MEDICAL POLICY DEVELOPMENT

AND APPLICATION OF CRITERIA IN UTILIZATION MANAGEMENT

Purpose

This document provides guidelines for the evolution and adoption of a medical policy.

Description

A medical policy or guideline is the standard by which coverage, decisions, and actions are determined. It is based on scientifically sound, current, reasonable, reliable, and comprehensive information and supplemented, when medically necessary, by expert opinion. Authoritative information used during development comes from a wide variety of sources, including, but not limited to, medical literature, medical consensus bodies, specialty societies, regulatory agencies, health care standards, database searches, evidence from national medical organizations, community physicians, state and federal government agencies and research organizations. Policies shall clearly identify, when applicable, experimental status, approval status, written research protocols, appropriate clinical application, efficacy, safety, research findings, and medical consensus regarding medical technology.

Policy

Medical policy is the primary basis of medical review decisions for prior authorization, concurrent review, retrospective review, case management, appeals, and claims adjudication. VCHCP uses several nationally developed protocols in the review process. Beginning in the fall of 2009, Milliman Care Guidelines was adopted as one of VCHCP's resources. Other guidelines utilized include UpToDate, other peer-reviewed medical and scientific literature, National Guideline Clearinghouse (http://www.guideline.gov) and additional Federal and state publications. VCHCP's own medical policies are developed to reflect the local characteristics of its membership and provider network, to augment the available national guidelines and they take precedence over the other review criteria (e.g., Milliman Care Guidelines) for determination of medical necessity. Medical policy primarily focuses on medical issues, however, it can also contain clarification on benefit interpretation and administrative policy.

Procedures for the Development of the Medical Policy

1. The physician authoring the policy, which is most frequently the Medical Director, completes the following steps:
    a. Performs a search of printed and online medical literature that includes professionally recognized guidelines, current evidence-based medicine, and community standards.
    b. Reviews the procedure or service to determine if it is considered investigational / experimental.
    c. Identifies issues of controversy and specific statutory requirement (e.g., Evidence of Coverage constraints are identified; Department of Managed Health Care (DMHC), Department of Health Services (DHS) and Medicare regulations are reviewed for

position statements decisions and approval status)

d. Identifies regulatory issues which are reviewed by legal counsel, when necessary
e. Develops a draft policy
f. Requests departmental input, if indicated, from, but not limited to, the following:
   i. Claims
   ii. Member Services
   iii. Legal Counsel

2. The draft policy is brought to the Medical Policy Committee which is an ad hoc sub-committee consisting of network specialists and subspecialists who assist VCHCP in the development and evaluation of appropriateness of medical criteria.
   The following characteristics are to be met;
   a. Content based on empirically valid and clinically practical and reasonable medical evidence
   b. Care guidelines which result in consistently effective and safe outcomes of acute and chronic care services
   c. Content applicable to various populations and reflects local provider network and member characteristics.
3. The policy is reviewed, revised as necessary and adopted. The Committee also reviews the instructions for application of the criteria to assure consistency and appropriateness for Plan members and the local delivery system. The Medical Policy Committee similarly evaluates policies on new technology and procedures.
4. The VCHCP Medical Policy Committee includes the VCHCP medical director, VCHCP associate medical director, VCHCP Health Services Director and UM/QA/UM Managers.
5. The VCHCP Medical Policy Committee findings are reviewed first in the Utilization Management Committee, then in the Quality Assurance Committee.
6. The Utilization Management Department then makes approved policies available to network providers via newsletters and on the provider portal and maintains an audit trail of revised medical policies.

MEDICAL POLICY REVIEW

Purpose

Medical Policies are reviewed and updated on an annual basis to ensure that national standards of care are maintained and that application of the policies are consistent and appropriate.

Policy

The VCHCP Medical Policy Committee reviews established national guidelines and internal VCHCP guidelines and makes recommendations for necessary revisions, additions, or both to the VCHCP Medical Policy Manual. The review may entail a formal literature review if further information is required or new information is available. The VCHCP Medical Policy Committee reviews all existing medical and administrative policies and technology assessments on a yearly basis and, when necessary, updates the policies. The date of review is indicated on each document. This annual review shall not interfere with policy revisions necessitated by new medical information.

In performing these reviews, the VCHCP Medical Policy Committee refers to evidence from the national medical community, which may include, but is not limited to, one or more of the following sources:

1. National medical organizations
2. Peer-reviewed medical and scientific journals and publications
3. Publications and standards from professional medical organizations
4. Professional and Specialist Associations and Organizations
5. Expert consensus reports
6. Written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device, or medical treatment
7. Federal and state publications
8. Federal and state statutes, court decisions

The UM and QA committee reviews and approves all polices and changes at least annually.

APPLICATION OF MEDICAL CRITERIA

Utilization Review staff are charged with appropriate and consistent application of plan policies and procedures and any other accepted criteria in making authorization determinations. However, staff has also been given instructions to include with every referral, the evaluation of the needs of the individual and characteristics of the local delivery system. The following criteria are distributed to all staff via email on an annual basis and to every new hire during onboarding. Staff is encouraged to have the criteria available at their workspace for easy accessibility and are expected to refer to these guidelines regularly.

Examples of Individual characteristics to consider include, but are not be limited to:

- Diagnosis
- Gender
- Availability of services such as Skilled Nursing Facilities (SNF), sub-acute, acute rehabilitation or home care in the service area
- Age
- Explanation of Benefits (“EOB”) or other coverage definitions
- Community standards
- Severity of illness Co-
- Morbidities

- Complications
- Home Environment, as appropriate
- Progress toward accomplishing treatment goals
- Cultural Factors, as they relate to the disease process
- Family Support
- Psychosocial needs
- Ability of hospitals to provide recommended services within the length of stay
- Availability of urgent care centers
- Access to tertiary and quaternary care, for specialist and sub-specialist care
- Assessment of coverage of benefits for SNF, subacute care facilities or home care when needed

If any of the above factors indicate that the usual UM guidelines are not appropriate, the staff is directed to elevate the referral to the Director of Health Services, Medical Director or designee for discussion, review and final decision.

INTER RATER RELIABILITY -Consistency in Applying Criteria

VCHCP has developed a mechanism for assessing the consistency with which physician and non-physician reviewers apply UM criteria. The mechanism takes the form of an annual audit of a sample of randomly selected UM determination files, including authorizations and denials. A blinded re-review is performed by a different physician reviewer, in the case of a file initially reviewed by a physician reviewer or a different non-physician reviewer, in the case of a file initially reviewed by a non-physician reviewer. The second reviewer shall not be a subordinate of the first reviewer. The auditing method used is 5 percent or 50 of the UM determination files, whichever is less. Additionally, regular UM "rounds" are periodically scheduled, attended by UM staff members and physicians to evaluate determinations and problem cases, as well as periodic review of determinations including side-by-side comparisons of how different UM staff members manage the same cases. VCHCP then acts on opportunities for improvement, if identified by any inconsistencies found.

Behavioral Health Clinical Criteria for UM Decisions

VCHCP delegates UM for Behavioral Health Services to OptumHealth Behavioral Solutions of California (OHBS-CA), our BHA. See Optum's appropriate policies for written criteria, applying criteria, availability of criteria and consistency in applying criteria. See the VCHCP Delegation Policy and the OHBS-CA delegation agreement for details including oversight activities.

These policies are reviewed at least annually by the QA committee which includes members from Optum.

The criteria are available to members and practitioners on Optum's website which can be accessed through the VCHCP website by an active link. The information regarding this availability is sent to members and practitioners in the same way VCHCP information is distributed.

Created by: Dr. Catherine Sanders & Dr. Albert Reeves

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