Population Health Management

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At a Glance

The MedStar Population Health Management department is responsible for managing healthcare resources for MedStar Medicare Choice Health Plan (Medicare Choice). Our goal is to provide you with the support you need to most effectively care for your members.

The Population Health Management department is your resource for ensuring your members get the most appropriate level of care, coordinating their care and providing additional resources as needed.

This department will, if applicable:

- Review and authorize certain procedures when deemed medically necessary. A list of these procedures can be found on the Quick Reference Guide at **www.MedStarProviderNetwork.com**
- Review and authorize appropriate out-of-network and out-of-area care, including transition of care and member transfers from out-of-network facilities
- Offer Care Advising services through the Personal Approach to Health (PATH) programs
- Administer member and provider surveys and assessments

Questions regarding Population Health Management resources can be directed to Medical Management at **855-242-4875,** Monday through Friday, 8 a.m. to 5 p.m., EST.

Procedures Requiring Prior Authorization

The Utilization Management (UM) department carries out the review of select services to promote high-quality, cost-effective and medically appropriate care for Medicare Choice.

Prior authorization is the process that the department uses to review specific procedures, treatments and devices to determine whether the coverage of a request will be approved or denied.

Please refer to the Quick Reference Guide for a list of procedures that require prior authorization. It is available online at **www.MedStarProviderNetwork.com.** If you would like a hard copy of the Quick Reference Guide mailed to you, please email Provider Relations at **MFC-ProviderRelations2@medstar.net**.

Medical policies outlining items, services and procedures utilized for review for prior authorization can be found at **www.MedStarProviderNetwork.com.** Clinical criteria or the benefit provision on which a decision has been based will be sent upon request. If a provider wishes to ask for a prior authorization or pre-determination review, a written request must be faxed to Prior Authorization at **855-431-8762.**

To initiate a prior authorization, the provider is asked to complete a prior authorization form and submit it to the fax number at the top of the form with any pertinent medical records to support the request. This information could include medical records, lab results or other diagnostic studies.

If coverage is not approved, the provider may appeal the decision by filing an appeal. The appeal process is outlined in the Provider Standards and Procedures section of this Provider Manual.

Please note, to obtain prior authorization for medications covered under the medical benefit, please call 855-266-0712.

How to Contact or Notify Medical Management

Providers can contact the Medical Management department for questions or to request a review for prior authorization. This department can be reached at **855-242-4875,** Monday through Friday, 8 a.m. to 5 p.m. EST.

When to Notify Medical Management

Medicare Choice providers must contact the Medical Management department to

- Obtain coverage for services requiring prior authorization
- Notify the plan of an admission to acute care hospitals, skilled nursing facilities, rehabilitation facilities and long-term acute care centers. This enables the department to identify members' special needs and coordinate their care. In some cases, clinical staff may work with the provider to facilitate care at an alternate setting that can most appropriately meet the needs of the member.

Utilization Management

The MedStar Population Health Management team develops and oversees the design and implementation of the Utilization Management (UM) program. The success of the program relies on the support by the providers in our network.

Program Goals

The following are goals of the UM program:

- To provide high quality, medically necessary and affordable healthcare services to our members through a qualified network of providers who are systematically selected and retained through the credentialing and performance appraisal process
- To maintain a health plan model that empowers the provider to make medical decisions, supports a medical home model and enables the provider to proactively manage the care of our members
- To coordinate preventive care, wellness efforts and chronic Care Advising, ensuring efforts are focused on the member
- To respect and value the confidentiality, safety and dignity of all members
- To verify that the UM program is in compliance with any and all applicable requirements of federal and state regulators and accrediting bodies
- To meet the guiding principles of the Triple Aim:
    - OUTCOME: improve the health of our members
    - SERVICE: enhance the member experience
    - EFFICIENCY: control the cost of health care

Qualification and Training

Appropriately licensed, qualified health professionals supervise the utilization management process and are involved in all medical necessity decisions. A physician or other appropriate healthcare professional with an unrestricted license performs all medical necessity denials of healthcare services offered under the plan's benefits.

Medical Directors

The medical director oversees every aspect of the UM program, including medical necessity review. Any requests that do not meet medical necessity are forwarded to the medical director for review and determinations are made based on medical necessity.

Utilization Management Review Staff

The UM staff and their activities are an integral component of the UM department. Their work supports activities across the continuum of care, including optimal outcomes and continuity of care and strives to manage care within the benefits of our members.

The primary function of the UM staff is to review and verify medical necessity for requests in the following categories:

- Prospective review /prior authorization of services
- Out-of-network services
- Transition of care
- Concurrent review of continued stay or ongoing services
- Discharge planning
- Case management referrals

- Retrospective (post-service) review of services

The UM department reports UM activity and uses this data to fine tune the utilization program.

All utilization review decisions are based only on appropriateness of care, service, existence of coverage and the setting of the covered service. Please note:

- We do not use financial incentives in conjunction with our UM program
- We do not reward doctors who conduct utilization review for issuing denials of coverage or service
- We do not offer financial incentives to UM decision makers that encourage decisions resulting in underutilization

Inter-rater Reliability

At least annually, our clinical leadership assesses the consistency with which physicians and UM RN Care Advisors apply UM criteria in decision making. The assessment is performed as a periodic review using InterQual® assessment sets to ensure consistent use of criteria in clinical decision making and ensure consistency.

Provider Access to Criteria and Other Pertinent Policies

Each contracted provider will have access to this Provider Manual, a Quick Reference Guide, a comprehensive orientation to the health plan programs and information about how, and when, to interact with the health plan. This information has been posted online at **www.MedStarProviderNetwork.com.**

Program Methods/Utilization Management Process

The UM process includes the following: after-hours service, referrals, prior authorization, pre-determination, concurrent review, ambulatory care, post-service review, discharge planning, case management/complex case management and care coordination. All services must be medically necessary to be approved. The clinical decision process begins when a request for authorization of service is received. Request types may include authorization of specialty services, skilled/rehab services, outpatient services, ancillary services, scheduled inpatient services and/or notification of emergent/urgent inpatient services. The process is complete when the requesting provider has been notified of the determination in writing.

Concurrent Review

Concurrent review is the review of the medical necessity of an inpatient stay, including extended stays or additional healthcare services required in the course of treatment. Concurrent review is performed by an Inpatient Care Advisor (ICA) or UM RN during the same time frame that care is provided to the member.

The inpatient concurrent review process begins with the UM staff, who will work with the clinical team to

- Assess the clinical status of the member
- Verify the need for continued hospitalization
- Facilitate the implementation of the provider's plan of care
- Consider the need for referral to Care Advising
- Promote timeliness of care
- Determine the appropriateness of the treatment rendered

- Determine the appropriateness of the level of care
- Monitor the quality of care to verify that professional standards of care are met

Information assessed during the review includes
- Clinical information to support the appropriateness and level of service proposed
- Whether the diagnosis is the same or changed
- Assessment of the clinical status of the member to determine special requirements to facilitate a safe discharge to another level of care
- Additional days/service/procedures proposed
- Reasons for extension

If at any time services cease to meet criteria, discharge criteria are met and/or alternative safe level of care options exist, the UM manager will notify the facility to see if additional information is available to justify the continuation of services. If the medical necessity for the case cannot be determined, or if there are potential quality issues, the case is referred to the medical director for review. The need for Care Advising or discharge planning services is assessed early after admission. Each concurrent review thereafter will meet the objective of planning for the most appropriate and cost-effective alternative to inpatient care. Potential quality of care issues will be promptly referred to the Complaints and Grievances department for investigation and resolution.

Inpatient Discharge Planning

Discharge planning facilitates coordinated, cost-effective care that minimizes the chance of readmission by arranging for the appropriate services upon discharge from the hospital. For members who have not fully recovered, or do not require the highly specialized services of acute hospital care, discharge planning can facilitate a safe discharge with additional healthcare services, such as home health care or appropriate placement in an extended care facility.

Discharge planning should occur as early as possible during a member's hospital stay. Prior to discharge, the Inpatient Care Advisor reviews the post-hospital needs of the member with the UM/UR staff of the hospital and arranges for follow-up/outpatient services.

Referral to Care Advising

The Inpatient Care Advisor should assess the need for Care Advisor intervention by considering the criteria outlined in the Personal Approach to Health (PATH) section.

Post-Service (Retrospective) Reviews

A retrospective review is offered on a case-by-case basis for medical necessity after the services have been provided to determine whether services were delivered as prescribed and were consistent with payment policies and procedures.

Identification of Post-Service Review

The medical review process begins by reviewing clinical data/medical records and/ or contacting the appropriate nurse/physician. Instances in which a post-service decision may be required:
- Out of area utilization
- Unplanned discharge
- Late notification of the hospitalization of a member who remains hospitalized

Obtaining Pertinent Information

The medical review process begins when the review staff examines clinical information from the medical record, hospital/utilization review nurse and referring/attending physician. The utilization review staff obtains relevant information to

- Verify that the proposed service is a covered benefit under that member's policy
- Assess the medical necessity of the care provided
- Assess the appropriate level of care

Adverse Decision/Determination

A denial of services is also called an adverse determination. An adverse determination means that an admission, extension of stay or other healthcare service has been reviewed and, based upon the information provided, the healthcare service does not meet the requirements for benefit payment under plan policy, contract or agreement, and coverage is therefore denied, reduced or terminated. Failure to make a medical necessity determination and notification with the required timeframes, may be considered an Adverse Benefit Determination for the purposes of initiating an appeal. Adverse decisions also include ending or discontinuing coverage that has a retroactive effect except when the coverage is discontinued as the result of failure to make timely payments toward the coverage.

Adverse determinations will be communicated in writing to the member and/or treating/attending provider. The notification shall be easily understandable and will include the specific reason/rationale for the determination and specific language outlining the criteria used to make this determination. Furthermore, the denial letter will inform the member (and provider, as applicable) of his/her ability to request this criteria, as well as instructions on how to file an appeal.

Verbal notification of an adverse determination is provided to the treating provider, the attending physician or primary care physician if the attending physician is unknown, and the facility. The Inpatient Care Advisor advises that the admission did not meet medical necessity.

Please note: The resubmission of a corrected claim due to a minor error or omission is not an appeal. Corrections or resubmissions of claims due to minor errors or omissions should be sent to the customary claim address. See the Administrative Appeal section below.

Appeal of Utilization Management Decisions

See the Provider Standards and Procedures section of this Provider Manual for more information regarding appeals.

Program Evaluation

Regulatory Compliance and Process

The UM program is evaluated on a minimum annual basis, and modifications are made as necessary. The program is evaluated by using

- The results of member satisfaction surveys and/or member complaint, grievance and appeal data
- Provider complaint and provider satisfaction surveys
- Relevant UM data
- Provider profiling
- Over- and under-utilization

Over- and Under-Utilization

Poor quality of care can be the result of either under- or over-utilization of services. Monitoring under-utilization is integral to the health management programs and specifically relative to services that assess the current state of the member's clinical condition such as medication refills and routine testing. Over-utilization is assessed in the ambulatory setting through a review and analysis of diagnostic, laboratory and pharmacy services, and in the inpatient setting through review of compliance with guidelines for admission and appropriateness of discharge planning. Occurrences of "never events" and hospital-acquired conditions are monitored and managed as a potential quality of care case. Results are trended for improvement opportunities.

The evaluation covers all aspects of the UM program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UM Committee for review, action and follow-up. The final document is then submitted to the governing body for approval.

Satisfaction with Utilization Management

Annually, Medicare Choice Population Health Management will evaluate both member and provider satisfaction with the UM process through the following: provider satisfaction survey results, member/provider complaints and appeals and feedback from members/providers. If the results indicate that there are areas of dissatisfaction, Medicare Choice Population Health Management will develop action plans to improve the areas of concern that may include staff retraining and member/provider education.

Personal Approach to Health (PATH)

The PATH model aims to improve people's lives through a collaborative, multidisciplinary Care Advising approach. The goals of the PATH approach are to improve the quality of care, enhance the member's experience and reduce the total cost of care by appropriately utilizing scarce medical resources. The Care Advising team consists of personnel including medical director leadership along with nurses, trained medical assistants, social workers, dietitians and pharmacists. The Care Advising team works with PCPs, specialists and home care agencies among others to coordinate follow-up care and support adherence to provider-developed care and treatment plans.

Here is a list of some programs available for Medicare Choice members. Specific programs may only be applicable to certain members depending on plan choice:

- Complex Care
- Condition Care
- Emergent Care
- Transition Care
- Catastrophic Care

Medicare Choice may introduce additional Care Advising programs in the near future. Please check back for updates on additional programs available to Medicare Choice members.

How can you refer a member for Care Advising programs?
Providers may refer a member for Care Advising programs or ask questions about the programs by calling Medical Management at **855-242-4875**. Representatives are available Monday through Friday, from 8 a.m. to 5 p.m. Additional information on the health management programs can be found in the provider section of the Medicare Choice website at **www.MedStarProviderNetwork.com**.

Complex Care

Sponsored by Medicare Choice, specially trained Registered Nurse Care Advisors assist members with needs spanning various aspects of social services and the medical community. The program consists of mutually reinforcing components, and its goal is to better prepare members under Care Advising for self-management. The intent of the program is to enhance the member and provider experience through a collaborative, multidisciplinary Care Advising approach to improve the quality of outcomes while avoiding unnecessary utilization.

This program focuses on the Triple Aim:
- Improving the experience of care
- Improving the health of populations
- Reducing the total cost of health care

The Complex Care program is a collaborative initiative that engages a multidisciplinary care team consisting of Care Advising staff, contracted physicians and providers including contracted network hospitals and other relevant stakeholders (community services, home care, durable medical equipment, behavioral health, etc.). The program includes

collaboration with acute care hospitals, nursing, social services, medical staff, pharmacy, ED and quality departments. The program focuses on members identified through a combination of claims data, as well as referrals from providers, members and caregivers.

Program Goals

- Improve care coordination for members across care settings
- Optimize chronic Care Advising
- Educate members about diagnoses and self-management
- Implement care plans for high-risk members and members with complex care needs
- Improve medication compliance
- Address member/caregiver needs regarding adequate support and resources at home
- Improve adherence to the hospital discharge care plan for members discharged to home
- Decrease “avoidable” utilization events (e.g., readmissions)

Program Methods

Complex Care focuses on impacting a complex member population with multiple chronic conditions and high rates of medical services utilization. The Care Advising team includes a regional medical director along with nurse Care Advisors, social workers, dietitians and pharmacists. The team will provide physician office, telephonic and when appropriate, in-home assessment and proactive intervention of members identified for Care Advising outreach. The Care Advising team will work with the PCPs, specialists and home care agencies (including home hospice) to coordinate follow-up care and promote adherence to care and treatment plans.

How are complex members identified?

Members with complex needs are identified through a variety of sources, including

- PCP/physician referral
- Claims or encounter data related to use of the services, types of providers seen and cost of care
- Pharmacy data, when available
- Hospital discharge data or information collected through UM processes, including precertification requests, concurrent reviews, prior authorization reviews and reviews of hospital admission and readmission data

Members can also be referred to Complex Care through

- Healthcare providers
- UM staff
- Member, family or other caregivers; self-referral
- Ancillary providers, behavioral health providers or behavioral health managed care organizations, pharmacists, the Medication Therapy Management program, disability management programs, other internal departments, employer groups or staff from community agencies

What services are provided?

The Care Advisor works with the member and his/her care team to best assist the member after assessing the situation, intensity of the need for healthcare services, level of services needed, care coordination, education and support. Coordination of the care plan with the treating practitioner will occur where appropriate.

Specific assistance offered:

- An evaluation of the member's cultural and linguistic needs, preferences or limitations
- An evaluation of the member's caregiver resources that are in place to support him or her with appropriate care and decision making
- An evaluation of available benefits and associated financial burdens, as well as what may be needed to support the member's treatment plan and identified needs
- Development of a shared care plan that
    - Addresses the identified needs
    - Includes long- and short-term goals
    - Establishes a time frame for re-evaluation
    - Identifies resources to be used and at what level of care
- Provides a continuity of care plan and determines the assistance that is needed and uses a collaborative approach that identifies who will be included, such as family, practitioner, pharmacist or community-based services
- Identification of barriers to the member's ability to meet goals or comply with the plan, which includes such factors as poor compliance to a treatment plan, lack of understanding, not ready to make a change, financial hardships, poor supports, transportation issues or fragmented care
- Helping the member to develop a self-management plan that may include how he or she will monitor the disease, use a practitioner-provided symptom response plan, comply with prescribed medications and attend practitioner visits
- Following the member's progress against the care plan that was developed for the member, including progress toward overcoming identified barriers, any adjustments to the care plan and following the self-management plan
- Coordination of care for multiple services, including inpatient, outpatient and ancillary services
- Facilitating access to care
- Establishing a safe and adequate support system through interactions with the member and/or applicable caregivers

Condition Care

The Condition Care program is an important component of Medicare Choice's effort to improve members' health by providing intensive Care Advising for members with specific chronic illnesses.

The goals of the program are to improve clinical outcomes and quality of life. The program is structured to identify members with chronic conditions, conduct outreach, assess members' needs, develop a coordinated care plan that is created with the members' input and monitor the members' progress with that plan. An assessment of members' medical and behavioral health and compliance status, use of self-monitoring tools, as well as their understanding of the condition is completed to determine areas for focused education or care coordination. All interventions are aimed at increasing the members' knowledge of their condition and improving their ability to manage their disease. A specialized team of Care Advisors, in collaboration with the members' providers, works to accomplish these goals through member education, coordination of care and timely treatment.

In addition, these programs provide help for members to manage their chronic illnesses through preventive practices and adherence to their treatment plans. Specific focus is made on closing gaps in care, both preventative and chronic disease related. Health management

programs also help form connections with community support groups and agencies.

Emergent Care

The research literature has described many opportunities to provide an improved experience as member's progress through the healthcare continuum. The purpose of Emergent Care is to improve care coordination, reduce fragmentation of care and improve the member experience while avoiding inappropriate utilization and managing medical costs. Members are considered for Emergent Care when they frequently use emergency department or urgent care for non-urgent or emergent conditions.

The goals of the Emergent Care program are to

- Identify members who are receiving frequent or uncoordinated care in emergency departments or urgent care centers
- Assess members' unique needs and develop a shared action plan
- Connect or reconnect these members with appropriate care providers, including but not limited to, primary care practices, specialty care, behavioral health and community resources
- Follow up with members over time to see if there are additional needs and/or refer them to other Care Advising programs

Transition Care

The Transition Care program's goal is to provide members with the tools necessary to get and stay well especially during the critical period after a hospital admission. Transition Care helps members decrease their chances of being readmitted to the hospital after they have been discharged.

Identifying Participants

Members will be identified to participate in Transition Care using health plan utilization management referrals, admission/discharge/transfer feeds or facility census reports. Members will be prioritized for outreach based on their clinical presentation/condition, recent utilization events and the presence of targeted chronic conditions. Members who meet the specific criteria as high risk for readmission will be noted as high priority.

Interventions of the Program

Eligible members who have been prioritized for outreach will receive a personalized Transition Care Advisor who will work closely with the member and his or her care team (both inpatient and ambulatory). The Care Advisor's main objectives are to

- Help to proactively identify members who are at high risk for readmission based on clinical, social and psychological/behavioral factors
- Help to activate and educate the members on their conditions and potential pitfalls
- Review the members discharge plan and identify potential barriers
- Ensure appropriate post-discharge follow-up
- Make sure that care is coordinated after discharge between primary care, specialists and others (e.g., home health, infusion)
- When appropriate, conduct basic medication reconciliation sometimes in conjunction with clinical pharmacy services
- Develop a post-discharge plan of care that includes contingency planning in case the member develops new or worsening symptoms

Catastrophic Care

The focus of the Catastrophic Care program is to manage and support members and caregivers in instances where a member experiences a significant, potentially life-changing diagnosis (i.e., closed head injury, malignant cancer, degenerative neurological diseases, etc.). The primary goal of the Catastrophic Care program is

- Support the implementation of the member's specialist's treatment plan to prevent readmissions
- Reduce unnecessary ER visits
- Manage the member's pain and remove barriers that may prevent them or their caregiver from adhering to the treatment plan
- Transition the member to the least restrictive setting.

Multidisciplinary Team

The Catastrophic Care program coordinates services for members with catastrophic and intensive needs using a multidisciplinary care team led by the member's PCP and specialist and overseen by a primary Registered Nurse (RN) Care Advisor (CA). Our team-based model focuses on optimizing the health of the member utilizing the broad skills of the PCP, RN CA, Registered Dietitian CA, social worker CA and the pharmacist CA to develop and implement personalized care plans for each eligible member.

The team focuses on the comprehensive needs of the member and caregiver, incorporating their physical and behavioral health status, personal preferences and confidence level and current lifestyle risks. Psycho-social, cognitive and functional disabilities, transportation and economic barriers that may impede health and adherence to the treatment plan are also addressed. The care team then considers the member's health plan benefits and local community and government agency resources that may provide services to improve the health and well-being of the member.

Program Goals and Objectives:

- Immediately identify catastrophic and highly intensive cases through the utilization management process, member self-referral, provider referral and medical and pharmacy claims
- Facilitate safe care transitions
- Honor the member's preferences for care
- Partner with the member, their caregiver and their primary and specialty care providers to develop a personalized plan of care in the least restrictive setting;
- Improve medication adherence
- Address member/caregiver needs related to adequate support and resources at home
- Coordinate a comprehensive community-based and home healthcare network of services
- Facilitate appropriate communication across the entire care team
- Optimize chronic Care Advising and close relevant gaps in evidence-based care
- Educate members about diagnoses and self-management
- Lower total medical expenses by avoiding readmissions, ER visits, duplicative and unwarranted services and specialist costs through coordinating care during acute, intensive care episodes

Clinical and Preventive Health Care Guidelines

Medicare Choice strongly endorses the value of clinical practice guidelines. The Medicare Choice Quality Improvement Committee (QIC) is responsible for the development and ongoing review of these guidelines. The QIC also assists Medicare Choice with monitoring adherence to practice guidelines and identifying opportunities for improvement when non-adherence is found.

Medicare Choice reviews all practice guidelines annually and updates them as needed to reflect changes in recent scientific evidence or technology.

These guidelines may include

- Adult cholesterol management
- Attention deficit/hyperactivity disorder
- Depression
- Diabetes mellitus health management guidelines
- Evaluation and management of heart failure—outpatient
- Management of asthma in infants, young children and adults
- Management of hypertension
- Prenatal care guidelines

If applicable, Medicare Choice annually reviews and updates a schedule of pediatric (birth to age 19) and adult (ages 19 and older) preventive health guidelines. Medicare Choice encourages its providers to follow these guidelines to reduce variation in care, prevent illness and improve members' health.

Medicare Choice continues to add and revise guidelines. To see the most current clinical and preventive healthcare guidelines, please visit **www.MedStarProviderNetwork.com** or call Provider Services at **855-222-1042** for a hard copy. Provider Services representatives are available Monday through Friday, 8 a.m. to 5 p.m.

Member and Provider Surveys and Assessments

Health Assessment Survey

In accordance with the Centers for Medicare & Medicaid Services' guidelines, Medicare Choice performs a health assessment survey for all new Medicare Choice members to determine their clinical risk for developing chronic illness. This tool assesses the member's clinical status and any psychological, emotional or environmental issues that may affect his or her health. This information assists in identifying high-risk members for enrollment in case and health management programs.

Member and Provider Satisfaction Surveys

Medicare Choice conducts annual surveys of member (patient) and provider satisfaction. Participation by members and providers enables Medicare Choice to develop quality improvement plans.

The surveys assess

- Access to care and/or services
- Overall satisfaction with the health plan
- Provider availability
- Quality of care received
- Responsiveness to administrative processes
- Responsiveness to inquiries

Provider Performance Tracking

Medicare Choice is continuously analyzing and identifying best practices and areas of improvement regarding quality of care and cost-effectiveness. Only providers with a predetermined minimum number of Medicare Choice members may have clinical profiles developed. These individual profiles compare providers to the performance of all other providers within their specialty and against national benchmarks. The profiles may be distributed to providers on a semiannual basis.

Quality Improvement Program

The goal of the Quality Improvement program is to continually examine clinical and administrative operations in an effort to improve Medicare Choice's ability to deliver high-quality, timely, safe and cost-effective healthcare services.

The Quality Improvement program operates in accordance with the guidelines established by the National Committee for Quality Assurance (NCQA) and the Centers for Medicare & Medicaid Services (CMS).

The program critically assesses Medicare Choice's performance regarding customer service, provider satisfaction, credentialing, pharmacy, preventive services, resource utilization and various healthcare initiatives.

At the center of the program are the providers who serve on the Quality Improvement Committee (QIC). The QIC, representing physicians and administrative leadership, operates directly under the auspices of the board of directors. The QIC is vital to Medicare Choice because it develops and evaluates clinical and operational standards for providers.

The Provider Agreement requires providers to comply with the Medicare Choice Quality Improvement program. To obtain additional information, providers may go online to **www.MedStarProviderNetwork.com** or call Provider Services at **855-222-1042**, Monday through Friday, 8 a.m. to 5 p.m.

Health Plan Definitions

Medical Necessity
Services or supplies are determined to be medically necessary if they are

- Commonly recognized throughout the provider's specialty as appropriate for the diagnosis and/or treatment of the member's condition, illness, disease or injury
- Provided in accordance with the standards of good medical practice and consistent with scientifically based guidelines of medical, research or healthcare coverage organizations or governmental agencies that are accepted by Medicare Choice
- Reasonably expected to improve an individual's condition or level of functioning
- In conformity, at the time of treatment, with medical management criteria/guidelines adopted by Medicare Choice or its designee
- Provided not only as a convenience or comfort measure or to improve physical appearance
- Rendered in the most cost-efficient manner and setting appropriate for the delivery of the health service

MedStar Medical Management reserves the right to determine in its sole judgment whether a service meets these criteria and will be authorized for payment. Authorization for payment decisions shall be made by MedStar Medical Management with input from the member's PCP or another provider performing the service.

Independent consultation with a provider other than the PCP or attending physician may be obtained at the discretion of MedStar Medical Management. The fact that a physician or other healthcare provider may order, prescribe, recommend or approve a service, supply or therapeutic regimen does not, of itself, determine medical necessity and appropriateness or make such a service, supply or treatment a covered service.

Other Pertinent Definitions

Assigning Lengths of Stay: a process for assigning approved days for an acute care inpatient admission based on relevant clinical information

Business Day: means Monday through Friday, except for Federal holidays

CMU: case manager utilization

CSR: clinical services representative

Covered Service: A healthcare service that is a covered benefit under the health plan

Concurrent Review: a review during a course of treatment to determine whether the amount, duration and scope of the prescribed services (including extended stays or additional healthcare services) continue to be medically necessary or whether a different service or lesser level of service is medically necessary

Emergency Medical Condition: a medical condition that reveals itself by acute symptoms of sufficient severity or pain such that a prudent layperson could reasonably expect the lack of immediate medical attention to result in: (a) placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious damage to bodily functions; or (c) serious dysfunction of any bodily organ or part

Identifi™: an integrated health management system for documenting information related to the member's health, hospital confinements, ongoing monitoring, care or case advising, etc.

InterQual® Criteria: a set of regularly updated, rules-based, member specific evidence-based medicine decision support system that ensures medical necessity reviews are based on established clinical guidelines and criteria. InterQual® criteria can also be used to help determine initial length of hospital stay.

Length of Stay (LOS): the number of days between hospital admission and hospital discharge. The day of admission is counted; the day of discharge is not.

LTAC: long term acute care facility

MDS (Minimal Data Set): clinical information needed for pre-authorization services

Ongoing Ambulatory Care: Ambulatory care of symptomatic conditions, usually requiring regular or frequent visits or encounters (e.g., allergy injections or therapy visits)

Personal Approach to Health (PATH): Medicare Choice's Care Advising approach

Participating or Network Provider: A facility, hospital, doctor or other healthcare professional that has been credentialed by and contracts with the health plans

Prior Authorization (Pre-service Decisions): A determination made by Medicare Choice to approve or deny coverage for a provider's request to provide a service or course of treatment of a specific duration and scope to a member prior to the provider's initiation or continuation of the requested service. (May also be referred to as prospective review, pre-certification or organization determination.)

Rehabilitation (Rehab): For the purposes of this document, facility-based care that includes a wide array of services, including evaluation and treatment to help members recover from an illness or injury, or therapy for those with disabilities. Treatment teams evaluate individual needs and develop a rehabilitation plan to meet those needs with a focus on helping the member gain independence.

Skilled Nursing Facility (SNF): A type of healthcare facility recognized by the Medicare and Medicaid systems as meeting long-term healthcare needs for individuals who have the potential to function independently after a limited period of care. A multidisciplinary team guides healthcare and rehabilitative services, including skilled nursing care. Skilled nursing care includes rehabilitation and various medical and nursing procedures.

Urgent Medical Condition: Any illness, injury or severe condition that under reasonable standards of medical practice would be diagnosed and treated within a 24-hour period and,

if left untreated, could rapidly become a crisis or emergency medical condition. The terms also include situations where a person's discharge from a hospital will be delayed until services are approved or a person's ability to avoid hospitalization depends upon prompt approval of services.

Utilization Management (UM): An objective and systematic process for planning, organizing, directing and coordinating healthcare resources to provide medically necessary, timely and quality healthcare services in the most cost-effective manner