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| **Policy Name** | Utilization Management Program- Notification of Non-Behavioral Health Utilization management Determinations (**Texas HMO**) |
| **Policy #** | 483A.01 |
| **Department** | Utilization Management |
| **Subcategory** | Operations |
| **Original Issue Date** | 06/30/2021 |
| **Committee Approval Date** | 06/30/2021 |
| **Effective Date** | 06/30/2021 |

**Company Entities Supported (Select All that Apply):**
__ Superior Vision Benefit Management
__ Superior Vision Services
__ Superior Vision of New Jersey, Inc.
_X_ Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
___ Davis Vision
(Collectively referred to as 'Versant Health' or 'the Company')

| **DEFINITIONS**: | |
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| **Term** | **Definition** |
| Organization Determination | An organization determination is any determination (i.e., an approval or denial) made by the Medicare health plan, or its delegated entity |
| Medically Necessary Services | Medically necessary services are healthcare services that are needed in order to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms based on evidenced-based clinical standards of care. The services must also meet criteria supplied by the health plan or national coverage determinations and/or local coverage determinations. |
| Prior Authorization | A form of prospective utilization review by a payer or its Utilization Review Agent of health care services proposed to be provided to an member |
| Concurrent Review | A service request/or materials that has an identified need for ongoing treatment. |
| Reconsideration | An member's first step in the appeal process after an adverse organization determination; a Medicare health plan or independent review entity |

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| | may reevaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained. |
| LCD | **L**ocal **C**overage **D**etermination |
| NCD | **N**ational **C**overage **D**etermination |
| Retrospective/Post Service Reviews | Retrospective/Post Service review involves services that have previously been rendered. The Company does not conduct retrospective reviews for services covered under its plans unless otherwise directed by a plan. |
| Representative | An individual appointed by a member or other party, or authorized under State or other applicable law, to act on behalf of a member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of an member or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process |
| Peer Review | Evaluation or review of colleague performance by professionals with similar types and degrees of expertise (e.g., evaluation of a physician's credentials and practice by another physician). |
| Authorization Representative | A trained non-licensed professional from Versant Health who is responsible for intake screening, data input and collection, non-clinical review and customer service and notification functions for prior authorization requests. |
| Clinical Reviewer | A licensed Doctor of Optometry from Versant Health serves as the Clinical Reviewer for organization determinations. The Optometrist is authorized to review and approve requests; however, if the request is found to not meet medical necessity, the Optometrist must forward the request to the Ophthalmologist for review and disposition. |
| Medical Director | A licensed Ophthalmologist from Versant Health serves as the Medical Director responsible for making organizational determinations. The Medical Director is authorized to render adverse determinations for requests submitted to Versant Health by all providers/practitioners. |
| Designee | A person authorized by the insured to assist in obtaining access to, or payment to, the insured for health care services |
| Utilization Management | Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed assistance to clinicians or patients, in cooperation with other parties, to ensure appropriate use of resources. |

**POLICY:**

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| Utilization Review | A review to determine whether health care services that have been provided, are being provided, or are proposed to be provided, to a patient, whether undertaken prior to, concurrent with or subsequent to the delivery of such services are medically necessary. |
| Initial Adverse Determination | Initial determination made by Utilization Review Department for a denial of a service authorization request on the basis that the requested service is not medically necessary or an approval of a service authorization in an amount, duration or scope is less than requested. |
| Complaint | A dispute or objection by a member regarding a health care provider/practitioner, or the coverage (including contract exclusions and non-covered benefits), operations or management policies of a managed care plan. |
| Grievance | A request by a member, or a health care provider/practitioner with the consent of the member, to have Versant health reconsider a decision solely concerning the medical necessity and appropriateness of a health care service. A grievance includes a decision that does any of the following:<br>• Disapproves full or partial payment for a requested health service<br>• Approves the provision of a requested health care service for a lesser scope or duration than requested<br>• Disapproves payment of the provision of a requested health care service, but approves payment for the provision of an alternative health care service.<br>*A Grievance does not include a Complaint* |

**PURPOSE**:

The purpose of this policy is to ensure health plan members and providers receive timely notification of non-behavioral health utilization management determinations.

**SCOPE**:

Texas HMO

**Policy**:

It is Versant Health's policy to review medically necessary and/or medical surgical prior authorization requests that are made by health plan members, the health plan, or a provider/practitioner on a member's behalf. Versant Health utilizes a systematic review process to determine the medical necessity, as applicable, to the requested services.

An eye care provider, PCP, member, or health plan notifies Versant Health's Utilization Management Department of a request for authorization for services. Members may also initiate requests for covered services.

Since routine vision and eye care services are limited to a frequency chosen by the client, most inquiries received by the Company are administrative eligibility questions. Administrative determinations are based solely on whether or not the member has an available benefit. No review is conducted to determine medical necessity and no denial will be made due to lack of clinical documentation.

Members may request an authorization for an in plan exception (also known as "out of network" exception) when a member believes network providers are unavailable or inadequate to meet the member's medical needs.

Some benefit plans include additional coverage for enhanced contact lens benefits. For benefit plans offering enhanced coverage, the Company reviews these requests to determine if the request meets established Company criteria. Based on clinical practice guidelines from the American Optometric Association (AOA) and the practice pattern guidelines of the American Academy of Ophthalmology, contact lenses may be determined to meet established criteria and appropriate in the treatment of the following nine (6) conditions:

- Keratoconus
- Aphakia
- Anisometropia
- High Ametropia (Progressive/Pathological Myopia/Hyperopia)
- Aniridia
- Irregular Astigmatism

Utilization Review is conducted to determine the following:

- The member is eligible for services
- The provider/practitioner is a participating provider/practitioner in the Versant Health network and the client's panel of providers
- The services under review are covered under the member's benefit plan
- The services being requested meet the required criteria for coverage; e.g., *change in prescription*
- The medical necessity of the requested service

**Process**

- Versant Health can receive request either through direct phone calls, emails or via fax.

- Versant Health's prior authorization representative enters the prior-authorization request into the utilization management system according to operational workflow, ensuring that the identified member is enrolled and eligible for the requested service. Should the member no longer be eligible for the requested service, the prior authorization representative contacts the requesting provider/practitioner via telephone or email to make them aware of status of eligibility.

- Request is reviewed for completeness.
    a. If there is missing information to be able to review request for medical necessity, the prior authorization representative will request additional information, following the timeframes and notification requirements of the member's plan

    b. Verbal attempt to obtain missing information will be made, followed up by written request for information

        i. Telephone;
        ii. Fax;
        iii. E-mail; and/or
        iv. Standard or overnight mail with certified return receipt

    c. A minimum of three (3) attempts are made to obtain additional information, in accordance with established plan specific time frames, prior to reviewing the request as submitted.

    d. Prior authorization representatives document each outreach to the provider/practitioner to obtain additional information by including the methods of communication in the utilization management system

        i. A specific description of the required information
        ii. Name, phone #, fax #, email and mailing address of contact (practitioner, plan, etc.)
        iii. Date and time of each request supported by date/time stamps call record, fax transmissions or emails.

The request for clinical information is limited to medical records and shall not include requests for mental health practitioners' progress or therapy notes prohibition extends to requiring an oral, electronic, facsimile, or written submission or rendition of a mental health therapist's process or progress notes "relate to the mental health therapist's treatment of an enrollee's mental or emotional condition or disorder. If additional information is required to

make a determination, the prior authorization representative will notify the health care provider/practitioner within 2 two-calendar days from the receipt of the request.

- "This prohibition does not preclude the Clinical Reviewer or Medical Director from requiring submission of:

    a. an enrollee's mental health medical record summary; or

    b. medical records or process or progress notes that relate to treatment of conditions or disorders other than a mental or emotional condition or disorder."

    c. Non-Clinical and non-licensed personnel may not obtain verbal or written information directly from a physician or other health care provider regarding the member's specific medical condition, diagnosis, or treatment options. Any information provided directly by a physician or other health care provider will be received by a licensed clinical professional of the same specialty.

- The prior authorization representative forwards all requests to the licensed healthcare professional, as per workflow, to review request for medical necessity. All reviews and documentation of decisions are completed in the authorization record of the utilization management system.

    a. Optometrists (Clinical Reviewer) serve as first level clinical review and review requests to determine medical necessity using evidence based criteria. Clinical Reviewers may render medical necessity approvals; however, if the request does not meet medical necessity, the Clinical Reviewer is required to forward the request to an Ophthalmologist (Medical Director) for review and disposition.
    b. Medical Directors review requests that do not meet medical necessity per evidenced based criteria and render medical necessity denials. A Medical Director can also serve as a first level reviewer, as needed.

- Medical necessity is determined by either CMS criterion (see CMS hierarchy) or health plan services criteria.
    a. CMS requires the use of published Medicare criteria or Plan criteria, in the following order of preference:

        i. Plan Eligibility and Coverage
        ii. CMS Criteria
        iii. National Coverage Determination (NCD)
        iv. Local Coverage Determination (LCD)
        v. Local Coverage Medical Policy Article
        vi. Medicare Benefit Policy Manual

vii. Health Plan criteria (e.g. Coverage Summary, Medical Policy)
viii. Evidence based criteria
ix. Other evidence-based resources such as Hayes or evidence based literature.

- Once a decision is rendered by either the Clinical Reviewer or Medical Director the request is forwarded back to the prior authorization representative to outreach and notify the member and the requesting and performing provider/practitioner of the disposition of the requested service.

    a. Denials – Urgent and Non-Urgent: verbal and written notification to member, individual acting on behalf of the member and the requesting and performing provider/practitioner. Member and the provider/practitioner are advised on appeal rights, and the provider/practitioner is advised of the right to a Peer Review. If a Peer Review is requested, the prior authorization representative follows the Peer to Peer policy/workflows.
    b. Company will maintain and submit upon request documentation that details the communication of peer to peer discussion opportunity prior to the issuing of adverse determination written notice. Such tracking and reporting will include date and time and outcome of any discussion that took place.
    c. Approvals – Urgent and Non-Urgent: written notification to member, individual acting on behalf of the member and the requesting and performing provider/practitioner

- The Company will make the established criteria list available to providers upon request along with the complete and exact preauthorization provisions, service types and timeframes no later than the 10th business day after the date a request is made. The criteria and the complete process description can also be found in the Company Provider Manual.

**Notification of Utilization Review Determinations**

The Company provides written notice of an adverse determination (Initial Adverse Determination) to the member, the member's designee and the health care provider including:

- A description of the Action that the Company has taken or plans to take
- Specific use of the terms "medical necessity" or "experimental or investigational"
- The reasons for the determination including the clinical rationale, if any, and its applicability to the member's specific clinical condition
- A reference to the guideline, protocol, contract, and/or specific plan provision upon which the determination was made, or other criteria used to make the determination
- A statement that the clinical review criteria used to make the determination is available free of charge to the member upon request

- A description of any additional information necessary to perfect the claim and an explanation of why the information is needed
- A statement that the provider has the right to discuss the adverse determination with a clinical peer reviewer
- A statement that the provider has the right to a utilization review reconsideration if the determination was made without discussion with the requesting practitioner
- A statement that this notice constitutes the Initial Adverse Determination
- Instructions for initiating Standard and Expedited Action Appeals
- A statement that the member may apply for an External Appeal within 30 days of receipt of the Final Adverse Determination
- For a member who has a life-threatening condition, the notice will include a description of the member's right to an immediate review by an independent review organization and of the procedures to obtain that review.
- For a member who is denied the provision of prescription drugs or intravenous infusions for which the member is receiving benefits under the health insurance policy, the notice will include a description of the member's right to an immediate review by an independent review organization and of the procedures to obtain that review.

A description of the member's Action Appeal (or a Complaint as Appeal) Rights including:

- A statement that the Company will not retaliate or take any discriminatory action against the member because he/she filed an appeal
- The right of the member to designate a representative to file an Appeal on his/her behalf
- The right of the member to submit written comments, documents or other information relevant to the Appeal
- The process and timeframe for filing an Action Appeal with the Company, including an explanation that an Expedited Action Appeal can be requested if a delay would significantly increase the risk to the member's health
- The procedures for appealing an adverse determination includes that the adverse determination may be appealed orally or in writing by the enrollee, a person acting on behalf of the enrollee and the enrollee's physician or other health care provider
- the Company's toll-free number for filing an oral Action Appeal
- The timeframe within which the Action Appeal Determination will be made

A statement that oral interpretation and alternate formats of written material for members with special needs are available and the process for accessing them.

**Confidentiality**

The URA preserves the confidentiality of all individual medical records to the extend required by law (Section 4201.551)

*Table 1*

**Timeframes for Determination and Notification**

| Category | Urgency | Determination/Notification Timeframes |
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| Pre-Service/Prospective | Standard | Determinations and written notice to the member, the member's designee and the requesting and performing provider/practitioner by telephone and in writing as fast as the member's condition requires but no greater than the 2nd business day after the date of the request and the URA receives all information necessary to complete the review.<br><br>Determinations are made within 3 business days after the decision has been rendered. |
| Pre-Service | Urgent (Expedited) | As fast as member's condition requires within 72 hours from receipt of service request. Additionally, if denied, the Company will make reasonable efforts to provide prompt oral notice of the denial to the member and will send written notice of the denial within 24 hours of the denial determination. |
| Post Stabilization treatment or a life-threatening condition | Standard | The Company will issue and transmit a determination indicating whether proposed services are preauthorized within the time appropriate to the circumstances relating to the delivery of the services and the condition of the member, but in no case to exceed one (1) hour from receipt of the request. If the request is received outside of the Company normal business hours, the determination will be issued and transmitted within one (1) hour from the beginning of the next business day. The determination must be provided to the provider of record.<br><br>If the Company issues an adverse determination in response to a request for post-stabilization treatment or a request for treatment involving a life-threatening condition, the Company must provide to the member or individual acting on behalf of the member, and the member's provider of record, the notification of how to file an appeal or request an independent review.<br><br>The Company will provide notice of an adverse determination for a concurrent review of the provision of prescription drugs or intravenous infusions for which the patient is receiving health benefits under the health insurance policy not later than the 30th day before the |

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| | | date on which the provision of prescription drugs or intravenous infusions will be discontinued. |
| Retrospective | Standard | The Company will provide notice of an adverse determination under the retrospective utilization review in writing to the provider of record and the patient within a reasonable period, but not later than 30 calendar days after the date on which the claim is received.<br><br>• The period may be extended once by the utilization review agent for a period not to exceed 15 days, if the utilization review agent<br>  ○ determines that an extension is necessary due to matters beyond the utilization review agent's control; and<br>  ○ notifies the provider of record and the patient before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the utilization review agent expects to make a determination.<br><br>• If the extension is required because of the failure of the provider of record or the patient to submit information necessary to reach a determination on the request, the notice of extension must:<br>  ○ specifically describe the required information necessary to complete the request; and<br>  ○ give the provider of record and the patient at least 45 days from the date of receipt of the notice of extension to provide the specified information.<br><br>• If the period for making the determination is extended because of the failure of the provider of record or the patient to submit the information necessary to make the determination, the period for making the determination is tolled from the date on which the utilization review agent sends the notification of the extension to the provider of record or the patient until the earlier of<br>  ○ the date on which the provider of record or the patient responds to the request for additional information; or |

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| | | ○ the date by which the specified information was to have been submitted. |

**For Texas there are no extensions of statutory and regulatory time frame requirements for prospective and concurrent utilization review. The Company must issue notification with the information available at the time within which the Company must issue determination. The notification will include all required elements and be issued to all required parties within deadlines.*

**DISCLAIMER, LIMITATIONS AND EXCLUSIONS**:

Policy applies to Texas HMO

| **RELATED POLICIES AND PROCEDURES** | |
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| **Policy Number** | **Policy Name** |
| 407A.02 | Handling of Emergency Services |
| 414A.02 | Confidentiality and UM Non-Incentives |
| 420A.05 | Peer to Peer Review |

| **REVISION HISTORY:** | | |
|---|---|---|
| ***Date*** | ***Revision*** | ***Version*** |
| 6/24/2021 | Updated into current format, assigned new ID and version number, previous Audit Control Number: 405.00 | 0.01 |

**Compliance Source(s):**

NCQA 2021 UM Standards 5-7

- 28 TAC Section 19.1709(b)
- 28 TAC Section 19.1709(d)
- U.S. Department of Health and Human Services in 45 C.F.R. §162.1102, (relating to Standards for Health Care Claims or Equivalent Encounter Information Transaction)
- Insurance Code §4201.304
- 28 TAC Section 19.1709(e)
- 14 TAC Chapter 4201