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Healthcare Foundations

Utilization Management and Customer Services

Learning Services

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Agenda

- Utilization Management
- Utilization Strategies and techniques
- Utilization Review and Authorization

- Customer Service Overview
- Appeals
- Channeling
- Customer Inquiry

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Utilization Management

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Utilization Management

What is a

Utilization Management ?

Utilization management (UM) refers to health plan programs that manage the use of medical services so that plan members receive necessary and appropriate care in a cost-effective manner and in an appropriate setting.

Typically it includes new activities or decisions based upon the analysis of a situation.

The goal of UM is for the member to receive the right services at the right time in the right place.

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Utilization Management - Contd..

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Utilization Management – Contd..

Standard utilization management services include prospective review, concurrent review, retrospective review, pre-certification of hospital stays and discharge planning.

Utilization management involves all the components of a health plan’s healthcare delivery system, including primary care, specialty care, and both inpatient and outpatient care in hospitals and other facilities.

It also affects emergency care, pharmaceuticals, and ancillary services (such as X-ray and laboratory work).

A health plan may conduct its own utilization management, or it may contract with an external organization that specialized in UM to perform some or all UM functions

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UM Strategies and Techniques

The strategies need to be applied by a health plan depends on its member population.

UM strategies are used either to address the needs of members with existing health condition (**Pre existing Condition**) or to help members at risk of developing condition (**Preventive Care**)

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UM Strategies and Techniques - Contd..

Health Risk Assessment (HRA) is a process by which a health plan uses information about a plan member's current health status, personal and family health history, and health-related behaviors to determine the member's likelihood of experiencing specific illnesses or injuries.

By identifying members who are at risk of developing certain health problems and helping them take steps to reduce their risk, the plan can improve health outcomes, reduce the need for complex and extended care, and reduce costs.

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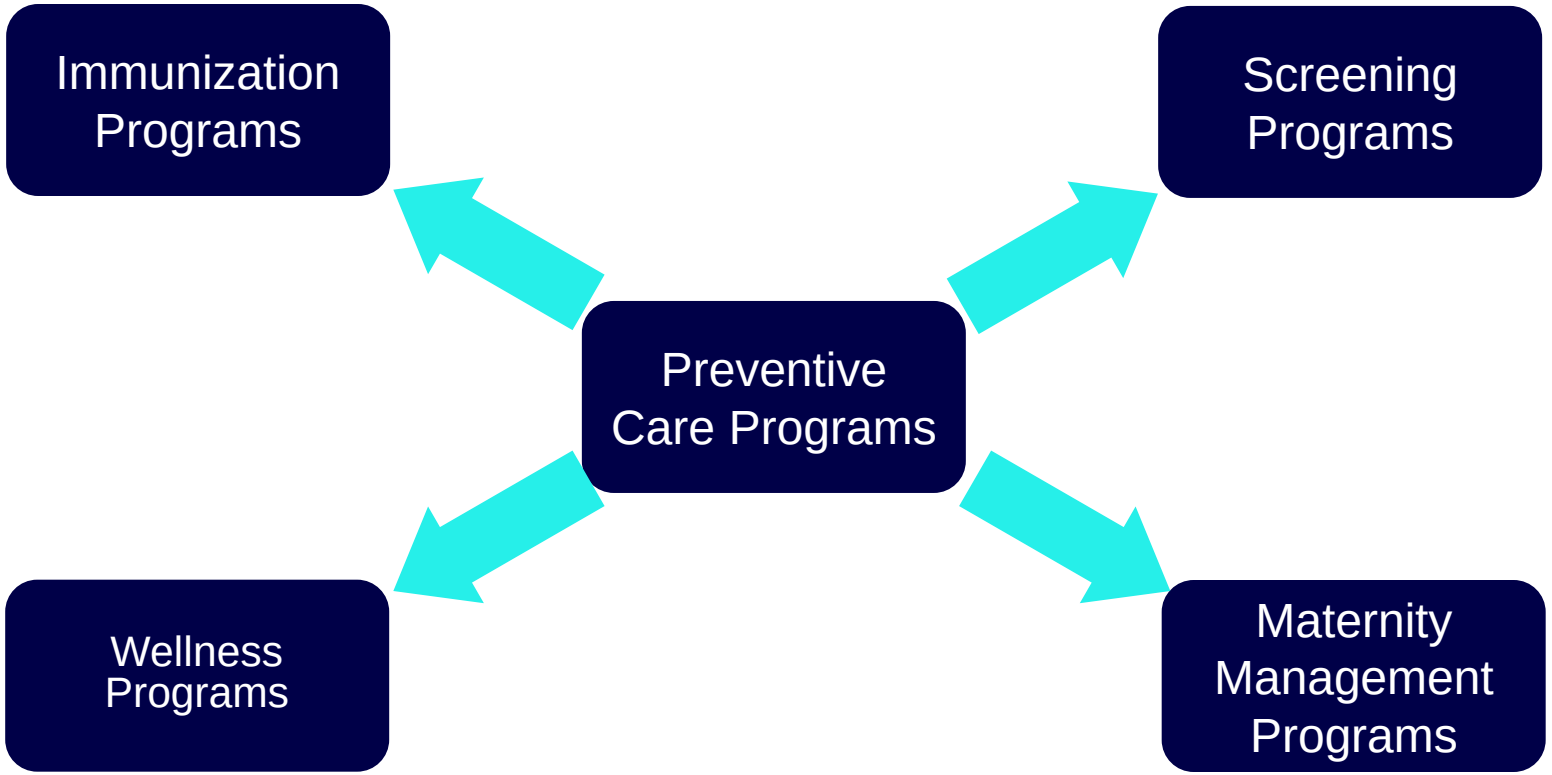
UM Strategies and Techniques - Contd..



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Utilization Review and Authorization

Utilization Review (UR)

- refers to an evaluation of the medical necessity, appropriateness, and cost-effectiveness of healthcare services and treatment plans for a given patient.

Authorization

- is a health plan’s system of approving payment of benefits for services that satisfy the plan’s requirements for coverage.

Medically necessary services

- Consistent with symptoms & diagnosis
- Accordance with standard of good medical practice
- Not solely for the convenience of the member
- Furnished in the least intensive type of medical care setting

Medically appropriate services are diagnostic or treatment measures for which the expected health benefits exceed the expected risks by a margin wide enough to justify the measures.

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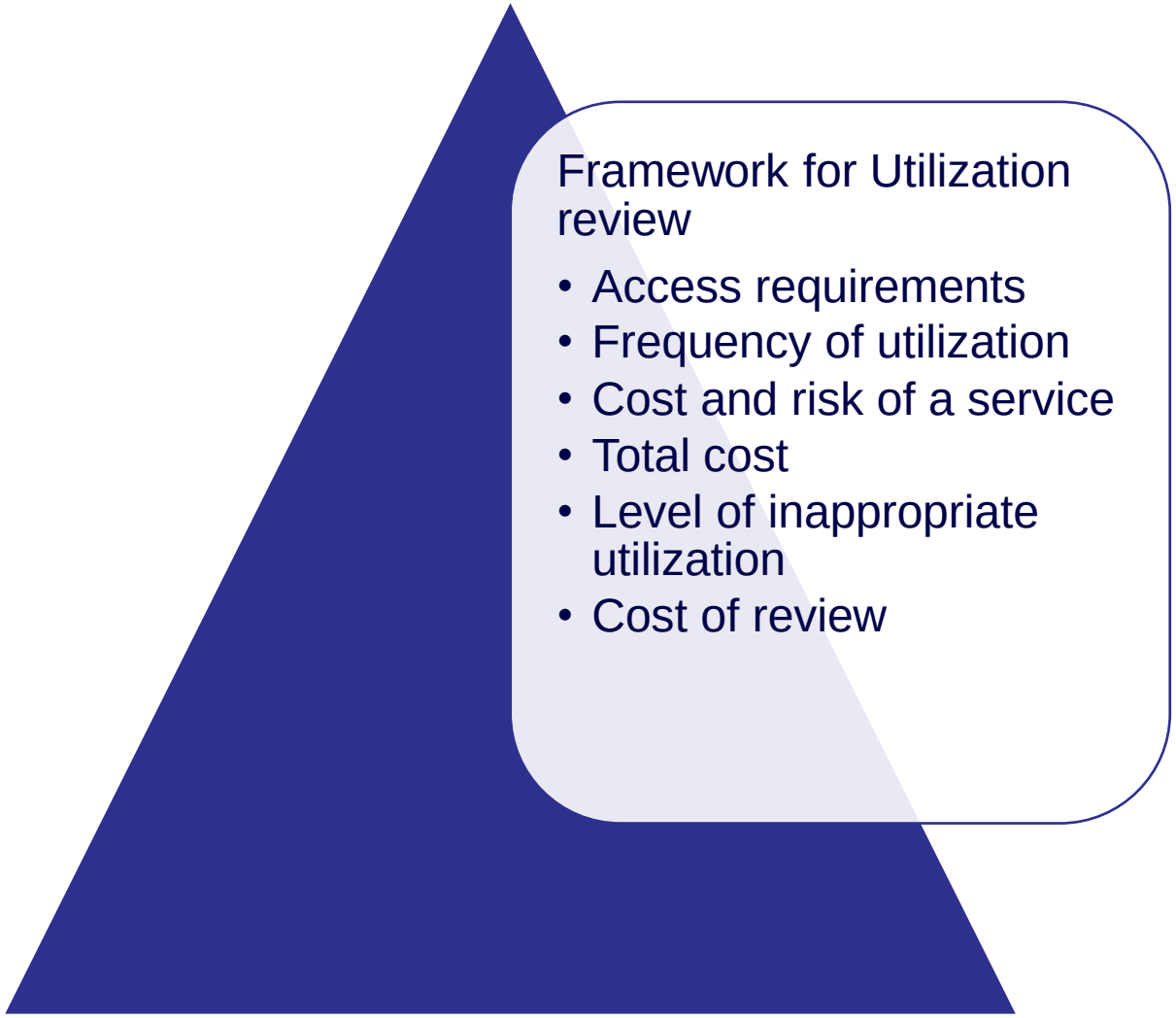
Utilization Review and Authorization – Contd..



Framework for Utilization review

- Access requirements
- Frequency of utilization
- Cost and risk of a service
- Total cost
- Level of inappropriate utilization
- Cost of review

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Customer Service

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Overview

Need for Customer Support Application

A health plan receives numerous customer inquiries, complaints, and requests from members, providers, representatives of groups or subgroups, and/or their attorneys, prospective members, and non-members

Inquiries may require immediate response, as when a customer is searching for a provider that meets specific criteria or when notifying the health plan of a change of primary care provider

Other inquiries, such as when a customer is registering a complaint and initiating an appeal, may require the representative to enter a record of the activity.

Let’s the user store information about the specific follow-up activities related to the call.

Provides other information stored in Facets, like the status of a claim or information regarding a pre-authorization

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Overview - Contd..

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Facets Customer Service Functionality

- Customer Service Application Group contains the applications that are used to handle the inquiries
- The customer service functionality can be divided as
  - Appeals Processing
  - Channeling
  - Customer Service Inquiry
- Facets contains a Customer Support (Customer Service) Dashboard that brings all the necessary information to the Customer Service Rep without the need for extensions

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Customer Service Inquiry

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Customer Service Inquiry

A customer service inquiry is usually initiated by the customer or the customer's representative

The purpose of the inquiry might be to request information about plan benefits, to change member or address information, to select a new PCP, or to register a complaint

The customer service representative can record the customer's member ID, the reason for the inquiry, and any other relevant details in the Customer Service application

Depending on the request, the customer service representative can complete the inquiry, pend it for follow up activity, or route it to another user or group

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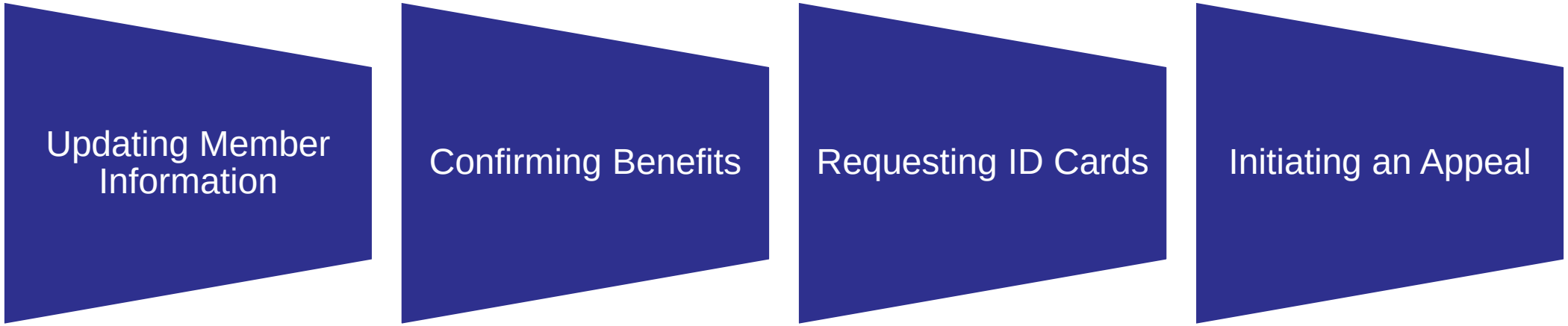
Types of Customer Service Inquiry



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Appeals Processing

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Know the Term

Appeal

An appeal is a complaint regarding any aspect of a plan's health care services.

Some of the issues that might provoke an appeal include

- access to services
- plan provision or coverage disputes
- denial of services due to prospective and ongoing utilization management and continuity of care issues.

Grievance

A grievance is a complaint regarding services that were rendered or not rendered within the member's plan.

Some of the issues that might provoke a grievance include

- delay in obtaining an appointment, long wait at appointment time, physician behavior, inability to obtain a service
- coverage disputes, such as denial of a claim or service and disputes over medical necessity
- underwriting disputes, such as refusal to insure or delays in issuing coverage
- marketing and sales disputes, such as failure to respond to enrollee request

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Appeal

An appeal or grievance can be initiated by a member, a member's representative, or a provider

Once the appeal has been initiated, the health plan designates an appeal reviewer to review the case and make a decision regarding that appeal

While there is a distinction between an appeal and a grievance, both types of complaints are handled through the same appeals procedures in Facets

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Appeal – Contd..

The Customer Service Representative tracks and reports information pertaining to an appeal in the Appeals application

Customer service representatives can also enter information about the persons who are reviewing the appeal, decisions reached by the reviewers, and any other activities associated with the appeal

It is important to note that all of these processes are mandated by the Centers for Medicare and Medicaid Services (CMS) and various state laws.

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Appeals Contact and Appeals Reviewer

Appeals Contact

- The individual who is to be contacted or notified of a decision on behalf of the member
- The primary contact record is established in the Appeals Contact application

Appeals Reviewer

- The individual assigned by the health plan to review the member's appeal and make a decision regarding that appeal.
- The appeals reviewer record is established in the Appeals Reviewer application

Prerequisite

- Contact and Appeals Reviewer records must be established in Facets prior to being linked to an appeal
- Without this info, the appeal can be started and then saved and pended

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Types of Appeal Processing

Standard Appeal

- Health plan notifies member/ the member's covering provider of its decision in writing
- Reviewer must provide the clinical review criteria that was used to make the determination

Expedited Appeal

- In the event that the time frame and standard review procedures for standard appeals would seriously jeopardize the life or health of the member, or would jeopardize the member's ability to regain maximum function, the appeals process may be expedited
- Communications between the health plan and the member or provider happens by telephone, facsimile, or the most expeditious method available
- If notification was not in writing, written confirmation should follow as soon as possible
- After receiving a request for an expedited review, the health plan should provide reasonable and timely access to an appeals reviewer who can perform the expedited review

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Levels of Appeal

There can be up to six levels of appeal logged in the Appeals application.

First Level Review	The member, member's representative, or provider are entitled to submit documentation to support their position. After the First Level of Review, litigation or Alternate Dispute Resolution (ADR) is sometimes an alternate choice
Second Level Review	If an adverse determination is made at the First level, the decision may be appealed. The member, member's representative, or provider is entitled to appear at the Second level review, in addition to providing documentation
Third Level Review	In some cases, it is possible to appeal the adverse decision of the Second level
Fourth Level Review	In some cases, it is possible to appeal the adverse decision of the Third level
Fifth Level Review	To comply with Medicare's standard six appeals levels, it is possible to appeal the adverse decision of the Fourth level
Sixth Level Review	To comply with Medicare's standard six appeals levels, it is possible to appeal the adverse decision of the Fifth level

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Channeling

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Channeling

Channeling is the process where a health plan finds the providers or facilities that match the specified criteria for a customer who needs the information

The customer service representative can define a customer's requirements, search the Facets database, and find one or more providers or facilities for the customer using the Channeling application

Details about the provider or facility, such as affiliations, number of beds, or office hours, can also be provided to assist the customer in selecting a provider

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Thank you

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Appendix

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Customer Service Application

- On opening, the application lands on “Start a new call” tab.
- Contact Info is of the person who is on the call.
- Customer Info is of the person whose details are being discussed.
- On clicking “Next”, Verification page pops up. Caller is required to verify at least 2 of the data.
- On completing verification, it points to General Task Page.

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Customer Service Application – Contd..

- Each task page includes fields in which the user can enter inquiry information and notes regarding a Customer Service task
- The **Subject** and **Category** fields are configurable in the CS Subject/Category Configuration application in Application Support.
- The **Click Notes** area provides additional data about a specific task, such as eligibility, deductibles, or benefits summary.
- Click notes are configurable using the CS List Configuration application found in the Application Support application group.

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Customer Service Application – Contd..

- Following member related data adds/changes can be done from CS application
    - Address Add or Address change
    - PCP Add or PCP Change
- All other data can be only viewed and not changed.
- In one call, multiple inquiries can be recorded and each one is called **Tasks**
- After all the details are recorded, status is updated for each task and the call be saved by clicking “End Call”

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Appeals - State Requirement

- Regulated by both Federal and State laws (may vary from state to state)
  - Most States require that credentials of the reviewers must be documented and that reviewers must not be involved in the initial determination
  - Some states require committees that are external to the Health Plan
  - All states also require adherence to the Privacy Act Provisions
- Finally, states usually require some type of register that reports the following information:
    - the Number of Appeals
    - the Date Received, Dates of Notification and Date Resolved
    - Reasons for the appeal
    - Resolution of each level of appeal
    - Name of the covered individual
    - Name of the Provider

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Appeals Application

- To create a new appeal record, complete the Member page by providing Subscriber Id, Suffix
- Check the Level , Primary User and Status of the Appeal.
- Fill the Category, Type, Sub-Type Description and Summary details in the Appeal Page
- From this page can navigate to Linked Records Page, Level Details, add Providers and view Appeal Reviews details.
- Level Indicative page has the User details and decision update on the appeal, can view the status History of the Appeal.
- The Level details will have the summary captured
- Contacts Page will have the details of Member’s / Provider’s representative to be reached

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Appeals Application – Contd..

Key Tables :

CMC_APAP_APPEALS	Core table for Appeals
CMC_APAL_ADM_LOG	Log table for administrative/ Follow up activities
CMC_APCT_CONTACTS	Will hold Contact information of Appeal Representatives

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Channeling Application

Key Tables :

CMC_CHCH_CHANNEL

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