COPE HEALTH SOLUTIONS

Understanding Utilization Management, Part I: The Basics

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Utilization Management (UM) is employed by payers and by providers in global risk with UM delegation to ensure that patients get the right care at the right time in the right place in a cost-effective manner while maintaining high quality patient care and services. Many UM programs have recently come under fire because of the administrative impact the process has on health care providers due to a burdensome process many of these groups employ to get a process approved. In addition, many have noted the delays created by the same process in attaining needed care for patients.

It is for this reason that understanding the core principles of UM has become even more important so that your organization can provide an effective program that achieves the goals outlined above, while reducing the administrative burden on those seeking approvals and ensuring a timely turn around that does not negatively impact the diagnosis and treatment of patients.

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Definitions:

Utilization Management: The process by which an organization reviews the use of medical services and resources to ensure they are medically necessary, are performed in the most appropriate care setting and are at or above quality standards.

Utilization Review: The process used to evaluate the services or resources requested.

Prior Authorization: The process of examining the need for a requested service or resource for appropriateness of setting, procedures and treatment. It may also be for using services outside of the network or for other clinical resources that fall under management of a high-cost service or medication.

Medical Necessity: The services that a physician, exercising prudent clinical judgement, would provide or prescribe for a patient. The services must be for:

- Treatment of an illness, injury, disease or its symptoms
- In accordance with generally accepted standards of medical practice
  - Based on scientific evidence published in peer-reviewed literature
  - Physician specialty society recommendations
  - The perspective of other physicians practicing in relevant clinical areas
- Clinically appropriate and effective for the patient's illness, injury or disease
- Not primarily for the convenience of the patient, provider
- Not more costly than an alternative service or sequence of services likely to produce equivalent results

Concurrent Review: The process used in following patient care and services provided during an inpatient hospital or post-acute facility stay.

Retrospective Review: The process used to review a medical record after a patient has been discharged from a facility to assess the care and quality provided, as well as to review any questionable billing that may have been received by the payer entity.

Discharge Planning: The process of assessing the patients needs after discharge from an inpatient facility stay to ensure a smooth transition to the next stage of the care continuum. This program ensures that services are in place before the discharge to ensure the patient's safe and timely move and ongoing care.

It is important to note that while the terms are often used interchangeably, Utilization Management is a prospective process of planning a patients care before and during the provision of services, while Utilization Review is more of a retrospective review of what happened during the care provided to the patient.

New CMS Final Rule for Part D and Medicare Advantage Programs for 2024

These are effective June 5, 2023 and applicable for coverage January 1, 2024

1. MA Plans must maintain the same access to medically necessary care for members as they would have under traditional Medicare. They must use the same National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) as well as general coverage and benefits included in traditional Medicare.
   - If there are no coverage criteria established, the plan may use internal criteria based on current evidence in widely used treatment guidelines found in the literature that is publicly available to CMS and members
2. Prior Authorization (PA) Policies may only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that a service is medically necessary. The plan must permit a 90 day transition plan when a member enrolls in a new MA plan, during which time no Prior Authorization may be required for any active treatment course
   - The plan must consider the individual patient's personal circumstances and clinical presentation when making coverage determinations
3. MA plans must establish a Utilization Management Committee to review all UM polices, PA programs and policies annually and make certain they are consistent with coverage requirements and coverage under traditional Medicare.
   - The Committee must be chaired by the health plan Medical director and must consist of a majority of practicing physicians, at least one who is independent and conflict free relative to the plan, and a physician with expertise in geriatric care
4. Any full or partial adverse determination based on medical necessity must be made by a physician or other appropriate health care professional with expertise in the same or similar area of specialty and aware of traditional Medicare coverage, before any determination is released
5. Effective January 1, 2024, physician ordered site of service must be honored by the plan
6. No plan may retroactively deny an approved, medically necessary service

Please feel free to reach out to COPE Health Solutions at info@copehealthsolutions.com or call 213-259-0245 if you are thinking about reviewing and optimizing your current UM program or developing a UM program to support success with risk based agreements.

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