POLICY AND PROCEDURE

DEPARTMENT: Utilization Management	**DOCUMENT NAME**: Clinical Information and Documentation
PAGE: 1 of 3	**REPLACES:**
APPROVED DATE: Jan 2011	**RETIRED:**
EFFECTIVE DATE: May 2011	**REVIEWED/REVISED**: 5/12; 6/13; 4/14; 04/2016; 1/15/2017; 12/27/2017
PRODUCT TYPE: All	**REFERENCE NUMBER: IL.UM.06**

SCOPE:
IlliniCare Health Plan (Plan) Medical Management Department

PURPOSE:
To ensure that utilization review decisions are based on relevant clinical information and appropriately documented and secure.

POLICY:
Plan will require prior authorization for those procedures which have either a significant financial or quality of care impact that can be favorably influenced by the authorization. The Medical Management department will review this list regularly to determine if any services should be added or removed from the list. Plan may modify this list as required to meet specific state regulatory or contractual needs.

For medical services that have been determined shall require referral, prior authorization and/or certification, only the minimally necessary information will be obtained. The information required will not be overly burdensome for the member, the practitioner/staff or the health care facility staff. Clinical information received as well as rationale for the medical necessity determination and/or leveling of care shall be documented and maintained in the clinical authorization system which is password secured.

PROCEDURE:

A. IlliniCare Authorization List

1. Plan is expected to conduct prior authorization for those procedures and services on the Prior Authorization list.
2. The Medical Management department will review this list at least annually against claims and authorization data to determine if procedures or services should be added or removed from the list.

B. Information for UM Decision Making:

Each request for certification requires collection of relevant information for consideration. Basic information needed to perform the review may include, as applicable, but is not limited to, the following information:

- Office and hospital records
- A history of the presenting problem
- Clinical exam
- Diagnostic testing results

- Treatment plans and progress notes
- Patient psychosocial history
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- Printed copy of criteria related to the request
- Information regarding benefits for service or procedure
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

C. Onsite Facility Reviews:

1. UM Staff conducting onsite facility reviews must wear their Plan identification badge at all times while conducting reviews. In addition, UM staff will follow facility specific identification procedures.
2. UM staff shall schedule onsite reviews in advance with the indicated facility staff, unless otherwise agreed upon. Onsite reviews at large volume hospitals may be setup in advance, as part of a preset routine schedule (i.e. weekly on Monday, Wednesday, and Friday).
3. While conducting onsite facility reviews, UM Staff shall adhere to applicable facility rules. UM staff shall receive an initial facility orientation to review facility rules. Orientation should include review of applicable contract language and facility rules/procedures with which UM staff is expected to comply.

D. Documentation of Information:

UM Staff shall request clinical information applicable to the case and document it in the clinical authorization system. The clinical criteria rationale used to make the decision shall also be documented. If a determination cannot be made due to lack of necessary information, the UM designee must document attempts to obtain the additional information.

REFERENCES:
HFS MCO Contract 2018-24-001 Section 5.2 Covered Services,
IL.UM.01 – UM Program Description
2018 NCQA MCO Standards and Guidelines (or most recent version of)

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ATTACHMENTS
Prior Authorization List - https://www.illinicare.com/providers/preauth-check/medicaid-pre-auth.html

DEFINITIONS:

REVISION LOG

REVISION	DATE
Changed 2013 to 2016 NCQA MCO Standards and Guidelines.	04/2016
Added (or most recent version of) in References for NCQA	1/15/2017
Change to 2018 NCQA removed BH Doc of Information for MM/BH Integration & added hyperlink to PA required website/tool	12/27/2017

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

V.P. Medical Management: __Approval on file_____