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**Overview**

WellCare's Utilization Management (UM) Program is designed to meet contractual requirements with the Ohio Department of Job & Family Services (ODJFS) and provide members access to high-quality, cost-effective and medically-necessary care while ensuring prompt and accurate payment to providers.

The focus of the UM Program is on:

- Evaluating requests for services by determining the medical necessity, efficiency, appropriateness and consistency with the member's diagnosis and level of care required;
- Providing access to medically-appropriate, cost-effective health care services in a culturally sensitive manner and facilitating timely communication of clinical information among providers;
- Reducing overall health care expenditures by developing and implementing programs that encourage preventive health care behaviors and member partnership;
- Facilitating communication and partnerships among members, families, providers, delegated entities and the Plan in an effort to enhance cooperation and appropriate utilization of health care services;
- Reviewing, revising and developing medical coverage policies to ensure members have appropriate access to new and emerging technology; and
- Enhancing the coordination and minimizing barriers in the delivery of behavioral health and medical health care services.

*Medically necessary or medical necessity* means health care services that a health care provider, exercising prudent clinical judgment, would provide to a patient and are necessary for the diagnosis or treatment of disease, illness

or injury, without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part or significant pain and discomfort.

A medically-necessary service must:

- Meet generally accepted standards of medical practice;
- Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;
- Be appropriate to the intensity of service and level of setting;
- Provide unique, essential and appropriate information when used for diagnostic purposes;
- Be the lowest cost alternative that effectively addresses and treats the medical problem; and
- Meet general principles regarding reimbursement for Medicaid covered services found in rule 5101:3-1-02 of Ohio Administrative Code.

Mental Health services shall be provided in accordance with:

- A process of mental health assessment that accurately determines the clinical condition of the member;
- The acceptable standard of practice for such clinical conditions; and
- The inclusion of distinct criteria for children and adults.

Preventive health care, though not customarily thought of as a medically-necessary service, is available through the Early Periodic Screening, Diagnosis and Treatment (EPSDT), also known as the Healthchek program.

#### **Plan Criteria for UM Decisions**

The Plan's UM department utilizes various criteria, which may include the following, when making coverage determinations:

- Member benefits
- Medical necessity
- InterQual™
- Local and federal statutes and laws
- Medicaid/Medicare guidelines
- WellCare Clinical Coverage Guidelines
- Hayes Health Technology Assessment

#### **Prior Authorization, Pre-certification and Referral Procedures**

The Plan shall:

- Not require prior authorization or pre-certification for emergency services, or post-stabilization services, as referenced in the **Quick Reference Guide**;
- Require prior authorization and/or pre-certification for all non-emergency inpatient and outpatient admissions except for normal newborn deliveries as referenced within the **Quick Reference Guide**;
- Require prior authorization and/or pre-certification for all non-emergent, out-of-network services, as referenced in the **Quick Reference Guide**;
- Conduct prior authorization and pre-certification reviews by a currently licensed, registered or certified health care professional who is appropriately trained in the principles, procedures and standards of utilization review;
- Notify the provider of prior authorization determinations in accordance with predetermined time frames;
- Require that members obtain a referral from their PCP prior to accessing non-emergency specialized services or as identified within specific provider contracts except for specialists to which members may self-refer.

#### **Service Authorization Forms**

The Inpatient, Outpatient or Ancillary Services Authorization Request form must be completed by the provider in order to obtain an authorization from the Plan. Copies of these forms are included in the **Forms** section of this manual.

- Forms must be filled out completely and legibly in order to be processed quickly;
- A current and operating fax number with area code must be included in order to receive an authorization number;
- If an office does not have a fax machine, contact Outpatient Services at the telephone number listed on the **Quick Reference Guide**.

#### **Services Requiring Referrals and Authorizations**

For specific instructions on services requiring a Plan authorization and/or a referral, refer to the **Quick Reference Guide** or visit the WellCare of Ohio Web site at [ohio.wellcare.com](http://ohio.wellcare.com).

#### **Process of Requesting an Authorization**

Providers may request a routine in-network or out-of-network authorization by:

- Faxing an Authorization/Certification Request form to the Plan, at least 14 calendar days prior to the start of the service or procedure.

#### **Service Authorization Decisions**

Providers may request immediate consideration for services that if delayed, could affect the member's health or functional capabilities and should be performed as soon as possible by:

- Calling Outpatient Services (have the member's name and ID number available when calling).

For **Initial Determinations**, the Plan will make a determination within 14 calendar days following the receipt of the request for service.

All pharmacy prior authorizations for medications to be administered to members in a physician's office, hospital inpatient or outpatient department, clinic, dialysis center or infusion center must be completed no later than the end of the second working day or as expeditiously as the member's condition warrants. All pharmacy service authorizations are completed in the Pharmacy department, not the Health Services/Utilization Management department.

The provider will be notified by telephone, fax, or through our Web site within two business days of making the initial determination. The provider and member will be notified of any decision to reduce, suspend, terminate or deny a service authorization request or a decision to authorize a service in amount, duration or scope that is less than requested.

For **Concurrent Review Determinations** (extended stay or additional services), the Plan will make the determination within three business days\* of obtaining all necessary information.

*\*Necessary information includes the results of any face-to-face clinical evaluation or second opinion that may be required.*

The provider and member will be notified by telephone, fax or through our Web site within two business days of making the determination.

Members and providers may file a verbal or written request for an **expedited authorization decision**. To file a verbal or written request please contact the Utilization Management department by telephone. Please refer to the **Quick Reference Guide** for contact information.

The Plan will document the verbal request in writing. Specifically state, "I would like an expedited decision," or "I believe that my health/the health of my patient could be seriously harmed by waiting the 14 days for a standard decision."

If a provider indicates, or the MCP determines that following the standard authorization time frame could seriously

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jeopardize the member's life or health or ability to attain, maintain or regain maximum function, the MCP must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than three working days after receipt of the request for service.

If requested by the member or MCP, expedited authorization decisions may be extended up to 14 additional calendar days. If requested by the MCP, the MCP must submit to ODJFS for prior-approval, documentation as to how the extension is in the member's interest. If ODJFS approves the MCP's extension request, the MCP must give the member written notice of the reason for the decision to extend the time frame and inform the member of the right to file a grievance if he or she disagrees with that decision. The MCP must carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

Service authorization decisions not reached within the time frames specified in paragraphs (A)(7)(c)(v) and (A)(7)(c)(vi) of this rule constitute a denial, and the MCPs must give notice to the member as specified in paragraph (B)(2)(d) of rule 5101:3-26-08.4 of the Administrative Code.

It is the provider's responsibility to respond as quickly as possible to any requests for further information as requested from the Plan. Non-receipt of essential information may cause a denial of requested services.

If the decision is to deny a service request, the Plan will send a written denial notification that provides the following:

- The utilization review criteria or covered benefits provision used in the adverse determination;
- The specific reason(s) for denial;
- The member's or authorized representative's right to file an appeal;
- The member's right to request a state hearing, if applicable;

- Procedures for exercising the member's rights to appeal or grieve the action;
- Circumstances under which expedited resolution is available and how to request it;
- Suggest a level of service that is covered under the member's benefit plan, when appropriate;
- Identify the physician who rendered the adverse determination; and
- The date the notice is being issued.

All medical claims are subject to retrospective review by WellCare.

**Concurrent Review**

The Plan's concurrent review involves oversight of members admitted to hospitals, rehabilitation centers, skilled nursing facilities and other inpatient settings. The concurrent review nurse follows the clinical status of the member on an ongoing basis through telephonic or faxed chart review, communication with the physicians and/or other health care professionals involved in the member's care.

The concurrent review process incorporates the use of nationally recognized standards of medical practice, InterQual™ guidelines and when appropriate, determinations will also include consideration of relevant and appropriate psychosocial factors.

Licensed nurses perform reviews under the direction of the Plan medical director. Admission and/or continued stay denials are determined by the medical director.

**Discharge Planning**

Discharge planning is an essential part of the concurrent review process. It may include coordinating services required to assist in arranging for and implementing a member's transition to a more appropriate or lower level of care, as needed.

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The concurrent review nurse coordinates services with the Primary Care Provider, attending physician and/or the discharge planning personnel at the hospital. Coordination of discharge planning activities should be implemented upon the member's admission to the hospital or other health care facility.

**Emergency/  
Urgent/Post  
Stabilization  
Care**

Emergency services are available to members 24 hours a day, seven days a week to treat an emergency medical condition.

Emergency and post-stabilization services and care do not require prior authorization. Members are instructed, in case of an emergency, to call **911** or proceed to the nearest hospital emergency room. Members should notify their PCP as soon as possible following emergency treatment in order to receive appropriate follow-up care.

WellCare has an Emergency department diversion program that is described in the **Care Management** section of this manual.

Once the member's condition is stabilized, the Plan may require pre-certification for hospital admission or prior authorization for follow-up care.

**Transition  
of Members**

For members enrolling in the Plan, the Plan will honor written documentation of prior authorization of ongoing covered services. WellCare will cover pre-authorized services for 90 calendar days after the effective date of enrollment.

**Second  
Medical  
Opinion**

Members may request a second medical opinion concerning surgical procedures or serious injury or illness. The member may choose a qualified physician that is participating with the Plan. If a qualified physician is not available within the Plan, the PCP must obtain prior authorization for the member to obtain a second medical opinion outside the network, at no cost to the member.

It is the responsibility of the PCP to coordinate tests ordered as a result of a second opinion with participating providers and develop a treatment plan for the member after review of the second medical opinion.

#### **After-Hours Utilization Management**

WellCare offers 24-hour utilization management to assist physicians and facilities with inpatient admissions and after-hours discharge planning. Providers needing after-hours assistance should refer to their **Quick Reference Guide** for the appropriate telephone number.

#### **Request for Ancillary Services**

Requests for ancillary services require the provider to complete an Authorization/Certification Request Form, as identified within the **Quick Reference Guide**. Also see the **Forms** section of this manual.

The additional information needed for each service is outlined below.

#### **Home Health Care**

1. Initial Home Health Care request:

- Medical reason for the home health service;
- MD prescription with the type of skilled service, frequency and duration;
- Meet Home Care Dependent status\*
- Name of participating/in-network home health provider.

2. Continuation of Home Health Care request:

- Complete home health evaluation note and most recent home health progress summary note;
- Meet Home Care Dependent status\*

3. Home Infusion Therapy and IV Drug request<sup>†</sup>:

- Drug name;
- Dosage;
- Frequency and duration;
- Type of access IV line;

- Mode of delivery (gravity or pump);
  - If member received this IV drug before;
  - Available caregiver to teach and train.
4. Home Wound Care and Wound Care Supplies request:
- Wound location;
  - Dimensions;
  - Necrotic tissue;
  - Viable tissue;
  - Drainage;
  - Odor;
  - Surrounding tissue;
  - Skin condition.

*\*Home Care Dependent means an individual who resides in a private home or other non-institutional and unlicensed living arrangement, without the presence of a parent or guardian, but has health and safety needs that require the provision of regularly scheduled home care services to remain in the home or other living arrangement because one of the following is the case: (1) The individual is at least 21 years of age but less than 60 years of age and has a physical disability or mental impairment. (2) The individual is 60 years of age or older, regardless of whether the individual has a physical disability or mental impairment.*

*†Home Infusion therapy and IV drugs administered in a patient's residence are covered by the Ohio Medicaid fee-for-service pharmacy benefit. The home health care visit is covered by WellCare under the medical benefit.*

### **Durable Medical Equipment**

1. Home Oxygen Therapy:
- Most recent ABG PO<sub>2</sub> rate of 55 percent or lower, Pulse Oximetry saturation rate of 88 percent or lower;
  - Flow rate, frequency and duration;
  - Delivery device and type of system.

2. Continuous Positive Air Way Device (CPAP, Bi-PAP):
  - Most recent polysomnogram narrative results with and without titration
3. Manual Wheelchairs and Accessories:
  - Most recent functional mobility status report (non-ambulatory, ability to self-propel etc.)
  - Height and weight;
  - Any specific body characteristic or limitations that need to be accommodated in the wheelchair by an extra optional device.
4. Electric Wheelchairs, Electric Scooters and Accessories:
  - Same information as manual wheelchair;
  - Upper body limitations that prevent the effective use of a manual wheelchair (i.e. inability to move upper extremities or severe reduction in movement).
5. Hospital Bed and Accessories:
  - Medically necessary bed positioning not feasible on a regular bed;
  - Height and weight;
  - Special needs to be accommodated by an optional device.
6. Orthotic and Prosthetic Devices:
  - Covered HCPCS code for the orthotic or prosthetic item.

**Outpatient Therapy**

1. Initial Outpatient Therapy requests:
  - Medical reason for the skilled therapy service;
  - Specific type of skilled therapy service;

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- MD prescription with frequency and duration;
  - Name of participating / in-network free-standing center.
2. Continuation of Outpatient Therapy requests:
- Complete initial therapy evaluation and progress summary notes with objective, measurable, clinical findings and updated goals;
  - MD prescription with frequency and duration.

**Delegated Entities**

All participating providers or entities delegated for utilization management shall apply the same standards as defined in this section. Compliance of delegated entities is monitored on a monthly basis and formal audits are conducted annually.

**Contact Information**

Refer to the **Quick Reference Guide** for telephone and fax numbers for the Utilization Management department.