If patient information is unavailable for the provider to obtain preauthorization or to notify within the required admission notification timeframes, FCH will review retrospectively those cases with extenuating circumstances where preauthorization or admission notification is required.

If Additional Information is required the member has up to 45 calendar days from the written receipt of notification of insufficient information to respond to request for additional information.

Note: FCHN policy does not allow a 15 calendar day extension.

Retrospective Review – Clinical Claims Review

A determination will be communicated to TPA Operations via the claims notes in Diamond, within 30 calendar days of the receipt of request in Medical Management. Processing with notification is the responsibility of TPA Operations.

Note: Typically member notification occurs via the Explanation of Benefits (EOB) and provider notification via the Remittance Advice (RA).

RELATED POLICIES AND PROCEDURES:

- FCHN.MM.01 Appropriate Professionals
- FCHN.MM.04 Medical Information
- FCHN.MM.07 Inpatient Medical Management
- FCHN.MM.09 Clinical Criteria
- FCHN.MM.12 Clinical Review Determination – Incomplete/Additional Information
- FCHN.MM.13 Clinical Review Determination – Non-certification
- UM-02 UM Precertification Process Desktop

REFERENCES

- Core 3.0 Standard 16 - PHI
- HUM 7.0 Standard 1 - Review Criteria Requirements
- HUM 7.0 Standard 17 - Prospective Review Timeframes
- HUM 7.0 Standard 18 - Retrospective Review Timeframes
- HUM 7.0 Standard 19 - Concurrent Review Time Frames
- HUM 7.0 Standard 20 - Certification Decision Notice and Tracking
- HUM 7.0 Standard 21 - Continued Certification Decision Requirements
- HUM 7.0 Standard 25 - Reversal of Certification Determinations
- HUM 7.0 Standard 30 - Lack of Information Policy and Procedure

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ATTACHMENTS:

MM Clinical Review Form

Att.MM.11a Template letter - PPO Notice of Certification