

NOTE: Due to the State of Minnesota's legislation, coverage for General Assistance Medical Care (GAMC) is switching from Health Plan coverage to Fee-For-Service coverage on April 1, 2010.

Chapter 6

Medical Management

Overview

This chapter provides information on South Country Health Alliance (SCHA) requirements for prior authorization, notification and medical necessity criteria for services that require a prior authorization.

This Chapter Includes:

- Definition of Terms
- Services Requiring Prior Authorization or Notification
- Authorization Requests and Decision Making
- Authorization Grid – Page 3
- Inpatient Hospital and Skilled Nursing Facility Admission and Notification Requirements
- Concurrent and Retrospective Reviews
- Prior Authorization, Notification and Authorization Documentation Submission
- Medical Necessity Criteria
- Continuity of Care
- Access to Specialty Care
- Disease Management

Definition of Terms

Approval Authority – MMSI is a third party administrator to whom SCHA has delegated the ability to make decisions to approve or deny prior authorizations and/or out-of-network authorizations. **Note: For chemical dependency services, approval authority is held by the person completing the admission assessment.**

Notification – Process of provider notifying MMSI about a service or treatment being provided within a specific period of time.

Prior Authorization – Approval of a service or treatment prior to the provision of the service or the treatment. Prior authorization requests are completed in writing by the provider of service. The prior authorization request is reviewed by medical professionals to determine if the service or treatment requested is medically necessary and appropriate, and that less expensive alternatives have been considered. Emergency services do not require prior authorization.

Authorization – A recommendation by a member's primary care physician or SCHA contracted provider that allows a member to be seen by an out-of-network provider.

Standing Referral – A member’s request to see an out-of-network specialist for a specified period of time.

Services Requiring Prior Authorization or Notification

SCHA focuses on removing barriers for members to see in-network providers for the purpose of obtaining necessary care. SCHA’s model is that every member is assigned to a primary care clinic. Members can access other in-network providers without an authorization from their primary care clinic. There are some services and treatments that do require prior authorization or notification. These services include:

- Services or treatments that have limited requirements
- Services or treatments that are listed as non-covered services, but the provider considers the service medically necessary
- Services where there are lower cost options that have similar safety and effectiveness

Included in this document is a prior authorization notification list that details which services require prior authorization or notification. If the service or treatment is not listed, call SCHA Provider Service Center at 1-800-995-4543 to determine if an authorization is needed.

Authorization Requests and Decision Making

Prior Authorization and Notification list can be found on our website at www.mnscha.org/provider.

Note: authorization for surgical procedures does not include/infer authorization for follow-up care. Refer to member’s benefit plan for coverage information.

SCHA/MMSI makes authorization decisions using evidence-based standards of care, medical necessity criteria and the member’s benefit coverage. SCHA/MMSI does not reward providers or other individuals for denying services to members, nor does SCHA/MMSI reward decisions that result in under-utilization of services. Decisions made by SCHA/MMSI do not constitute the practice of medicine. SCHA and MMSI encourage open access to covered services at appropriate levels of care.

Prior authorization confirms medical necessity only and does not guarantee payment.

Payment is determined at the time the claim is received and is subject to health plan exclusions and out-of-network benefit limitations. Plan coverage must be in effect for the member at the time service(s) is rendered.

Prior Authorization and Notification Documentation Submission

Requests that require prior authorization for non-urgent conditions must be received at SCHA/MMSI at least 14 calendar days prior to the first date of service. SCHA/MMSI will respond to your request in writing within 10 working days. If a request is marked urgent, the reason for the urgency must be included. Urgent requests will be processed within 72 hours.

Prior Authorization requests and notifications for medical/surgical and mental health/chemical health should be faxed or mailed to:

MMSI

Attn: Health Services
4001 41st Street NW
Rochester, MN 55901
Fax: 888-889-7822
Phone: 800-645-6296

Medical and Behavioral Health Services

MMSI Health Services
4001 41st Street NW
Rochester, MN 55901-8901
800-995-4543

Chiropractic Services

Clinical Resource Group, Inc.
866-281-1997

Dental Services

DentaQuest
800-341-8478

Pharmacy Services

Prime Therapeutics, LLC
866-325-5233

Inpatient Hospital and Skilled Nursing Facility Admission and Notification Requirements

Hospital and Skilled Nursing Facility Responsibility

1. Prior to providing service, verify member eligibility
2. Notification of an inpatient hospital admission is requested within 24 hours of admission
3. Medical and surgical hospital and SNF inpatient admission and discharge information can be faxed (1-888-889-7822) to MMSI. All required forms are found on SCHA web site www.mnscha.org.

- A. Hospital admissions – complete the SCHA Inpatient worksheet and fax to MMSI. Be sure to include the following information on the form:
 - a. member name
 - b. SCHA ID number
 - c. date of birth
 - d. diagnosis
 - e. admission date,
 - f. admission facility
 - g. Utilization Review contact and phone number
 - h. return fax number
- B. Skilled nursing facility admissions for 180 day custodial stays – complete the SNF admission form along with the RUG code and fax to MMSI.
- C. Skilled nursing facility admissions – complete the SNF admission form, and if the stay qualifies for Medicare skilled days, include clinical information that supports the need for skilled care. Fax the Skilled Nursing Facility Admission Form and clinical information to MMSI.
4. Retrospective admission – complete the (form) and include pertinent clinical information. Fax the form and clinical information to MMSI.

Mental Health and Chemical Dependency Admissions

1. Notification of hospital admission is required within 24 hours of admission.
2. The first three days of the hospital stay are approved. The fourth (4th) day requires utilization review for continued inpatient stay
3. Complete the Minnesota Universal Outpatient Mental Health/Chemical Health Authorization Form and fax to MMSI.
4. A retrospective admission requires that clinical documentation supporting the need for admission be faxed to MMSI, Attn: Behavioral health staff.

Concurrent and Retrospective Reviews

SCHA performs concurrent or retrospective reviews dependent on utilization triggers. A medical director is consulted if review of clinical documentation does not clearly demonstrate medical necessity of the admission or services provided. SCHA's intent is to be actively involved in hospital discharge planning and member's case management needs. Review information may include:

1. Clinical information upon request for any inpatient stays;
2. Clinical information for all medical and surgical inpatient stays greater than 7 days faxed to MMSI (888-889-7822);
3. Access to hospital utilization review staff and additional information and clarification of information as requested;
4. Notification to MMSI of members with complex discharge needs or those who may benefit from case management.

Medical Necessity Criteria

Please Note: CMS criteria will be used for those members eligible for Medicare benefits.

Panniculectomy_(Resection of redundant skin following massive weight loss)

1. Panniculectomy/abdominoplasty is considered reconstructive when ALL of the following criteria are met:
 - A. Patient has a Body Mass Index (BMI) of 27 or less after massive weight loss
 - B. Patient has maintained a steady weight loss for one (1) year
 - C. Patient has Braden Stage III skin ulcers and failure to respond to conservative therapy documented by the patient's surgeon or physician

Personal Care Assistant Services

PCA services provide assistance and support to persons living independently in the community with special health care needs. Prior Authorization is required for all PCA services. Additional information regarding PCA services may be found in the Home Care Chapter.

1. PCA Services must be:
 - A. Medically necessary;
 - B. Ordered by a physician, for an eligible recipient, whose illness, injury, physical or mental condition creates a need for the service;
 - C. Provided under the supervision of a qualified professional or the recipient or his or her responsible party;
 - D. Medical Assistance Health Status Assessment (MAHSA) completed by public health indicating member is eligible for PCA services due to ADL dependencies;
 - E. The PCA hours recommended must be within PCA limitations per member's case mix.
2. Recipients must be given a choice of either supervising PCA services or having a qualified professional supervise the services
3. Eligibility – PCA services are available to recipients covered by:
 - A. Medical Assistance
 - B. Minnesota Care Expanded Benefit set; (pregnant women and children under age 21)
 - C. Minnesota Senior Care+
 - D. Senior Care Complete
4. PCA services are not covered for GAMC recipients, or non-pregnant adults enrolled in MinnesotaCare.

5. PCA's are limited to a maximum of 275 hours/month for services provided by an individual PCA. Member may have more hours but must use a second PCA.
6. PCA services are limited to a maximum of 16 hours/day.
7. **PCA and PDN services provided to a member on AbilityCare are covered through DHS. Providers need to bill all PCA and PDN services to DHS.**

Breast Reconstruction and Breast Prosthesis

1. Breast reconstruction following a medically necessary mastectomy is a covered service.
2. Breast reconstruction of the non-diseased contralateral breast in a patient who has had a medically necessary mastectomy. This may include mastopexy, reduction, or augmentation.
3. Breast reconstruction for a diagnosis of Poland syndrome.
4. Prophylactic mastectomy and reconstruction for members with a strong family history of breast cancer as documented by a genetic or specialty assessment and recommended by a physician.
5. When there is documentation of implant rupture or symptoms, e.g. infection, ulceration, leakage, pain, or displacement.
6. MRI screening of symptomatic breast prosthesis

Breast Reduction

For reduction mammoplasty to be considered medically necessary ALL of the following criteria must be met:

1. A diagnosis of Macromastia/mammary hypertrophy/mammary hyperplasia. (Documentation by photographs is required).
2. Documentation of at least one of the following symptoms or signs:
 - A. Orthopedic function-related (including but not limited to occipital headaches, cervical lordosis, thoracic kyphosis, low back pain associated with lumbar lordosis)
 - a. Documentation or prior documentation of symptoms and signs present for a minimum of one year; and
 - b. Documentation that symptoms and signs cannot primarily be explained by a musculoskeletal condition, e.g. arthritis spondylitis, acromioclavicular strain. Documented with X-rays if necessary; and
 - c. Documentation that mammoplasty is likely to improve above symptoms
 - B. Dermatologic-related (including but not limited to bra strap caused shoulder severe soft tissue grooving and/or skin ulceration)
 - a. Documentation or prior documentation of symptoms and signs present for a minimum of one year
3. BMI less than 35

4. Removal of a minimum amount of breast tissue
 - A. 500 grams of breast tissue and skin per breast in a person 60 inches and over in height
 - B. 400 grams of breast tissue and skin per breast in a person less than 60 inches in height
 - C. The weight of tissue removed may be verified by requesting submission of a surgical pathology report indicating the weight of tissue actually removed
 - D. All women 40 years of age or older are required to have a mammogram that was negative for cancer performed within the year prior to the date of planned reduction mammoplasty

Gastric Restrictive Surgery

Surgery for selected individuals with clinically severe obesity when less invasive methods of weight loss have failed and the individual is at risk for obesity-associated morbidity and mortality.

1. Bariatric surgery patients must meet ALL of the following criteria:
 1. Patient must have a body mass index (BMI) greater than 40 **or** have a BMI greater than 35 with medical management of one of the following co-morbid conditions:
 - a. Diabetes, type 2
 - b. Dyslipidemia
 - c. Hypertension
 - d. Obstructive Sleep apnea
 - e. Coronary artery disease
 2. In addition to the above, ALL the following must be met:
 - a. Patient must have documentation demonstrating at least a one-year effort to reduce weight with non-surgical treatment without a significant change in weight as defined by less than 5% of initial body weight
 - b. Procedure must be performed at a Mayo Clinic/Mayo Health System Hospital, OR a Medicare certified facility (<http://www.cms.hhs.gov/MedicareApprovedFacilitie/BSF/list.asp>)
OR a ASMBS Bariatric Surgery Center of Excellence (<http://www.surgicalreview.org/locate.aspx?state=US-KS#srchResults>)
 3. Procedure must be performed as part of a comprehensive program that includes the following documented components:
 - a. Patient must undergo a medical pre-operative evaluation and deemed an acceptable surgical candidate
 - b. Patient must undergo a mental health assessment and is felt to be an acceptable surgical candidate
 - c. Patient must be deemed appropriate for surgery by the surgeon performing the procedure

- d. A one year post-operative care plan including medical and psychological follow-up care must be available
- 2. Request for a second bariatric procedure must be reviewed by a medical director
- 3. Request for bariatric procedure for members who are under age 18 must be reviewed by a medical director

Blepharoplasty and Brow Lift Surgery

- 1. All criteria must be met for Blepharoplasty surgery approval
 - A. At least one of the following diagnoses must be present describing the member's condition:
 - a. Blepharochalasis (ICD-9-CM: 374.34)
 - b. Dermatochalasis (ICD-9-CM: 374.87) 10
 - c. Fitting/adjustment of prosthetic device, artificial eye (ICD-9-CM: V52.2)
 - d. Mechanical ptosis (ICD-9-CM: 374.33)
 - e. Myogenic ptosis (ICD-9-CM: 374.32)
 - f. Paralytic ptosis (ICD-9-CM: 374.31)
 - g. Ptosis of eyelid, unspecified (ICD-9-CM: 374.30)
 - B. Surgical correction is considered functional/reconstructive if at least one of the following conditions exist:
 - a. Visual impairment with near or far vision as a result of dermatochalasis, blepharochalasis, or blepharoptosis.
 - b. Symptomatic skin weighing down the upper eyelid lashes.
 - c. Chronic symptomatic dermatitis of the pretarsal skin caused by redundant upper eyelid skin.
 - d. Prosthesis difficulties in an anophthalmic socket.
 - C. Documentation demonstrating that patient has interference with superior fields of vision.
 - a. Visual field testing must be done manually and document limitation within 10 to 20 degrees of the visual axis (Photographic documentation is required)
 - D. Brow lift surgery is covered only when the surgeon can document that the patient's visual impairment will not be corrected by blepharoplasty alone or when performed in conjunction with a seventh nerve palsy repair.

Varicose Vein Treatment

Varicose veins are abnormally swollen and tortuous vessels, especially the superficial veins of the legs. Common varicose vein treatments include: sclerotherapy, endoluminal radiofrequency ablation (e.g., ERFA/VNUS), ligation and surgical stripping.

1. Treatment of varicose veins is covered with documentation of clinical symptoms and demonstration of at least one (1) of the following:
 - A. Episodic bleeding or bruising
 - B. Recurrent episodes of superficial phlebitis, inflammation and thrombosis
 - C. Complications of venous stasis such as dermatitis, ulcer or skin breakdown
 - D. Moderate to severe dependent edema refractory to treatment

2. With appropriate clinical or objective signs, the member must also meet ALL of the following criteria for ERFA/VNUS therapy:
 - A. Reflux in non-aneurysmal veins
 - B. Non-tortuous veins that allow for catheter advancement
 - C. Clinically significant reflux and greater saphenous vein (GSV) insufficiency above the knee

Synagis (Palivizumab) Immunization

Synagis is given for the prevention of respiratory syncytial virus (RSV) disease in high risk infants and young children.

1. Coverage for Synagis injections will follow the recommendations made by the American Academy of Pediatrics:
 - A. Infants < 1 year old born at < 28 weeks gestation
 - B. Infants < 6 months old born at 29 to 32 weeks gestation
 - C. Infants < 6 months old born at 32 to 35 weeks gestation with additional risk factors for RSV infection
 - D. Children < than 2 years old with chronic lung disease and medical therapy in the previous 6 months

Continuity of Care

In accordance with Minnesota Statutes 62Q.56 SCHA enrollees are required to access services through selected primary care provider for coverage. However if a provider has had their contract terminated, SCHA will:

- Inform affected members about termination at least 30 days before the termination is effective providing SCHA has had at least 120 days' prior notice.
- SCHA/MMSI will inform the affected enrollees about what other participating providers are available to assume care and how it facilitate a transfer either by telephone or in writing.

- If a member that will be transferring to another participating provider has special medical needs, special risks or other special circumstances, such as cultural or language barriers, SCHA/MMSI will work closely with the member and allow, if needed a longer transition period.
- Members with special needs will be identified by SCHA/MMSI staff, County Case Managers, or TPA case managers. Criteria will be based on medical, physical, mental and cultural needs.

Members with special medical needs or at special risk continuity of care will be provided for the enrollee may continue care for up to 120 days for the following conditions:

- an acute condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last of at least one year, or can be expected to result in death; or
- a disabling or chronic condition that is in an acute phase; or
- a disabling or chronic condition that is in an acute phase; or
- for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

The request for authorization may come from the enrollee's current provider. SCHA/MMSI will grant the requests for authorization to receive services unless the enrollee does not meet the criteria provided above

For new members who are subject to a change in a health plan, upon request, SCHA/MMSI may do an authorization to receive services that are otherwise covered under the terms of the new health plan through the member's current provider if:
an acute condition;

- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last of at least one year, or can be expected to result in death; or
- a disabling or chronic condition that is in an acute phase; or
- a disabling or chronic condition that is in an acute phase; or
- for the rest of the enrollee's life if a physician certifies that the enrollee has an expected lifetime of 180 days or less.

SCHA may require medical records and other supporting documentation be submitted with the requests for authorization.

Access to Specialty Care

In accordance with Minnesota Statutes 62Q.58 SCHA will approve standing authorizations for a health care provider who is a specialist and SCHA does not have an

appropriate participating specialist who is reasonably available and accessible to treat the member's condition or disease.

The member must meet one of the following conditions:

- a chronic health condition;
- a life-threatening mental or physical illness;
- pregnancy beyond the first trimester of pregnancy;
- a degenerative disease or disability; or
- any other condition or disease of sufficient seriousness and complexity to require treatment by a specialist.

Disease Management

SCHA conducts Disease Management Programs for members with heart failure, diabetes and adult and child asthma and post partum depression. Members who may benefit from participation in one of these programs are identified in a variety of ways, such as new member assessments, claims screening, UM process, referrals from a caregiver, county staff, case managers, care coordinators, providers, and by self-referral.

The program addresses condition monitoring, member's adherence to the program's treatment plans, considers other health conditions and lifestyle.

Members who are in the program are stratified into severity level. This stratification determines the interventions a member may receive.

To assure good care coordination with members, the members who are enrolled or contacted regarding a DM program are charted in the Client Contact Manager (CCM) program. Members are encouraged to discuss any of the materials they receive with their Providers and to always follow their Provider's advice and treatment plan.

Additional documents on each program can be found on the www.mnscha.org web page under Provider Resources.