Section 6
Clinical Programs and Utilization Management

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My Care Family Care Management Program

My Care Family is dedicated to providing well-managed patient-centered care to My Care Family patients. For optimal coordinated care, My Care Family patients should always be referred within the My Care Family network.

The My Care Family care management program primarily serves patients identified as high-risk and rising-risk. Interventions are tailored to meet patients where they are with increased services being made available to those with complex, costly, and/or chronic needs.

The care management program combines local, in-person care management at the points of care and in the community with remote, health-plan-based, telephonic Care Management. As appropriate, services may be delivered in the patient's home.

With this well-coordinated and patient-centered model, the care management program promotes high-quality and efficient care delivery. The program is intended to help reduce avoidable readmission and ED utilization, while improving member health outcomes and satisfaction.

My Care Family Care Teams

Integrated and multidisciplinary care teams are available to patients across all My Care Family practices. These collaborative teams will include cross-organizational clinical staff and primarily serve those that are identified as high risk or rising risk patients. With this collaborative model, this program expects to:

- Deliver stronger care coordination
- Improve communication with patient and within care team
- Improve patient outcomes
- Reduce duplicative spending and services
- Develop and strengthen community physician relations
- Improve quality of care
- Improve patient satisfaction and engagement
- Ensure that the patient has access to the right care at the right time

My Care Family Care Management Services

High-risk and rising-risk patients enrolled in My Care Family's Care Management Program are eligible to receive the following services as appropriate based on individual patient needs and goals:

- Comprehensive Assessments (if Care Needs Screening indicates the member has a Special Health Care Need)
- Development of patient-centered Care Plans
- Referrals to specialty and disease management programs as appropriate (HIV, High Risk OB, Diabetes, Hepatitis C, etc.)
- Referrals to LTSS and BH CPs as needed and appropriate
- Home visits
- Face-to-face and/or telephonic Care Management
- Care Management focused on improving health outcomes, reducing inappropriate utilization of resources, and ensuring communication and collaboration across the care continuum.
- Assistance when appropriate with improving Social Determinants of Health (SDOH) as they relate to and affect the members' health status
- Disease management
- Wellness programs
- Transitions of care management
- Medication reconciliation and medication education

Additional Care Management Services

In addition to services through the My Care Family Care Management program, My Care Family patients have access, when appropriate, to existing care management

programs at Greater Lawrence Family Health Center, Lawrence General Hospital, and AllWays Health Partners.

My Care Family Utilization Management

The Utilization Management (UM) program is designed to ensure the provision of the highest quality of health care to My Care Family patients while at the same time promoting appropriate, efficient and cost effective resource utilization. As such, the UM program focuses on:

- Evaluating requests for services by determining the medical necessity, appropriateness and effectiveness of the requested services
- Promoting continuity of patient care through the facilitation and coordination of patient services to ensure a smooth transition for members across the continuum of health care
- Analyzing utilization statistics to identify trends and opportunities for improvement
- Reviewing, revising and developing medical coverage policies to ensure that utilization management criteria are objective and based on medical evidence and that My Care Family patients have appropriate access to new and emerging efficacious technologies.

Referrals, prior authorization, notification, concurrent review, retrospective review, and discharge planning are all elements of the utilization management program.

As underutilization of medically appropriate services has the potential to adversely affect patients' health and wellness, My Care Family promotes appropriate utilization of services. Utilization management decisions are based on appropriateness of care and service and the existence of coverage. My Care Family does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does My Care Family provide financial incentives to UM decision makers to encourage decisions that result in underutilization.

The treating provider, in conjunction with the member or designee, is responsible for making all clinical decisions regarding the care and treatment of the member. My Care Family clinicians are responsible for making all utilization decisions in accordance with the patient's plan of covered benefits and established medical necessity criteria.

My Care Family network providers are contractually prohibited from holding any My Care Family member financially liable for any service administratively denied by AllWays Health Partners for the failure of the provider to obtain the required prior authorization or notification for the service, or for services denied because the provider failed to submit supporting clinical documentation with their request.

My Care Family periodically reviews the services for which prior authorization is required as practice patterns in the network warrant. Providers are notified of changes via the eNewsletter, the provider portal, and/or written communications.

Requesting and Obtaining an Authorization or Referral

Prior authorization, referral and notification requirements for general services are available on allwaysprovider.org.

Most Surgical Day Care (SDC) services do not require authorization. A consolidated list of SDC procedures requiring authorization can be found on allwaysprovider.org.

Not all DME and orthotics require authorization. See the Prior Authorization Exemptions for DME, Orthotic and Prosthetics list on allwaysprovider.org.

Submission through the Provider Portal

Required referrals, authorizations and notifications must be submitted through

AllWays Health Partners online authorization tool, accessed through the provider portal, allwaysprovider.org. Clinical documentation to support authorization requests can also be submitted through allwaysprovider.org. To expedite decision making, complete clinical information supporting medical necessity should be uploaded with the request on allwaysprovider.org.

Authorization or referral requests to a non-My Care Family network provider cannot be submitted through the provider portal and requires fax submission:

Fax 617-586-1700

Valid Prior Authorization Requests

A valid prior authorization request is defined as one where:

- The request is initiated by the primary care provider (PCP), treating specialist, or the treating provider.
- The patient is actively enrolled with My Care Family at the time of the service.
- The appropriate authorization template is completed for those service requests that require submission through allwaysprovider.org.
- The appropriate authorization form is completed for service requests that are still faxed or mailed.
- A physician prescription is included with a request for enteral formulas, infusion therapy and DME.
- Clinical documentation to support medical necessity is included.

Confirmation of Requested Authorizations

My Care Family providers obtain confirmation of received authorization requests and UM decision-making from allwaysprovider.org including the authorization identification number, authorization decision, number of days/visits, and the duration approved or denied. Authorization reports specific to a member, individual authorization, or an aggregate of all requests made by the servicing provider are available through the provider portal.

Only those requests made by the requesting servicing provider may be viewed by the requesting servicing provider.

Existence of an authorization identification number does not ensure that a request has been approved. All requests are assigned an authorization identification number for tracking purposes independent of the approval status. It is imperative that providers validate the status of a specific authorization request.

The *Service Authorization Report* informs the provider that a request was either:

- Approved (A) based on medical necessity, benefit coverage and member eligibility,
- Closed (C) due to a change in level of care (i.e., an observation stay that escalates to an inpatient admission) or administrative error,
- Denied (D) based on medical necessity or administrative guidelines, or
- Pended (P) awaiting clinical review or more information.
- Medreview (M) awaiting clinical review or more information.

All authorization decisions resulting in an adverse determination are also communicated to the requesting provider by phone and in writing.

Utilization Management Methods

Referrals

My Care Family promotes a health care delivery model that supports PCP coordination and oversight of care. My Care Family recognizes that its members are best served when there is coordination between specialty and primary care clinicians. Referrals are not required to specialists within the My Care Family network.

To ensure reimbursement, care provided by a non-My Care Family specialist may require a referral from the PCP. The My Care Family PCP is the only provider authorized to make referrals to specialists. The PCP should submit the referral before the initial recommended specialty visit and no later than 90 days after the initial specialty visit. Without the required referrals, payment is subject to denial.

Some services such as family planning, gynecologist or obstetrician for routine, preventive, or urgent care, behavioral health services, and emergency services do not require a referral.

Prior Authorization (Prospective Review)

Prior authorization allows for the efficient use of covered health care services and helps to ensure that members receive the most appropriate level of care in the most appropriate setting.

My Care Family identifies certain services as requiring prior medical necessity review and approval subsequent to meeting established criteria. Prior authorization processes support care management involvement by connecting the Utilization Management Care Manager with the provider and member prior to the delivery of services. Certain requested services, procedures, or admissions require prior authorization. Prior authorizations are based on medical necessity and are not a guarantee of payment. Requests for services requiring prior authorization must be submitted prior to delivery of service. Failure to obtain required prior authorization can result in a denial of payment to the provider.

For elective services, such as admissions and surgical day, My Care Family requires at a minimum, submission five business days prior to the admission. Authorization determinations for elective services can take up to 14 calendar days to ensure adequate time for review and processing (See “UM Time Frame for Decision-making and Notification”).

Prior authorization is not required for:

- Emergency room care
- Observation
- Emergent acute inpatient admissions.

Requests for prior authorization services are forwarded to a Utilization Management Care Manager for review. The Utilization Management Care Manager will determine whether the requested service meets established review criteria guidelines. The Utilization Management Care Manager will contact the servicing provider or PCP whenever there is a question regarding the requested type of service or setting. Additional clinical information may be required in order to make a medical necessity decision.

Prior authorization approvals are made by My Care Family Utilization Management Care Managers based on medical necessity criteria. Prior authorization denials (adverse determination) for medical necessity are made only by the Chief Medical Officer, an AllWays Health Partners Medical Director, or a designated physician reviewer, based upon medical necessity criteria, the specific needs of the individual patient and the availability of local resources.

Durable Medical Equipment (DME)

DME purchases and rentals must be requested by the patient’s PCP, treating provider, or an approved vendor.

Some DME items are not subject to authorization requirements. For a list of services that require prior authorization, please review the DME Prior Authorization list on the provider portal. This list also includes medical supplies, oxygen related equipment, orthotics and prosthetics that require prior authorization.

DME prior authorization requests are submitted through allwaysprovider.org. The physician’s prescription and supportive documentation for the requested DME must be attached to the electronic request. A valid

authorization request, supportive documentation, and a physician's prescription are required before a requested service can be approved.

Providers need to submit requests including supporting information and a prescription directly to the participating vendor. My Care Family staff works directly with the vendors to insure efficient and timely filling of requests.

Enteral Products

Authorization requests for enteral products are submitted through allwaysprovider.org. A valid authorization request and completed Combined MassHealth Managed Care Organization (MCO) Medical Necessity Review Form for Enteral Nutrition Products (special formula) form indicating the specific product and quantity are required before a determination can be made to approve a requested service.

Prior Authorization Requests Submitted Directly to a Delegated Entity

eviCore Healthcare

The following elective outpatient services require prior authorization through eviCore Healthcare:

- Outpatient Radiology/High Tech Imaging
- Selected Cardiac Imaging & Diagnostic Services
- Selected Molecular & Genetic Testing
- Radiation Therapy

When these services are rendered as part of a hospital emergency room, observation stay, surgical care or inpatient stay, they are not subject to prior authorization requirements.

Submit requests directly to eviCore by:

- Accessing online services at www.evicore.com. After a quick and easy one-time registration, you can initiate a request, check status, review guidelines, and more.
- Calling eviCore toll-free, 8 AM to 9 PM **ET** at: **888-693-3211**

Once approved, an authorization number is faxed to the ordering/referring practitioner and the rendering/performing provider. eviCore approves by the specific facility performing the study and by the specific CPT code(s). It is the responsibility of the rendering/performing facility to confirm that they are the approved facility for rendering the service and the specific study authorized by CPT code. Any change in the authorized study or provider requires a new authorization. Failure to obtain authorization or submit supporting documentation to establish medical necessity could result in an administrative denial of services to the provider.

Sleep Studies and Therapy Management

My Care Family partners with SMS (Sleep Management Solutions) and their parent company, CareCentrix (CCX) to provide sleep study and therapy management services. Testing may be approved in the patient's home, using a Home Sleep Test (HST) or in an in-network sleep lab using a polysomnogram.

Submit requests directly to SMS by:

- Visiting the SMS website http://www.sleepmanagementsolutions.com and accessing the secure Sleep Portal to submit the request.
- Phoning SMS/CCX Monday through Friday, 8AM to 5:00 PM, EST, at: (886)-827-5861

For information on billable codes, access AllWays Health Partners' Provider Payment Guideline for Sleep Studies and Therapy Management. Criteria for medical necessity decision making is available on allwaysprovider.org.

Behavioral Health Services

My Care Family partners with Optum to manage the delivery of behavioral health services for all My Care Family patients. For more information, contact Optum at 844-451-3519.

Concurrent Review

Concurrent review is required for subsequent days of care or visits or services beyond the initial authorization or required notification. Concurrent review must be conducted via allwaysprovider.org where indicated. For services that cannot be conducted via allwaysprovider.org, you may fax, mail, or work with an on-site utilization management care manager at designated facilities.

Most requests for concurrent services are submitted through the provider portal. Follow the provider portal User Guide for revising authorizations. Those service requests that are not accepted through the provider portal must be faxed or mailed to AllWays Health Partners. All concurrent requests must be supported by clinical documentation to determine medical necessity. Failure to obtain authorization or submit supporting documentation to establish medical necessity could result in an administrative denial of services to the provider.

Concurrent review includes utilization management, discharge planning, and quality of care activities that take place during an inpatient stay, an ongoing outpatient course of treatment or ongoing home care course of treatment (for example, acute hospital, skilled nursing facilities, skilled home care, and continuous DME supplies/equipment).

The concurrent review process also includes:

- Collecting relevant clinical information by chart review, assignment of certified days and estimated length of stay, application of professionally developed medical necessity criteria, assignment of level of care, and benefit review. These criteria are not absolute and are used in conjunction with an assessment of the needs of the member and the availability of local health care resources.
- Obtaining a request from the appropriate facility staff, practitioners or providers for authorization of services.
- Reviewing relevant clinical information to support the medical necessity.
- Determining benefit coverage for authorization of service
- Communication with the health care team involved in the member's care, the member and/or his or her representative and the provider
- Notifying facility staff, practitioners and providers of coverage determinations in the appropriate manner and time frame
- Identifying discharge planning needs and facilitating timely discharge planning.
- Identifying and referring potential quality of care concerns, Never Events/Serious Reportable Events and Hospital Acquired Conditions for additional review
- Identifying members for referral to My Care Family's Care Management specialty programs

All existing services will be continued without liability to the member until the member has been notified of an adverse determination. However, denial of payment to the facility and/or attending physician may be made when days of care or visits do not support medically necessary care.

Retrospective Review

As part of My Care Family's UM program in assessing overutilization and underutilization of services, focused retrospective review activity may be performed as cost drivers, HEDIS scores, changes in medical and pharmacy utilization trends, provider profiling and financial audits suggest.

Retrospective review is also performed on a case- by-case basis and is routinely applied to hi-tech radiology cases.

In the event that the Utilization Management Care Manager is unable to perform concurrent review, cases may be reviewed retrospectively. For facilities in which on-site Care Management review is performed, the medical record may be reviewed in the Medical Records department. In all other cases, a copy of the medical record will be

requested in accordance with applicable confidentiality requirements.

UM Time Frame for Decision-Making and Notification

Authorizations are made as expeditiously as possible, but no later than within the designated time frames.

MassHealth members do not receive written notification of prior authorization or concurrent authorization approvals.

UM Time Frame for Decision-Making and Notification

UM Subset	Decision Time Frame	Verbal Notification Provider	Written/Electronic Provider Approval Notification	Written Denial Notification
Pre-service/Initial Determination *Non-urgent Standard*	Within 14 *calendar* days after receipt of the request the member or authorized representative may request an extension for up to 14 additional *calendar* days	**Denial** Within 14 *calendar* days after receipt of the request	Electronic notification is available on the next *business* day after the decision determination and within 14 *calendar* days after receipt of the request	Within 14 *calendar* days after receipt of the request
Pre-service/Initial Determination *Urgent/Expedited*	Up to 72 hours/three *calendar* days of receipt of the request the member or authorized representative may request an extension for up to 14 additional *calendar* days	**Denial** Within 72 hours/three *calendar* day of receipt of request	Electronic notification is available on the next business day after the decision determination and within three business days after receipt of the request	Within 72 hours/three calendar days of verbal notification and not to exceed three business days from receipt of receipt of the request
Concurrent Review *Urgent/Expedited* Inpatient stays are always considered Urgent/Expedited	Within 24 hours/one *calendar* day of receipt of the request. The member or authorized representative may request an extension for up to 14 additional calendar days	**Denial** Within 24 hours/one *calendar* day of receipt of request **Approval** Within 24 hours/1 *calendar* day of receipt of request	Electronic notification is available on the next business after the decision determination and within three business days after receipt of the request	Within 72 hours/three *calendar* days of verbal notification and not to exceed 3 business days from receipt of request exceed three business days from receipt of request Service is continued Service is continued without liability to member until notification

UM Subset	Decision Time Frame	Verbal Notification Provider	Written/Electronic Provider Approval Notification	Written Denial Notification
Concurrent *Non-urgent/ Standard*	Within 14 *calendar* days after receipt of the request. The member or authorized representative may request an extension for up to 14 additional *calendar* days	**Denial** Within 14 *calendar* days after receipt of the request **Approval** Within 14 *calendar* days of receipt of the request	Electronic notification is available on the next *business* day after the decision determination and within 14 *calendar* days after receipt of the request	Within 1 business day following verbal notification, but no later than 14 calendar days after receipt of the request
Reconsideration of Adverse Determination (Initial and concurrent medical necessity review determination)	Within one *business* day of receipt of request for reconsideration	Within one *business* day of receipt of request for reconsideration	According to type of request as described above	According to type of request as described above
For termination, suspension, or reduction of a previous authorization	N/A	N/A	N/A	At least 10 *calendar* days prior to date of action

Notification

Notification to AllWays Health Partners of provided services assists Utilization Management Care Managers in identifying those members who might benefit from care management intervention. Notification also allows AllWays Health Partners to monitor utilization statistics.

Depending on the service type, notification is either "requested" or "required". "Required" notification is a condition for payment. Please refer to the Prior Authorization and Notification Grid for further clarification and the most current information on services subject to prior authorization or notification requirements.

Requested Notification

Requested notification is not a condition for payment. Claims will adjudicate as long as all other claims processing rules have been met, the provider rendering the service is in the My Care Family network and the patient has active eligibility.

Emergency care providers should contact a patient's primary care provider to coordinate care once the patient is screened and stabilized.

Required Notification

"Required notification" applies to services that often would require prior authorization but due to the emergent nature of the service, AllWays Health Partners allows notification within one business day. To ensure payment, a provider must submit the required notification. Failure to provide required notification within one business day could result in an administrative denial of services to the provider. Please refer to the Prior Authorization and Notification Grid for further clarification and the most current information on services subject to prior authorization or notification requirements.

My Care Family network providers are contractually prohibited from holding any My Care Family patient financially liable for any service administratively denied by AllWays Health Partners for the failure of the provider to provide timely notification of provided services.

Most notifications for network providers are submitted through allwaysprovider.org. Information that normally would accompany a prior authorization request should be submitted at the time of the notification. Failure to submit supporting documentation could result in an administrative denial of services to the provider. Examples of services that require notification are:

- Emergency admissions and sick newborn admissions (inpatient and transfers); concurrent authorization is required for days of care following notification. All admissions are reviewed for medical necessity.
- For Skilled home nursing care, providers are required to notify AllWays Health Partners of any service initiated during non-business days/hours; subsequent services require authorization.
- Medical supplies (DME) associated with the home care plan for services initiated during non-business days/hours
- Observation

Notification of Birth Process

To ensure the continuity of care for mothers and newborns, and to help facilitate newborns' enrollment into MassHealth, the facility where the delivery took place must submit an NOB-1 Form to MassHealth within 30 calendar days from the newborn's date of birth. The form allows the facility to identify the mother's health plan (i.e., AllWays Health Partners), providing greater specificity and enhancing the newborn enrollment process and provider reimbursement.

My Care Family strongly encourages providers to submit the forms as soon as possible after the baby's birth to allow adequate time for processing. While the form must be submitted to MassHealth directly, AllWays Health Partners welcomes courtesy copies of these forms specific to AllWays Health Partners newborns for our files. These

may be faxed to AllWays Health Partners at 617-586-1700.

Please follow the instructions on completing and submitting the NOB-1 form on MassHealth's website.

The NOB-1 form should be sent to:

Fax 617- 887-8777

Out-of-Network Requests

My Care Family PCPs should always refer members within the My Care Family network. Should the PCP refer a member outside the My Care Family network, the PCP must obtain the applicable referral and prior authorizations to confirm coverage.

Authorization is required for all non-emergent out-of-network service requests except for early intervention services, and family planning services provided to My Care Family patient. My Care Family patient may obtain family planning services at any MassHealth family service planning provider, even if the provider is out of the My Care Family network.

My Care Family providers can be found in the Provider Directory.

My Care Family works with patients and clinicians to provide continuity of care and to ensure uninterrupted access to medically necessary covered services, whether current patients or newly enrolled.

In most cases, a pre-existing relationship with an out-of-network provider is not reason alone to justify the need for an out- of-network provider.

Authorization requests for out-of-network specialists are submitted by fax or mail and are subject to medical necessity review.

Discharge Planning

Discharge planning occurs through the entire continuum of care for members engaged in medical as well as behavioral health treatments since members are discharged from home care and outpatient service, as well as inpatient stays more commonly associated with discharge planning.

Discharge planning for My Care Family members is initiated as expeditiously as possible on admission to the inpatient facility and with the initiation of home and outpatient services, and is addressed through- out the continuum of care to facilitate timely and appropriate discharge and post-discharge services.

Utilization Management Care Managers ensure that treating providers have up-to-date benefit information, understand the member's benefit plan, possible barriers with authorizing transition services, and know how to access covered. Discharge planning transcends the care setting, and therefore, all Utilization Management Care Managers are required to be proficient in all operations that encompass discharge planning, including a full understand of community resources available to the member.

Utilization Management Care Managers arrange for in-network services and out-of-network authorizations when the network of providers cannot meet the member's after care needs. In addition to assisting the provider with traditional authorization/benefit information, the Utilization Management Care Manager collaborates and coordinates services with the provider and works with other appropriate members of the health care team, including but limited to, My Care Family care management programs, behavioral health care management programs, community and agency resources and the patient's designee on their unique discharge planning needs in order to coordinate services and facilitate a smooth transfer of the patient to the appropriate level of care and/ or into

clinical care management programs that will continue to support the patient's recovery.

Medical Necessity Decision-Making

Underutilization of medically appropriate services has the potential to adversely affect our members' health and wellness. For this reason, My Care Family promotes appropriate utilization of services. My Care Family utilization management decisions are based only on appropriateness of care and service and existence of coverage. My Care Family does not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely because of the diagnosis, type of illness, or condition of the patient or make authorization determinations solely on diagnosis, type of illness or the condition of the patient.

All medical necessity decisions are made only after careful consideration of the applicable written medical criteria, interpreted in light of the individual needs of the member and the unique characteristics of the situation.

My Care Family does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does My Care Family provide financial incentives to UM decision-makers to encourage decisions that result in underutilization.

In all instances of medical necessity denials, it is My Care Family's policy to provide the treating/referring practitioner with an opportunity to discuss a potential denial decision with the appropriate practitioner.

Collection of Clinical Information for UM Decision-making

The clinical operations staff requests only that clinical information which is relevant and necessary for decision-making. My Care Family uses relevant clinical information and consults with appropriate health care providers when making a medical necessity decision.

When the provided clinical information does not support an authorization for medical necessity coverage, the care manager and/or physician reviewer outreaches to the treating provider for case discussion. A decision will be made based on the available information if the treating provider does not respond within the time frame specified.

All clinical information is collected in accordance with applicable federal and state regulations regarding the confidentiality of medical information.

Utilization Management Care Managers conducting utilization review at a facility are required to become familiar with the facility's rules and policies and procedures governing on-site review activity prior to initiating review and follow such rules and policies and procedures as required and agreed upon by the facility.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), My Care Family is entitled to request and receive protected health information for purposes of treatment, payment, and health care operations without the authorization of the patient.

Clinical Criteria

My Care Family internally develops and uses medical necessity guidelines and criteria to review medical appropriateness of targeted services based on its member population and service utilization. Utilization management criteria and procedures for their application are reviewed at least annually and guidelines and criteria are updated when appropriate.

My Care Family has adopted McKesson's InterQual Level of Care Criteria for Acute Care Adult, Acute Care Pediatric, Rehabilitation Adult and Pediatric, Sub Acute and Skilled Nursing Facilities Adult. InterQual criteria represent the gold standard in evidence-

based clinical decision support, used by CMS and thousands of hospitals and health plans across the country to assess appropriateness of care.

Guidelines and criteria are developed and amended by My Care Family clinicians under the direction of the Chief Medical Officer and Medical Directors and are approved, as appropriate, by the Utilization Management Committee, the Pharmaceutical and Therapeutics Committee, and the Clinical Policy and Quality Committee.

Medical necessity guidelines and criteria are based on sound clinical evidence of safety and efficacy, and developed and amended using various professional and government agencies and local health care delivery plans.

The Utilization Management Care Manager and/or physician reviewer evaluates all relevant information before making a determination of medical necessity. Clinical guidelines and criteria are used to facilitate fair and consistent medical necessity decisions. At a minimum, the Care Manager considers the following factors when applying criteria to a given member: age, co-morbidities, complications, progress of treatment, psychosocial situation, home and family environment, when applicable. Medical necessity criteria are applied in context with individual member's unique circumstances and the capacity of the local provider delivery system. When criteria do not appropriately address the individual member's needs or unique circumstances, the Care Manager and/or physician reviewer may override the criteria for an approval of services.

Providers can obtain a copy of internally developed criteria used for a specific determination of medical necessity by accessing allwaysprovider.org. Proprietary criteria are made available to providers and members on request and only to the extent it is relevant to the particular treatment or service.

MassHealth's Definition of Medical Necessity

Medically necessary services for My Care Family members are those health care services:

- Reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity
- For which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative or less costly of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality

Information Request

PROVIDER SERVICE
Phone 855-444-4647
Mon.-Fri. 8:00 a.m.-6:00 p.m.

MEMBER SERVICE
Phone 800-462-5449
TTY 711
Mon.-Fri. 8:00 a.m.-6:00 p.m.
Thursday, 8:00 a.m.-8:00 p.m.

For after-hour requests and utilization management issues, these lines are available 24 hours a day, seven days a week. All requests and messages will be retrieved on the next business day. Language assistance is available to all members.

Medical Necessity Denials

A medical necessity denial is a decision made to deny, terminate, modify or suspend a requested health care benefit based on failure to meet medical necessity, appropriateness of health care setting, or criteria for level of care or effectiveness of care.

Only a My Care Family physician reviewer or physician designee may make medical

necessity determinations for denial of service. Appropriate My Care Family network specialists and external review specialists are used for complex specialty reviews and to review new procedures or technology. Reconsideration (clinical peer review) may be requested for services that are denied prospectively or concurrently on the basis of medical necessity. Reconsideration is an informal process offered to providers. It is not an appeal nor is it a precondition for filing a formal appeal. A physician reviewer conducts the reconsideration within one business day of the request.

Written notifications of medical necessity denials contain the following information:

- The specific information upon which the denial was made
- The member's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical necessity review criteria
- Specification of any alternative treatment option that is available through My Care Family or the community, if any
- A summary of the applicable medical necessity review criteria and applicable clinical practice guidelines
- How the provider may contact a physician reviewer to discuss the denial
- A description of the formal appeals process, the mechanism for instituting the appeals process, and the procedures for obtaining an external review of the decision

Administrative Denials

Administrative denials for authorization of requested services or payment for services rendered may be made when:

Member issued

- A service is explicitly excluded as a covered benefit under the member's benefit plan.
- The requested benefit has been exhausted.

Provider only issued

- A service was provided without obtaining the required prior authorization.
- Required notification was not made in a timely manner.
- Failure to submit clinical documentation necessary to make a medical necessity determination with the requested service.

My Care Family network providers are contractually prohibited from holding any My Care Family patient financially liable for any service administratively denied by AllWays Health Partners for failure of the provider to adhere to established utilization processes.

Delegation of Utilization Management

My Care Family delegates some utilization management activities to external entities and provides oversight of those entities. UM delegation arrangements are made in accordance with the requirements of the National Committee on Quality Assurance (NCQA), the Massachusetts Division of Insurance, the Executive Office of Health and Human Services (EOHHS), and other regulatory requirements.

- Optum for the utilization and care management of behavioral health services on behalf of My Care Family patients. Optum is a fully NCQA accredited Managed Behavioral Health Organization.
- CVS Caremark has been delegated certain utilization management functions for a select group of pharmaceuticals. AllWays Health Partners' Pharmacy and Therapeutics Committee approves all pharmaceuticals to be included in CVS Caremark's prior authorization process. The responsibility for making denials based on medical necessity remains with AllWays Health Partners.
- eviCore has been delegated certain utilization management functions for elective, non-emergent outpatient high tech radiology services (including MRI, MRA, CT and PET imaging studies), selected cardiac imaging & diagnostic services, selected molecular &

genetic testing, and radiation therapy.

- Focus Health provides consultative reviews of prior authorization requests for spinal surgery. Focus Health is a medical management services organization specializing in the evaluation of pain management services, including spinal surgery.
- Sleep Management Solutions has been delegated sleep diagnostic and therapy management services.
- Medical Review Institute of America (MRIoA) has been delegated to supplement the prior authorization review process. MRIoA is an external review organization that is staffed with board-certified physicians with a wide variety of specialties. In the rare instance when My Care Family physician reviewers are unavailable, MRIoA will provide support for the UM reviews. In these instances, MRIoA representatives may reach out to the requesting provider to obtain additional clinical information or conduct a physician-to-physician review.

My Care Family maintains close communications with its delegated partners to ensure seamless operations and positive member and provider experiences.

Online Clinical Reports on the Provider Portal

Clinical reports to help effectively manage patients are available via the provider portal. This provision of timely, actionable site and patient-level data allows PCPs to download electronic versions of a variety of reports and analyze the data based on the specific needs of their practice.

Available reports include both quality and utilization information. This includes both quality measures and utilization for members with asthma and diabetes as well as ER utilization.

Access to the data is entirely at the discretion of the provider office. To protect the confidentiality of our members and due to the sensitive contents of these reports, providers are strongly encouraged to grant role-based access only and review user permissions regularly.

Nurse Advice Line

My Care Family members have access to a toll free 24/7 Nurse Advice Line. Patients can speak directly with a registered nurse at any time of the day, seven days a week. Members may also listen to automated information on a wide range of health-related topics, ranging from aging and women's health to nutrition and surgery. The Nurse Advice Line doesn't take the place of a primary care visit. It is intended to help our members decide if they should make an appointment with their PCP or go to the emergency room. The nurse also provides helpful suggestions for how your patients might care for themselves at home.

Your patients may access the My Care Family Nurse Advice Line at 1-833-372-5644.