



**CHILDREN'S MEDICAL SERVICES
MANAGED CARE PLAN
UTILIZATION MANAGEMENT PLAN
FEBRUARY 2018**

TABLE OF CONTENTS

Purpose and Philosophy	3
Utilization Management Program Description	4
Utilization Management Program Functions	6
Time Frames	10
Denials	13
Appeals	13
Emergency Services	15
Notifications	16
Reporting Availability	16
Evaluation of the Utilization Management Program	17
New Technology	17
Relationship between Quality Improvement and Utilization Management	17
Practice Guidelines	17
Fraud, Waste, and Abuse	18
Pharmaceutical Management	18
Non-Covered Services	18
Out-of-Network Services	19
Utilization Management Program Approval	21

**Children's Medical Services Managed Care Plan
Policy and Procedure
Utilization Management Plan**

PURPOSE AND PHILOSOPHY

Children's Medical Services (CMS) Utilization Management (UM) philosophy and approach are geared toward providing CMS enrollees high quality and cost effective health care. This UM program is designed to achieve congruence with goals of enrollees' and providers' satisfaction, efficiency, and effectiveness. CMS has partnered with two (2) Integrated Care Systems (ICSs) **Ped-I-Care** and **Community Care Plan (CCP)** to authorize the services described in this plan when provided to CMS enrollees. These partners will make the determination to approve a service based on review of submitted information and a determination of medical necessity. **Ped-I-Care** and **CCP** each support CMS in different areas of the state. CMS, through our contracted entities, includes physician involvement in all aspects of the UM program.

CMS's interest is in assuring that systems and resources can adequately meet the quality of medical care and the service demands of our enrollees in the most cost-effective manner. CMS ensures compliance with all state and federal standards, requirements of the CMS UM program, and appropriate data collection and reporting to meet enrollee and provider needs through periodic updates and audits. CMS gives consideration to characteristics of the local delivery systems available for specific enrollees as well as enrollee-specific factors such as enrollee's age, comorbidities, complications, progress in treatment, psychosocial situations, and home environment.

CMS views the UM function as directed toward comprehensive care of an enrollee rather than fragmented care, delivered and managed at different entry points into the health care delivery system. This system encourages and supports the development of cost-effective alternatives to traditional modes of medical practice without compromising the quality of care rendered to enrollees.

Key components of utilization management and medical management have been outlined to include prospective, concurrent, and retrospective review, including care coordination.

It is CMS's expectation that the principles and requirements of this UM program will be met through:

- (1) CMS's coordinated efforts on an on-going basis with our two (2) Integrated Care Systems (ICSs); and/or
- (2) Guidance of the CMS Utilization Management/Quality Improvement Committee.

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

The written UM program description outlines the program structure and accountability including but not limited to processes for evaluating medical necessity, the criteria utilized, information sources and the process utilized to review and approve the provision of medical services. The overall scope of the plan is to establish a planned and systematic process to effectively and efficiently maintain the promotion and delivery of high quality health care to all enrollees. CMS operates in compliance with 42 CFR 438, subpart K regarding parity in mental health and substance use disorder benefits. CMS complies with 42 CFR 438.910(d) with regards to quantitative and non-quantitative treatment limits.

Through our ICSs, procedures are in place to support the major components of the UM program such as physician involvement, timely authorization of prescribed health services and to ensure the needed services are rendered in the most appropriate and cost-effective setting in accordance with the enrollee's coverage benefits. Consistent application of review criteria for authorization decisions is used throughout the state by each ICS. Each ICS will consult with the requesting provider when appropriate to coordinate the services to be rendered.

For the UM program, the evaluation for medical necessity or medically necessary is determined using the following definition from Rule 59G-1.010, Florida Administrative Code (F.A.C.)

Services that include medical or allied care, goods, or services furnished or ordered must:

1. Meet the following conditions:
 - a. Be necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain;
 - b. Be individualized, specific and consistent with symptoms or confirm diagnosis of the illness or injury under treatment and not in excess of the patient's needs;
 - c. Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not be experimental or investigational;
 - d. Be reflective of the level of service that can be safely furnished and for which no equally effective and more conservative or less costly treatment is available statewide; and
 - e. Be furnished in a manner not primarily intended for the convenience of the enrollee, the enrollee's caretaker, or the provider.
2. "Medically necessary" or "medical necessity" for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
3. The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary, a medical necessity or a covered service.

The Agency for Health Care Administration (AHCA) contract instructs CMS UM program to use the most recent versions of the Medicaid Coverage and Limitations Handbook or the Medicaid State Plan in order to determine the medical necessity of covered services for all prior authorization requirements. The Medicaid Coverage and Limitations Handbook is Florida's Medicaid document that provides information to a Medicaid provider about enrollee eligibility; claims submission and processing; provider participation; covered care, goods, and services; limitations; procedure codes and fees; and other matters related to participation in the Medicaid program.

The UM program is reviewed and approved by the CMS Utilization Management Committee which is part of the Quality Improvement Committee annually. The Quality Improvement Committee provides direction and oversight of the comprehensive UM program. CMS central office delegates are active participants of our Central Office Quality Improvement Committee and both ICS Quality Improvement Committees.

Annual review of the UM program and its effectiveness includes measuring provider and enrollee satisfaction to identify areas of dissatisfaction with the prior authorization and referral processes. If issues are identified, appropriate interventions will be implemented. The annual review is reported to the QI Committee and the Governing Body. Survey results are posted via the website in order to communicate results to the provider network and or enrollees.

CMS uses automated systems for authorizations, as required in s.409.967(2)(c)3., Florida Statutes (F.S.) and does not require paper authorizations in addition as a condition for providing treatment. CMS service authorization systems provide the authorization number and effective dates for authorization to providers and non-participating providers. The automated system provides written notice of all denials, service limitations and reductions of authorization to providers and enrollees.

In accordance with s.627.42392, F.S., if CMS did not provide an electronic prior authorization process for use by its contracted providers, providers would only use the prior authorization form approved by the Financial Services Commission.

Functions completed by the UM nurses include, but are not limited to, prior authorization, concurrent review, retrospective review and working with Care Coordinators regarding discharge planning and care coordination activities.

All medical utilization decisions are made by qualified licensed professionals. The UM department of each ICS is composed of the Medical Director, licensed nurses, and clerical support. The clerical support staff is not involved in medical utilization decisions. The UM Nurses work under the direct supervision of each ICS Medical Director.

The ICS Medical Director is responsible for providing professional medical oversight in developing, implementing and managing the Utilization Management and Quality Improvement

Programs. The ICS Medical Director is responsible for ensuring the ICS meets the health care needs of all enrollees with a focus on quality and efficiency. Responsibilities include the clinical component of the Utilization Management Program. The ICS Medical Director is responsible for approving clinical guidelines and programs and final decisions related to authorization criteria for services including grievances. For detailed ICS staff functions, refer to each CMS/ICS's UM Plans.

UTILIZATION MANAGEMENT PROGRAM FUNCTIONS

A. Prospective Review or Precertification:

Prospective review or precertification is the prior authorization process. The purpose of this process is to review the appropriateness of location, medical necessity of services and to improve the delivery of medical care which results in cost-effective delivery of quality health care services. The basic elements of prior authorization review include; eligibility verification and medical necessity review of services. Requests for services requiring authorization are reviewed and determinations made by the appropriate UM personnel at each ICS. All recommended reductions, denials, or suspensions, regardless of the reason for the reduction, denial, or suspension, require review and signature by the ICS Medical Director. Please refer to the CMS Provider Handbook for specific information on services requiring prior authorization.

B. Concurrent Review:

The care of hospitalized enrollees is reviewed on a concurrent basis in order to determine that service delivery and the level of care are appropriate. The enrollee's progress also is evaluated in order to plan for a timely discharge and appropriate discharge planning. Ongoing communication with the Care Coordinator is also part of this process. Concurrent reviews are performed by each ICS.

C. Retrospective Review or Post-Service Decisions:

Each ICS has a licensed nurse determine if the services were medically necessary as defined by established criteria. If the licensed nurse is unable to determine medical necessity, the case is referred to the appropriate ICS Medical Director with supporting information for additional review and discussion. When the Medical Director makes a determination, the requesting provider is notified of the decision and is advised of his/her appeal rights in the case of an adverse benefit determination.

D. Confidentiality:

CMS, all of its contracted entities, and enrollees recognize that confidentiality is vital for effective management of enrollee care, and therefore agree to respect and maintain

the confidentiality of all discussions, deliberations, records, and other information generated in connection with all committees and other activities. CMS, all of its contracted entities, and enrollees will not make any voluntary disclosure of such confidential information except to persons authorized to receive such information. CMS, all its contracted entities, and enrollees will comply with all regulatory agency conditions pertaining to confidentiality. CMS and all contracted entities apply Health Insurance Portability and Accountability (HIPAA) privacy and confidentiality standards to all staff and physician reviewers.

E. CMS Coverage and Utilization Management Criteria

CMS and both ICS's will follow the Medicaid Coverage and Service Limitations Handbook and authorization requirements established by the Florida Medicaid program. UM criteria is based upon the Florida Medicaid Plan coverage as well as nationally and professionally recognized inter-rater reliability criteria such as InterQual, Centers for Medicaid and Medicare Services, or other evidence-based guidelines approved by AHCA as a guide to approve services. Such criteria and guidelines will not solely be used to deny, reduce, suspend, or terminate a good or services, but is used as evidence of generally accepted medical practices which support the basis of medically necessity determination. Criteria and guidelines are used in order to provide effective mechanisms that ensure consistent application of the UM review criteria. Coverage for services outside the current Medicaid State Plan must be considered based on medical necessity as required by Federal Omnibus Budget Reconciliation Act (OBRA). Application of coverage and UM criteria is consistent throughout CMS.

F. Behavioral Health

Services are obtained through referrals and triage for behavioral health and substance abuse services through both ICS's and their contracted Managed Behavioral Health Organization (MBHO). CMS provides a full range of medically necessary behavioral health services authorized under the Medicaid State Plan and specified in the contract between AHCA and the Department of Health (DOH) to all enrollees. CMS coordinates with other entities, including Long-Term Care (LTC) Managed Care Plans, Medicare plans, Medicare providers, and state-funded programs and services. CMS, through our contracted ICSs, will coordinate and deliver behavioral health care services in the least restrictive setting with treatment and recovery capabilities that address enrollee needs in accordance with s. 409.967(2)(d), F.S. CMS provides for emergency behavioral health services. CMS, through the ICS contractual agreement, will operate, as part of its crisis support/emergency services, a crisis emergency hotline available to all enrollees twenty-four hours a day, seven days a week (24/7). For each county it serves, CMS, through the ICS contractual agreement, will designate an emergency service

facility that operates twenty-four hours a day, seven days a week, (24/7) with Registered Nurse coverage and on-call coverage by a behavioral health specialist. Behavioral health practitioners are involved in the assessment and UM decision-making activities for these services. Only a licensed psychiatrist may authorize a reduction, suspension, or denial for an initial or concurrent authorization of any request for behavioral health services. The psychiatrist's review will be a part of the UM process and not part of the clinical review, which may be requested by a provider or the enrollee, after the issuance of a reduction, suspension, or denial. Through both ICS's and their contracted MBHO, CMS has adopted the following access standards for behavioral health and substance abuse:

1. Routine care available within ten (10) business days;
2. Follow-Up Appointment scheduled within seven (7) days after discharge from a facility;
3. Urgent care available within one (1) day of the request;
4. Non-life threatening emergency care available within 6 hours; and
5. Life threatening emergency care available 24 hours/7 days a week (see above).

CMS operates in compliance with 42 CFR 438, subpart K regarding parity in mental health and substance use disorder benefits. CMS complies with 42 CFR 438.910(d) with regards to quantitative and non-quantitative treatment limits.

G. Chronic Conditions/Disease Management Program

Eligible enrollees are encouraged to participate in the CMS Chronic Conditions/Disease Management Program. Care Coordinators educate and attempt to engage enrollees to join the Chronic Conditions/Disease Management Program. CMS has a comprehensive management program that consists of:

- Care coordination that includes a plan of treatment that is tailored to the individual enrollee;
- Enrollee education based on the enrollee assessment of health risks and chronic conditions;
- Symptom management including addressing needs such as working with the enrollee on health goals;
- Emotional issues of the caregiver;
- Behavioral management issues of the enrollee;
- Medication management, including the review of medications that an enrollee is currently taking to ensure that the enrollee does not suffer adverse effects or interactions from contra-indicated medications;

- Opportunities to opt-in or opt-out of the Chronic Conditions/Disease Management Program but not care coordination under the CMS Medicaid Specialty Plan;
- Provider coordination and effective communication;
- Addresses co-morbid conditions and considers the whole health of the enrollee;
- Development of clinical practice guidelines and preventive health performance measures related to identified chronic conditions;
- Data from the Chronic Conditions/Disease Management Program is collected and analyzed for the program's performance; and
- Any corrective actions implemented to the Chronic Conditions/Disease Management Program will be reported to the governing body.

For program specific information, please refer to the Chronic Conditions/Disease Management Program Plan and policy, CMS Chronic Conditions/Disease Management (DOHP 145-114).

H. Second Opinions

All CMS enrollees are entitled to obtain a second medical opinion at no expense to the enrollee. If authorization is needed, CMS, through our ICS's will authorize claims for such services. Second opinions are in accordance with 42 CFR 438.236(c) and s. 641.51, F.S.

I. Prescribed Drugs

CMS assures that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on the CMS Managed Care Plan website and providing timely responses to providers. CMS makes provisions for all required prescriptions for behavioral health to be authorized at the time of discharge from a facility.

J. Non-emergency inpatient hospital admissions

CMS requires prior authorization for all non-emergency inpatient hospital admissions.

K. Changes to UM Components

CMS will obtain written approval from AHCA for its service authorization protocols and any changes. CMS will provide no less than thirty (30) days' written notice to AHCA before making any changes to the administration and/or management procedures and/or authorization, denial, or review procedures, including any delegations, as described in this plan and the AHCA contract.

L. Multidisciplinary Team (MDT)

For enrollees receiving Enhanced Care Coordination due to private duty nursing (PDN) or who reside in a skilled nursing facility, a MDT will be convened to develop a person centered individualized service plan that reflects the services and supports needed by the enrollee. A MDT meeting will occur at least every six (6) months for enrollees receiving PDN to provide a comprehensive review of the services and supports that the enrollee needs and to authorize any Medicaid reimbursable services that are prescribed for the enrollee. For enrollees residing in a skilled nursing facility, the MDT will be held at least every six (6) months until the enrollee is transitioned home or to another community based setting. An MDT for enrollees receiving specialized therapeutic foster care or therapeutic group care services will be convened to develop a person centered individualized treatment plan and will occur at least every six (6) months at a minimum.

M. Referrals

CMS does not require authorizations for referrals to specialist physicians. CMS communicates this to our enrollees and provider network through our member and provider handbooks. CMS requests that all specialty providers communicate their clinical findings to the referring provider by providing documentation of visits and consultations.

TIME FRAMES

Time frames are mandated by state and federal regulations as well as industry standards and requirements. Time frames are updated as necessary to remain in compliance with regulations, standards, and requirements. The AHCA standards are measured on a monthly basis for processing authorization requests in a timely manner. The following time frames are used by both ICS's:

- Routine Request or Non-Urgent Request (Standard Authorizations)-The ICS will process ninety-five percent (95%) of all routine or non-urgent authorizations within fourteen (14) days. The ICS's average turnaround time for routine authorization shall not exceed seven (7) days. The time frame for authorization decisions can be extended up to seven (7) additional days if the enrollee or provider requests extension or CMS, through the ICS, justifies the need for additional information and how the extension is in the enrollee's interest. For routine authorizations, providers will be notified as expeditiously as the enrollee's health condition requires and within no more than seven (7) days following receipt of the request for service.
- Urgent Request or Expedited Request-The ICS will process ninety-five percent (95%) of all urgent authorizations within three (3) business days. The ICS's

average turnaround time for urgent authorizations will not exceed (2) business days. The ICS may extend the time frame for urgent authorizations up to two (2) additional business days if the enrollee or the provider requests an extension or if CMS, through the ICS, justifies the need for additional information and how the extension is in the enrollee's interest. For urgent authorizations, providers will be notified within forty-eight (48) hours following the request for service.

- Concurrent review of urgent care (typically inpatient) is made within twenty-four (24) hours of receiving all the necessary information by the ICS.
- Retrospective review (services were already provided or started) is made within thirty (30) calendar days of receiving all the necessary information by the ICS.

CMS, through the ICS, will notify the provider and give the enrollee written notice of any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested.

For Private Duty Nursing, the ICS will notify CMS Central Office in any situation where there is a recommended reduction or suspension in the amount, scope, and duration of services. Central Office will make the final determination of reduction or suspension of services.

Urgent or Expedited Requests are required when a provider indicates, or CMS through the ICS, determines that following the standard timeline could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function. An urgent or expedited decision must be made no later than forty-eight (48) hours after receipt of the request for service.

CMS will not delay service authorization if written documentation is not available in a timely manner. However, CMS is not required to approve claims for which it has received no written documentation.

CMS will provide the enrollee with a written notice of adverse benefit determination using the template provided by AHCA and that includes the following:

- The adverse benefit determination that CMS or its subcontractor has made or intends to make;
- The reasons for the adverse benefit determination, including the right of the enrollee to be provided, upon request and free of charge, reasonable access to, and copies of all documents and information relevant to the enrollee's adverse benefit determination;
- The enrollee or provider's right to file a plan appeal with CMS;
- The enrollee's right to request a Medicaid Fair Hearing, after completing the plan appeal process;
- The procedures for exercising the rights specified in the notice;

- The circumstances under which expedited plan appeal resolution is available and how to request it; and
- The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued and the circumstances in which the enrollee may be required to pay the cost of services.

CMS will include an identifying number on each notice of adverse benefit determination in a manner prescribed by AHCA.

CMS, through the ICS, will mail the notice of adverse benefit determination as follows:

- For termination, suspension or reduction of previously authorized Medicaid covered services no later than ten (10) days before the adverse benefit determination is to take effect. Certain exceptions apply under 42 CFR 431.213 and 214;
- For denial of payment, at the time of any adverse benefit determination affecting the claim;
- For routine or standard service authorization decisions that deny or limit services no more than seven (7) days following the request for service or within forty-eight (48) hours following an expedited service request;

If CMS, through the ICS, extends the timeframe for a service authorization decision, the ICS will:

- Notify the enrollee of the reason for extending the timeframe and advise of the right to file a grievance if the enrollee disagrees with the extension of time;
- Issue and carry out its determination as expeditiously as possible but no later than the date the extension expires; and
- Send notice of the extension to the enrollee within five (5) business days of determining the need for an extension.

For service authorization decisions not reached within the required timeframes, on the date the timeframes expire, this expiration will constitute a denial and are, therefore, an adverse benefit determination and also, for expedited service authorization decisions, a denial is constituted if decisions are not made within the timeframes specified.

CMS, through our ICSs, will ensure a notice of action is provided to enrollees under the age of twenty-one (21) years receiving residential psychiatric treatment (including SIPP and TGC services) in each instance during a course of treatment where CMS authorizes fewer units or days subsequent to the initial authorization for the service.

DENIALS

Each ICS Medical Director or an ICS Associate Medical Director reviews all potential UM suspensions, denials, and reductions. CMS, through our ICSs, ensures that all decisions to deny a service authorization request, or limit a service in amount, duration or scope that is less than requested must be:

- Made by a licensed physician, psychiatrist, or dentist, as appropriate, or other professional as approved by AHCA, who has the appropriate clinical expertise in treating the enrollee's condition or disease; and
- Determined using the acceptable standards of care, state and federal laws, AHCA's medical necessity definition, and clinical judgment of a licensed physician, psychiatrist or dentist, as appropriate, or other professional as approved by AHCA.

Physicians requesting services may be contacted by the Medical Director for additional information or to discuss alternatives to care. Providers and enrollees receive written notification of all denials, suspensions, and reductions from the ICS. Notifications include the reason for the denial, suspension or reduction and the appeal mechanism. Requesting providers may consult with the reviewing physician and may request an expedited response for urgently needed services. When an authorization is denied, suspended, or reduced, the enrollee or provider has the right to appeal the decision. CMS does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the enrollee's diagnosis, type of illness or condition.

For Private Duty Nursing, the ICS will notify CMS Central Office in any situation where there is a recommended modification in the amount, scope, and duration of services. Central Office will make the final determination of modification of services.

APPEALS

There is a formal established process to appeal reductions, suspensions, or denials. CMS will consider as parties to the plan appeal the enrollee, or an authorized representative or, if the enrollee is deceased, the legal representative of the estate. An enrollee, authorized representative, or legal representative of the estate may file an appeal orally or in writing within sixty (60) days from the date on the notice of adverse benefit determination and this must be followed with a written, signed appeal within ten (10) days of the oral filing, unless the enrollee requests an expedited resolution. The date of oral filing shall constitute the date of receipt. CMS will acknowledge each plan appeal in writing within five (5) business days of receipt of each plan appeal unless the enrollee requests an expedited resolution. Appeals are reviewed by an ICS Medical Director who was not involved in the initial decision. Appeal rights exist beyond the ICS appeals process.

Upon request, CMS will provide the enrollee and his or her authorized representative the enrollee's case file, free of charge, including the opportunity before and during the appeal process for the enrollee or an authorized representative to examine the case file, medical records, and any additional documents/records considered or relied upon by CMS regarding a plan appeal.

CMS will continue the enrollee's benefits during the plan appeal if all of the following occur:

- The enrollee or the enrollee's authorized representative files the request for a plan appeal timely in accordance with 42 CFR 438.402(c)(2)(ii);
- The plan appeal involves the termination, suspension, or reduction of previously authorized course of treatment;
- The services were ordered by an authorized provider;
- The period covered by the original authorization has not expired; and
- The enrollee timely files for continuation of benefits.

If, at the enrollee's request, the CMS plan continues or reinstates the benefits while the plan appeal is pending, the benefits must continue until one (1) of the following occurs:

- The enrollee withdraws the plan appeal; or
- The enrollee fails to request a fair hearing and continuation of benefits within ten (10) days after CMS Plan sends the notice of plan appeal resolution that is not wholly in the enrollee's favor.

CMS provides the enrollee a reasonable opportunity to present evidence and testimony and make allegations of fact or law in person as well as in writing.

If the final resolution of the plan appeal is adverse to the enrollee, CMS may recover the cost of services furnished to the enrollee while the plan appeal was pending to the extent they were furnished solely because of the requirements for continuation of benefits.

For standard resolution, a plan appeal will be heard and notice of plan appeal resolution will be sent to the enrollee no later than thirty (30) days from the date CMS receives the plan appeal.

If CMS fails to adhere to the notice and timing requirements for resolution of the plan appeal, the enrollee is deemed to have completed CMS's plan appeals process, and the enrollee may initiate a fair hearing.

The timeframe for a plan appeal may be extended up to fourteen (14) days if:

- The enrollee asks for an extension, or CMS documents that additional information is needed and the delay is in the enrollee's interest;

- If the timeframe is extended other than at the enrollee's request, CMS will provide oral notice of the reason for the delay to the enrollee by close of business on the day of the determination, and written notice of the reason for the delay to the enrollee within two (2) days of determination.

CMS has an expedited review process for plan appeals for use when taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function. For expedited appeals, CMS will:

- Resolve each expedited appeal and provide notice to the enrollee, as quickly as the enrollee's health condition requires, within state established timeframes not to exceed seventy-two (72) hours after CMS receives the plan appeal request, whether the plan appeal was made orally or in writing;
- Inform the enrollee of the limited time available to present evidence and allegations of fact or law, in the case of expedited plan appeal resolution, and ensure that the enrollee understands any time limits that may apply;
- Immediately transfer the plan appeal to the timeframe for standard resolution and so notify the enrollee in the case that CMS denied the request for expedited plan appeal;
- Treat the request as a denial for expedited plan appeal and immediately transfer the plan appeal to the timeframe for standard resolution and so notify the enrollee, if the enrollee asks for an extension. Nothing in the AHCA contract relieves the plan of its obligation to resolve the enrollee's appeal as expeditiously as the enrollee's health condition requires, in accordance with 42 CFR 438.408; and
- Provide oral notice to the enrollee by close of business on the day of resolution, in the case of an expedited plan appeal denial, and written notice to the enrollee within two (2) days of the disposition.

For both the Denial and Appeals processes, providers **are not** prohibited from advocating on behalf of enrollees for the UM process. CMS and all contracted entities that conduct UM activities do not provide incentives for denial, limitation, or discontinuation of medically necessary services to any enrollee, in accordance with 42 Code of Federal Regulations (CFR) 438.210(e). CMS Denial and Appeals processes comply with state and federal requirements.

Please refer to the policy, Title XIX Grievance System (DOHP 145-030) for further information on the content of notice and appeal information.

EMERGENCY SERVICES

Care that is needed on an emergency basis is not subject to prior authorization, regardless of the time of day, day of the week or place of service. However, by the following business day, the hospital must notify the utilization management department listed on the enrollee's ID card and provide enrollee demographics, facility name and admitting diagnosis. Any post-discharge

services requiring authorization must be communicated through the normal authorization process.

CMS, through the ICS, will provide post-authorization to County Health Departments (CHDs) for emergency shelter medical screenings provided for children being taken into the child welfare system.

NOTIFICATIONS

CMS requests to be notified but will not deny claims payment based solely on lack of notification, for the following:

- Inpatient emergency admissions (within ten (10) days);
- Obstetrical care (at first visit);
- Obstetrical admissions forty-eight (48) hours for vaginal delivery and ninety-six (96) hours for caesarean sections; and
- Transplants.

REPORTING AVAILABILITY

UM reports are submitted by each ICS so that the Central Office QI committee can monitor and evaluate performance. These reports include, but are not limited to:

- Evaluation of program results to include enrollee and provider satisfaction surveys;
- UM reports for timeliness, denials, suspensions, and appeals (submitted by each ICS on a monthly and quarterly basis);
- Ongoing analysis for over/under utilization of services. Trending data is submitted on a regular basis by MED3000 to both ICS's. This data is analyzed by each ICS's QI/UM Committee to determine consequences related to over or under utilization of services. Opportunities for improvement are identified and implemented based on committee findings. After interventions have been implemented, an evaluation is conducted and the results are reviewed by each ICS's QI/UM committee; and
- Monitoring of consistent application of UM criteria and implementation of corrective action(s) to address variances.

Each ICS is responsible for reporting quarterly to the Central Office Quality Improvement Committee.

Continuous oversight of each ICS to ensure compliance with the CMS UM activities is the responsibility of the Central Office Managed Care Unit (MCU). CMS's MCU will coordinate reviews with the contracted entities for areas including UM at a minimum of annually to ensure compliance. Oversight will include desk reviews, weekly meetings, and/or site reviews.

EVALUATION OF THE UTILIZATION MANAGEMENT PROGRAM

The UM program is formally evaluated on an annual basis and revised as necessary by the CMS Governing Body and the CMS Central Office QI Program. During this annual review, analyses of variances along with corrective actions are reviewed with the Governing Body and the CMS Central Office QI program. The program is reviewed to add or modify activities as appropriate to improve the efficiency and effectiveness of the processes thus providing quality service to our customers. Enrollee and Provider satisfaction survey results and any interventions related to the satisfaction surveys are reported to the Governing Body. Trend reports are utilized to determine areas of need for corrective measures as well as areas that have shown improvement. Evaluation of the UM program includes enrollee and provider satisfaction data and complaints/grievances data. Both satisfaction surveys include data related to the prior authorization and referral processes. UM criteria is made available to practitioners in the CMS Provider Handbook and on the CMS Managed Care Plan website.

NEW TECHNOLOGY

CMS, through our ICS's, evaluates the inclusion of new medical technologies and the new application of existing technologies. This includes medical procedures, drugs, and devices. The process includes a review of information from appropriate government regulatory bodies as well as published scientific evidence. Each ICS Medical Director or designee has access to the internet for literature searches to assist in the evaluation to determine the status of technologies. Representation from the provider network is used for development, adoption, and evaluation of the new medical technology program. CMS, through our ICS's and Pharmacy Benefits Manager (PBM), implements this process to assess new technologies and new applications of existing technologies.

RELATIONSHIP BETWEEN QUALITY IMPROVEMENT AND UTILIZATION MANAGEMENT

The Quality Improvement Plans for CMS and both ICS's addresses utilization management as these three entities are interlinked together. CMS can help improve quality through utilization management. By sharing aggregate utilization data with the QI Committee, a meaningful feedback loop between utilization management and quality improvement can be developed. Information/data collected by the UM staff can serve as an important indicator of quality. Action plans for QI involve the UM staff. CMS realizes that UM can significantly contribute to QI. By creating a framework that includes UM and QI, and in which there is freely flowing information, the individual enrollee and CMS will ultimately benefit.

PRACTICE GUIDELINES

CMS, through our contracted ICS's, adopts and disseminates clinical practice and preventive health guidelines appropriate to the population that the ICS physicians serve. Guidelines are based on valid and reliable clinical evidence or consensus of health care professionals in a

particular field and consider specific needs of the enrolled population with consideration given to characteristics of the local delivery systems available for specific enrollees as well as enrollee-specific factors, such as enrollee's age, co-morbidities, complications, progress in treatment, psychosocial situation, and home environment. Clinical Practice Guidelines can be developed either involving representative practitioners from appropriate specialties or the ICS may elect to adopt evidence-based clinical practice and preventive health guidelines from recognized sources. Recognized sources are organizations that develop or promulgate evidence-based clinical practice and preventive health guidelines, including professional medical associations such as the American Academy of Pediatrics and government agencies such as National Institutes of Health Centers and Institutes. Practice Guidelines meet the requirements of 42 CFR 438.236(c).

Practice guidelines may be developed with input from health care professionals and are reviewed and updated as needed but at a minimum of every two (2) years. Current practice guidelines or revised practice guidelines are communicated to all appropriate providers through the CMS Managed Care Plan website and to individual enrollees or potential enrollees when requested. All decisions with respect to utilization management, enrollee education, coverage of services and other health care issues to which the guidelines apply are consistent throughout CMS.

Through the ICS, CMS analyzes performance against its clinical practice and preventive health guidelines. Physician profiling is used as an analytic tool that uses methods to compare physician practice patterns across various quality of care dimensions (process and clinical). Physician profiling has as its purpose the goal of assessing and improving the quality of enrollee care and clinical outcomes. The ICS implements corrective action in cases of substandard performances against clinical practice and preventive health guidelines.

FRAUD, WASTE, AND ABUSE

CMS is dedicated to the prevention and detection of fraud, waste, and abuse through a collaborative effort. CMS actively endeavors to prevent and identify suspected incidents of Medicaid fraud, waste, and abuse. All activities seen as fraud, waste and/or abuse will be reported to the CMS Compliance Officer for investigation and follow-up. The reporting of fraud, waste or abuse offenses may occur by the ICS or CMS to AHCA's Bureau of Medicaid Program Integrity (MPI), depending on the contract under which the offense falls. In all instances, CMS will be notified. For additional information on fraud, waste, and abuse, please refer to the CMS policy and procedure "CMS Fraud and Abuse," DOHP 145-009.

PHARMACEUTICAL MANAGEMENT

For the pharmaceutical management program, the CMS Pharmacy Benefits Manager (PBM) is responsible for formulating policy and procedures regarding evaluation and therapeutic use

of drugs and related devices in accordance with applicable state, federal and accreditation standards. Refer to the CMS policy, Title XIX Pharmacy Benefits, DOHP 145-027. The PBM works to ensure the pharmaceutical program promotes safety in medication management. The PBM will assure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on the CMS Managed Care Plan website and providing timely responses to providers.

CMS works with Magellan through AHCA for the plan pharmacy benefits. Through our relationship with Magellan, we are able to participate in a drug utilization review (DUR) program in compliance with 42 CFR 438.3(s)(4).

The Magellan DUR encourages coordination between an enrollee's PCP and a prescriber of a psychotropic or similar prescription drug for behavioral health problems. The DUR program identifies those medications for other serious medical conditions (such as hypertension, diabetes, neurological disorders, or cardiac problems) where there is a significant risk to the enrollee by potential drug interactions between drugs for these conditions and behavioral-related drugs.

The DUR program notifies all related prescribers that certain drugs may be contra-indicated due to the potential for drug interactions and encourages prescribers to coordinate their care. Notice may be provided electronically or via mail, or by telephonic or direct consultation.

Magellan provides an annual, detailed description of its drug utilization review program activities to AHCA. The DUR is in accordance with 42 CFR 438.3(s)(6).

Magellan conducts a prior authorization program for the pharmacy services program in accordance with 42 CFR 438.3(s)(6).

NONCOVERED SERVICES

CMS, through our contracted ICSs, has developed a process for authorization of any medically necessary service to enrollees under the age of twenty-one (21) years, in accordance with Section 1905(a) of the Social Security Act when:

- The service is not listed in the service-specific Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or is not a covered service of the plan; or
- The amount, frequency, or duration of the service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule.

OUT-OF-NETWORK SERVICES

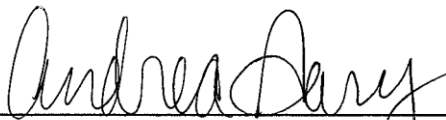
CMS will provide timely approval or denial of authorization of out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to

and documents the approval. Written follow-up documentation of the approval must be provided to the non-participating provider within one (1) business day after the approval.

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UTILIZATION MANGEMENT PROGRAM APPROVAL


Areas of responsibility include the Director, Office of CMS Plan & Specialty Programs, Director, Office of CMS Plan Administration, Director, Office of CMS Plan Operations & Specialty Programs. **Signatures below indicate the Utilization Management Program has been approved for implementation as CMS policies and procedures.**



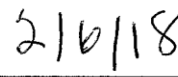
Andrea Gary
Director, Office of Children's Medical Services
Plan Administration



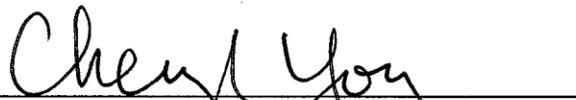
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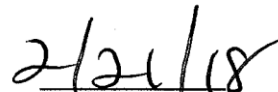
Kelli Stannard, RN, BSN
Director, Office of Children's Medical Services
Plan Operations & Specialty Programs



Date



Cheryl Young
Director, Office of Children's Medical Services
Plan & Specialty Programs

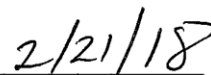


Date

GOVERNING BODY UTILIZATION MANAGEMENT PROGRAM APPROVAL



for Cheryl Young
CEO Children's Medical Services
Managed Care Plan
Governing Body Representative



Date