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AmeriChoice West 2010 AQS Plan Of Correction

2010 Annual Quality Survey Corrective Action Plan			
Areas of Noncompliance	Action Steps/Progress	Intended Completion Date	Responsible Person/Titles
<p>Notification of changes to written materials The MCO had updates to the policy regarding co-pay changes effective 1/1/2010, but the members were not provided the written 30 days in advance.</p>	<p>As benefit changes are identified, AmeriChoice will contact the state and request template changes at least 90 days prior to the effective date of the change. If the state does not intend to provide a template for the member communication, AmeriChoice will develop the communication and submit for approval no later than 60 days prior to the effective date of the change. AmeriChoice will communicate with the approved language no later than 30 days prior to the effective date of the change. If AmeriChoice is given less than 60 days notice, then AmeriChoice will request that the state clarify contract expectations around member notification for that benefit change event. The Health Plan will update the member communication policy to reflect the notification requirements around benefit change communications.</p>	<p>September 1, 2010</p>	<p>Compliance Officer and Vice President of Community Development</p>
<p>Undeliverable Mail (EPSDT) The MCO should ensure that, when mail is returned as undeliverable, both attempts to find family occur within the required time frames.</p>	<p>In 2010, the Health Plan initiated a new process for EPSDT returned mail by adding a bar code to all EPSDT mail so that when mail is returned, it is scanned electronically and a list generated for automated calls. The 1st attempt process did not change and continues to meet the 30 day timeframe. The bar code scanning process was completed and the first 2010 monthly "Returned Mail Call Campaign" was conducted March 12, 2010. Returned Mail Call Campaigns continue monthly to meet the 90 day 2nd attempt timeline.</p>	<p>Completed</p>	<p>Manager, Prevention and Wellness Education TENnderCare/EPSDT</p>

CONFIDENTIAL

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<p>Display of non-discrimination posters The MCO should include the information on the posters located in their break rooms informing their employees regarding the Omnibus Budget Reconciliation Act of 1981. The MCO should continue to include the current information like employees' rights and obligations under Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act of 1990 and the Age Discrimination Act of 1975.</p>	<p>Order new posters which include required non-discrimination language and display in the employee break rooms.</p>	<p>Completed - New posters displayed in the employee breakrooms on June 29, 2010.</p>	<p>Compliance Officer</p>

CONFIDENTIAL

CONFIDENTIAL

AmeriChoice **Middle** 2010 AQS Plan Of Correction

2010 Annual Quality Survey Corrective Action Plan			
Areas of Noncompliance	Action Steps/Progress	Intended Completion Date	Responsible Person/Titles
<p>Clinical Criteria for UM Decisions: Denial File Review One record did not meet the initial notification time standard</p>	<p>1. Complete UM documentation audits every month for timely turn around time</p> <p>2. Re-educate on Medical Necessity Policy (HS UM 1)</p> <p>3. Initiated a new Denial Letter tasking process</p>	<p>1. Ongoing monthly process</p> <p>2. Completed</p> <p>3. Completed - Implemented new tasking process 6/28/2010 to identify a request for denial letter to be completed. Ongoing monitoring and tracking will take place during month UM documentation audits.</p>	<p>Associate Director Medical Clinical Operations</p>
<p>Notification of changes to written materials The MCO had updates to the policy regarding co-pay changes effective 1/1/2010, but the members were not provided the written 30 days in advance.</p>	<p>As benefit changes are identified, Americhoice will contact the state and request template changes at least 90 days prior to the effective date of the change. If the state does not intend to provide a template for the member communication, AmeriChoice will develop the communication and submit for approval no later than 60 days prior to the effective date of the change. AmeriChoice will communicate with the approved language no later than 30 days prior to the effective date of the change. If AmeriChoice is given less than 60 days notice, then AmeriChoice will request that the state clarify contract expectations around member notification for that benefit change event. The Health Plan will update the member communication policy to reflect the notification requirements around benefit change communications.</p>	<p>September 1, 2010</p>	<p>Compliance Officer and Vice President of Marketing Outreach and Communication</p>

CONFIDENTIAL

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CONFIDENTIAL

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CONFIDENTIAL

AmeriChoice **East** 2010 AQS Plan Of Correction

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CONFIDENTIAL

AmeriChoice **East** 2010 AQS Plan Of Correction

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August 6, 2010

Ms. Lauren Barca, Manager
MCO Performance UnitedHealth Group
Quality Oversight Division
Bureau of TennCare
310 Great Circle Road
Nashville, TN 37243

RE: AMERICHOICE EAST, MIDDLE AND WEST REVISED AQS CORRECTIVE ACTION PLANS

Dear Ms. Barca:

Attached, please find our response to your request dated July 28, 2010, regarding revisions required to our East, Middle and West TN Corrective Action Plans (CAPs) from the Annual Quality Survey findings. Please see below for our response to each element noted in your letter.

QUALITY PROCESS STANDARD: ENROLLEE RIGHTS AND RESPONSIBILITIES

A draft revised member communication policy is attached for your review. The final approved policy is on target to be completed by September 1, 2010, as indicated in our CAP.

QUALITY PROCESS STANDARD: JOHN B. CONSENT DECREE (EPSDT)

The new posters were displayed in the employee break rooms on June 29, 2010.

QUALITY PROCESS STANDARD: CLINICAL CRITERIA FOR UM DECISIONS

The training conducted with our UM staff covered AmeriChoice's Health Services Medical Review policy. The mandatory training required staff members to review the policy, which highlighted specific timeline requirements. Attached, you will find documentation demonstrating staff that completed the training and dates indicating staff completion of the policy review. Additionally, the policy is attached with the timeline requirements highlighted in red.

Furthermore, we have attached documentation of monthly audit results for the staff, as well as the new denial letter tasking process.

CONFIDENTIAL

Please let me know if I can be of further assistance in this matter.

Sincerely,

A handwritten signature in cursive script that reads "Kim L. Seay".

Kim L. Seay, Director
Quality Improvement

KLS:hmc

Attachments (6)

cc: OCCP, Bureau of TennCare
Judy Womack, Bureau of TennCare
Pauline McIntyre, Bureau of TennCare
Hayley Clothier, AmeriChoice

8 Cadillac Drive, Suite 100, Brentwood, TN 37027
1-800-690-1606 www.AmeriChoice.com

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UnitedHealthcare Plan of the River Valley, Inc.	LINES OF BUSINESS: TennCare, SNP, <i>hawk-i</i>
TITLE: Members Materials Development and Requirements	Number: HP XX.X.X
EFFECTIVE DATE: 06/05/2008	Page 1 of 5
LATEST REVISION: 08/03/10	AUTHORIZED BY: CHIEF MEDICAL OFFICER
QMC REVIEW DATES: N/A	CROSS REFERENCES:

I. SCOPE: Health Plan

II. POLICY: AmeriChoice will distribute member materials as required including, but not limited to, member handbooks, provider directories, quarterly member newsletters, and identification cards. Member materials and outreach activities are designed to promote health and/or educate members. For TennCare these guidelines are outlined in CRA 2.7.3 and 2.17.

AmeriChoice will have member materials related to programs and activities that enhance the general health and well-being of members. Health education, outreach programs, and activities may include the following:

- General physical and behavioral health education;
- Mental illness awareness programs and education campaigns with special emphasis on events such as National Mental Health Month and National Depression Screening Day;
- Smoking cessation programs with targeted outreach for adolescents and pregnant women;
- Nutrition education and counseling;
- Early intervention and risk reduction strategies to avoid complications of disability and chronic illness;
- Prenatal care education;
- Prevention and treatment of alcohol and substance abuse;
- Self-care training, including self-examination;
- Need for clear understanding of how to take medications and the importance of coordinating all medications;
- Understanding the difference between emergent, urgent and routine health conditions;
- Telephone calls, mailings and home visits to current members for the sole purpose of educating current members about services offered by or available through the health plan;
- General activities that benefit the entire community (e.g., health fairs and school activity sponsorships).

CONFIDENTIAL

	
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EFFECTIVE DATE: 06/05/2008	Page 2 of 5
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AmeriChoice will report on these activities as required by contract on a quarterly basis using the Health Education/Outreach Report and the TENNderCare Reports specifically for TennCare. In addition, these reports are submitted to the Quality Management Committee (QMC) for oversight.

III. PROCEDURE:

A. Development and Distribution of All Member Materials

1. The Provider Directory is based on provider set-up, audits for accuracy and completeness, our annual Provider Verification Outreach Audit (POV), and Secret Shopper Audits. For data control, we rely on FACETS, our core transaction system, to store all data on physical, behavioral, vision, facility, and ancillary health providers, and for the three venues available to Members to obtain Provider Directory information distribution: 1) the traditional published Directory for each Grand Region in TN and other areas specified by the specific health plan; 2) the Member Portal with a downloadable, printable Directory on a PDF file and a searchable database; and 3) our Customer Service toll-free number to request provider information from a Customer Service Representative. Members are mailed a Provider Directory within 30 days of enrollment, annually, and upon request to our Customer Service toll-free number.
2. The member ID card is generated as per policy GR24.2. The ID card is sent to the member by mail and identifies the member as a participant in their AmeriChoice program within (30) calendar days of notification of enrollment into the health plan or prior to the member's enrollment effective date. If an ID card is lost, a new one may be generated for the member upon request to our Customer Service toll-free number.
3. Health Educational Materials for members are generated by the Health Services Department within AmeriChoice. The types of materials developed are chosen based on population health data provided by governmental departments and agencies, trends in membership health data, Disease Management education, and provider and member request for educational information. Health educational materials include evidenced based practice guidelines, are written in 6th grade level, and are distributed to members and

CONFIDENTIAL

	
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TITLE: Members Materials Development and Requirements	Number: HP XX.X.X
EFFECTIVE DATE: 06/05/2008	Page 3 of 5
LATEST REVISION: 08/03/10	AUTHORIZED BY: CHIEF MEDICAL OFFICER
QMC REVIEW DATES: N/A	CROSS REFERENCES:

providers through mailings, the provider and member websites, newsletters, health fairs, and other community outreach events.

4. Other Educational Materials are generated by the Government Relations Department in conjunction with Department of Communications to ensure members are notified of key processes as it relates to their benefits.

B. Prior Approval Process for All Member Materials

1. All member materials and proposed health education and outreach activities will be submitted to contractor and/or CMS for review and written prior approval will be obtained on all activities and materials that will be distributed to members (referred to as member materials). This includes but is not limited to member handbooks, provider directories, member newsletters, identification cards, fact sheets, notices, brochures, form letters, mass mailings, member education and outreach activities, system generated letters and any other additional, but not required, materials and information provided to members designed to promote health and/or educate members.
2. All member materials will be submitted on paper and electronic file media, in the format prescribed by contractor and/or CMS. The materials shall be accompanied by a plan that describes the health plan's intent and procedure for the use of the materials. Materials developed by a recognized entity having no association with the health plan that are related to management of specific types of diseases (e.g., heart, diabetes, asthma, etc.) or general health improvement must be submitted for approval; however, unless otherwise requested by contractor, an electronic file for these materials is not required. The electronic files must be submitted in a format acceptable to contractor and/or CMS. Electronic files submitted in any other format than those approved by contractor and/or CMS will not be processed.
3. As benefit changes are identified, AmeriChoice will contact the state and request template changes at least 90 days prior to the effective date of the change. If the state does not intend to provide a template for the member communications, AmeriChoice will develop the communication and submit for approval no later than 60 days prior to the effective date of the change. AmeriChoice will

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TITLE: Members Materials Development and Requirements	Number: HP XX.X.X
EFFECTIVE DATE: 06/05/2008	Page 4 of 5
LATEST REVISION: 08/03/10	AUTHORIZED BY: CHIEF MEDICAL OFFICER
QMC REVIEW DATES: N/A	CROSS REFERENCES:

communicate with the approved language no later than 30 days prior to the effective date of the change. If AmeriChoice is given less than 60 days notice, then AmeriChoice will request that the state clarify contract expectations around member notification for the benefit change event.

4. In the event that contractor/CMS does not approve the materials, the health plan may resubmit the materials with the recommended changes.
5. Once member materials have been approved, the health plan shall submit the final version as per the requirements. For TennCare, the health plan must submit an electronic version of the final printed product and five (5) original prints of the final product, unless otherwise specified by TennCare, within thirty (30) calendar days from the print date. Photo copies may not be submitted as a final product. Upon request, the health plan shall provide additional original prints of the final product to TennCare.
6. Prior to modifying any approved member material, the health plan will submit for approval a detailed description of the proposed modification. Proposed modifications shall be submitted in accordance with the requirements.
7. Contractor and/or CMS reserves the right to notify the health plan to discontinue or modify member materials after approval.
8. For TennCare, the health plan will submit a quarterly Health Education/Outreach Report which provides information on the programs and activities the health plan has conducted in the areas of health education and outreach during the previous quarter. The report shall be submitted in a format specified by TennCare.
9. For TennCare, the health plan will submit a quarterly TENNderCare Report that provides information on programs and activities specifically promoting health and education of TENNderCare requirements.

C. Written Material Guidelines

The health plan's Communications Department and Governmental Relations Department will comply with the following requirements as it relates to written member materials:

CONFIDENTIAL

	
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EFFECTIVE DATE: 06/05/2008	Page 5 of 5
LATEST REVISION: 08/03/10	AUTHORIZED BY: CHIEF MEDICAL OFFICER
QMC REVIEW DATES: N/A	CROSS REFERENCES:

1. All member materials shall be worded at a sixth (6th) grade reading level using Flash Kinkaid Reading Level unless otherwise approved;
2. All written materials shall be clearly legible with a minimum font size of 12pt. with the exception of member I.D. cards, and unless otherwise approved;
3. All written materials shall be printed with the assurance of non-discrimination;
4. For TennCare, the following shall not be used on any written materials, including but not limited to member materials, without the written approval of TennCare:
 - a. The Seal of the State of Tennessee;
 - b. The TennCare name unless the initials “SM” denoting a service mark, is superscripted to the right of the name (TennCaresm);
 - c. The word “free” unless the service is at no cost to all members. If members have cost sharing responsibilities, the service is not free. Any conditions of payments must be clearly and conspicuously disclosed in close proximity to the “free” good or service offer; and
 - d. The use of phrases to encourage enrollment such as “keep your doctor” implying that enrollees can keep all of their physicians. Enrollees in TennCare should not be led to think that they can continue to go to their current physician, unless that particular physician is a contract provider with the health plan.
5. All vital health plan documents must be translated and available in Spanish. For TennCare, within ninety (90) calendar days of notification from TennCare, all vital health plan documents must be translated and available to each Limited English Proficiency group identified by TennCare that constitutes five percent (5%) of the TennCare population or one-thousand (1,000) enrollees, whichever is less;
6. All written member materials shall notify enrollees that oral interpretation is available for any language at no expense to them and how to access those services;
7. All written member materials shall be made available in alternative formats for persons with special needs at no expense to the member; and

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8. The health plan will provide written notice to members of any changes in policies or procedures described in written materials previously sent to members. The health plan will provide written notice at least thirty (30) days before the effective date of the change.

D. Internal Process

1. New member material is initiated when the health plan finds there is a need for a new material due to a contractual requirement or business need as outlined in A.
2. The appropriate health plan department produces the literature/materials in Word format following all requirements outlined above in C. A PDF file of the material is also produced if appropriate.
3. The new literature is routed to internal legal and marketing departments for review.
4. Once the literature has been approved internally, the files are sent to the Government Relations department.
5. Government Relations reviews the literature/materials and the required non-discrimination and language statements.

Government Relations then submits the literature to TennCare, CMS, or required contractor reviewer for approval. TennCare’s reviews can take up to 15 calendar days for each submission.7. Once approval has been obtained in writing, the approval and final versions are returned to the originating department and the health plan’s marketing department.8. The marketing department sends the files to the printer and requests stock to be stored with our mailing vendor if the item is to be mailed. The quantity is based on total plan membership, disease specific membership, predicted enrollment and requests for additional copies to be sent. As needed, mailing lists are sent to the mailing vendor. The vendor then organizes, posts, and mails individual pieces or packets as necessary.

10. As member materials need updated, such as the member handbook, the internal process begins at step 1 of the Internal Process description.

IV. ATTACHMENTS: N/A

V. RELATED POLICIES: N/A

VI. REFERENCE:

CONFIDENTIAL

AmeriChoice by UnitedHealthcare	POLICY AND PROCEDURES
UnitedHealthcare Plan of the River Valley, Inc.	LINES OF BUSINESS: TennCare, SNP, <i>hawk-i</i>
TITLE: Members Materials Development and Requirements	Number: HP XX.X.X
EFFECTIVE DATE: 06/05/2008	Page 7 of 5
LATEST REVISION: 08/03/10	AUTHORIZED BY: CHIEF MEDICAL OFFICER
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- A. TennCare Contractor Risk Agreement
- B. Medicare Managed Care Manual, Chapter 11 – Medicare Advantage Application, Procedures and Contract Requirements
- C. Contract for Health Care Services Under the Healthy and Well Kids In Iowa Program
- D. NCQA Standards and Guidelines for the Accreditation of Health Plans

APPROVED BY:

Chief Medical Officer

Date

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	<p>POLICY AND PROCEDURES</p>
<p>UnitedHealthcare Plan of the River Valley, Inc.</p>	<p>LINES OF BUSINESS: TennCare, SNP, <i>hawk-i</i></p>
<p>TITLE: MEDICAL NECESSITY REVIEW</p>	<p>Number: HS UM 1</p>
<p>EFFECTIVE DATE: 10/1998</p>	<p>Page 1 of 7</p>
<p>LATEST REVISION: 5/2008, 10/2008</p>	<p>AUTHORIZED BY: CHIEF MEDICAL OFFICER</p>
<p>QMC REVIEW DATES: 5/2002, 12/2003, 12/2004, 1/2005, 8/2006, 6/2008, 10/2008</p>	<p>CROSS REFERENCES: UM-GUP4-P1</p>

I. SCOPE: UTILIZATION MANAGEMENT

II. POLICY:

The Health Plan will make medical necessity determinations on a case-by-case basis in accordance with the definition of medical necessity as defined in TCA 71-5-144 and TennCare Contracts and Rules and Regulations. However, the Health Plan shall use alternative services as are medically appropriate and cost effective. Cost effective alternative services may be provided because they are either (1) alternatives to covered Medicaid services that the Medical Director determines to be cost effective or (2) preventive in nature and offered to avoid the development of conditions that, in the opinion of the Medical Director, would require more costly treatment in the future. Cost effective alternative (CEA) services need not be determined medically necessary except to the extent that they are provided as an alternative to covered Medicaid services. Only CEA services listed in Attachment A may be provided without obtaining prior approval from TennCare. Services not listed in this attachment must be prior approved in writing by TennCare. All CEA services are subject to medical necessity review and approval by the Medical Director. If a service is denied, the Medical Director who made the determination will be available to discuss the case/decision with the ordering physician. A Member, or a provider on behalf of a member, may appeal the denied service that was originally requested in lieu of the CEA using the standard appeals process.

Care management services will be offered to all eligible members.

The Health Plan shall provide all medically necessary EPSDT services, e.g., TENNderCare/EPSDT, to members under age twenty-one (21) in accordance with TennCare and Federal EPSDT requirements including TennCare Rules and Regulations. TennCare policies and procedures, 42 USC 1396(a)(43), 1396d(a) and (r), 42 CFR Part 441, Subpart B, the Omnibus Budget Reconciliation Act of 1989, and the State Medicaid Manual.

- 2.4 Medical Necessity Review
- 2.6 Cost Effective Alternative Services
- 11.1.3 UM P&P

CONFIDENTIAL

	<p>POLICY AND PROCEDURES</p>
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<p>TITLE: MEDICAL NECESSITY REVIEW</p>	<p>Number: HS UM 1</p>
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<p>LATEST REVISION: 5/2008, 10/2008</p>	<p>AUTHORIZED BY: CHIEF MEDICAL OFFICER</p>
<p>QMC REVIEW DATES: 5/2002, 12/2003, 12/2004, 1/2005, 8/2006, 6/2008, 10/2008</p>	<p>CROSS REFERENCES: UM-GUP4-P1</p>

TENNderCare/EPSTD services refer to the early and periodic screening, diagnosis and treatment of members under age twenty-one (21) to ascertain children’s individual (or individualized/or on an individual basis) health needs, and providing treatment to correct or ameliorate, or prevent from worsening health conditions discovered by the screening services, regardless of whether the required service is a covered benefit.

The Health Plan follows evidence-based medical criteria and guidelines to review for medical necessity of procedures. The specific medical necessity criteria used to make a medical necessity determination is made available upon request. The Health Plan will make individualized determinations of medical necessity and shall not employ utilization control guidelines or quantitative coverage limits to determine medical necessity.

The Health Plan bases Utilization Management (UM) determinations only on the appropriateness of care and services, individual member need, the availability of community resources and benefit coverage. The Health Plan will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, condition, or tentative limits per the Clinical Guidelines. For example, excluding limitations on substance abuse services which include 10 days detox, \$30,000 medically necessary lifetime benefits for members 21 years of age or older for TennCare Members.

Customer Service Representatives (CSRs) may quote benefit information by referencing the *Physical Health Benefits and Behavioral Health Benefits Charts* or Coverage Policy Library. If there is any doubt on behalf of the CSR regarding coverage for any service, the request is sent on to the appropriate Health Services Management Staff for review. CSR's are not responsible for clinical screening or determining medical necessity.

The Health Plan may deny services that are non-covered except as otherwise required by TENNderCare/EPSTD or unless otherwise directed to provide by TennCare and/or an administrative law judge.

- 2.4 Medical Necessity Review
- 2.6 Cost Effective Alternative Services
- 11.1.3 UM P&P

	<p>POLICY AND PROCEDURES</p>
<p>UnitedHealthcare Plan of the River Valley, Inc.</p>	<p>LINES OF BUSINESS: TennCare, SNP, <i>hawk-i</i></p>
<p>TITLE: MEDICAL NECESSITY REVIEW</p>	<p>Number: HS UM 1</p>
<p>EFFECTIVE DATE: 10/1998</p>	<p>Page 3 of 7</p>
<p>LATEST REVISION: 5/2008, 10/2008</p>	<p>AUTHORIZED BY: CHIEF MEDICAL OFFICER</p>
<p>QMC REVIEW DATES: 5/2002, 12/2003, 12/2004, 1/2005, 8/2006, 6/2008, 10/2008</p>	<p>CROSS REFERENCES: UM-GUP4-P1</p>

The Health Plan does not compensate or reward UM reviewers for denials of coverage, nor do reviewers receive financial incentives to influence UM decisions. The Health Plan offers providers the opportunity to discuss any UM denials for medical necessity with a Medical Director or an appropriate behavioral health practitioner.

The Medical Necessity review process is a process to determine if a requested procedure, treatment or device meets established medical necessity criteria. The Health Plan may not deny services required by TENNderCare/EPSTD or directed to provide by TENNCARE and/or an administrative law judge. Medical Necessity criteria utilized by the health plan is adopted from recognized specialty societies, developed internally using evidence-based research and published peer-reviewed literature, or supplied by TennCare. Criteria supplied by TennCare supersede all other criteria.

The Health Plan adopts the most stringent timelines standards. Coverage/Medical necessity determinations are made by the Health Plan within 14 days or as expeditiously as the member's health condition requires. Expedited service authorization decisions are made within 72 hours.

The five (5) components of Medical Necessity listed in the definition below are referenced/utilized to determine the most appropriate level of care for the member.

DEFINITION:

Medically Necessary shall mean services or supplies provided by an institution, physician or other health care provider that are required to identify or treat a TennCare enrollee's illness or injury and which are:

- A. Recommended by a licensed physician who is treating the enrollee or other licensed healthcare provider practicing within the scope of his or her license who is treating the enrollee
- B. Required in order to diagnose or treat an enrollee's medical condition

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- C. Safe and Effective
- D. Not experimental or investigational
- E. The least costly alternative course of diagnosis or treatment that is adequate for the enrollee’s medical condition.

III. PROCEDURE:

The medical necessity review process begins when a procedure or treatment request requiring medical necessity authorization is identified.

- A. Upon identification of the request, staff with the appropriate training and system security profiles verifies member eligibility and provider network status.
- B. If the requesting individual is not an eligible member with the Health Plan, staff will notify the requester and/or provider by telephone that the service will not be reviewed due to ineligibility.
- C. Upon verification of the member’s eligibility, UM will proceed with processing the request and enter the request into the clinical information system, CareOne. The clinical information system, CareOne, inclusive of written request, dates, times, and any additional documentation submitted, serves as the Health Plan’s file of record.
- D. UM will make a determination and authorize the most appropriate level and type of care based on pertinent sections(s) of the medical necessity criteria, the member’s benefit plan, available community resources and individual member need.
- E. UM will consider several factors when applying criteria to the request, e.g. the patient’s age, co-morbidities, progress of treatment and/or psychosocial situation. If UM is unable to approve the request, e.g., the information provided with the request does not meet medical

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criteria, the request is forwarded to the Medical Director or appropriate behavioral health practitioner for review. UM may approve services but may not reduce or deny. All cases not meeting criteria are referred to the Medical Director or an appropriate behavioral health practitioner for review.

- F. The Medical Director or the appropriate behavioral health practitioner reviews each case based on the individual clinical and psychosocial circumstances of the case. Specialty review with external consultants will be obtained as needed and when requested by the Medical Director or the appropriate behavioral health practitioner. An authorization decision is made using the Medical Director or the appropriate behavioral health practitioner’s clinical judgment based on his/her clinical training, licensure, certification and/or expertise.
- G. The Health Plan reminds providers at least annually that they have the opportunity to discuss any UM denials for medical necessity with a Medical Director or an appropriate behavioral health practitioner. This reminder is included in the Provider Newsletter, which is also posted on the Provider Website.
- H. The Health Plan adheres to all HIPAA requirements which include confidentiality and maintaining medical necessity files in locked cabinets.
- I. After reviewing the supporting medical documentation, UM will enter the necessary medical information into CareOne, the clinical information system, and notify the provider by telephone or fax of approvals. All denial of services including cost effective alternatives are communicated by telephone and the appropriate approved denial letters (Grier for TennCare) are mailed to the member and provider. The Medical Director or an appropriate behavioral health practitioner reviews and signs off on all procedure and/or treatment requests that cannot be approved by UM. If photos are submitted with the request, they are copied and returned to the requesting provider.

2.4 Medical Necessity Review
 2.6 Cost Effective Alternative Services
 11.1.3 UM P&P

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- J. Requests by non-network providers in which the requested service is a covered benefit will be reviewed for availability of the service within the network. UM will follow the standard out of network prior authorization policies and procedures.

- K. The Health Plan will document the request, supporting documentation, and provider/member correspondence on file. UM will communicate all decisions to members/ providers. Denial letters must contain:
 - 1. The clinical rationale which were used to make the determination. The rationale is to be written in language that is easily understandable to the member.
 - 2. A reference to the appropriate section in the member's Evidence of Coverage or Member Handbook that was used to make an administrative determination.
 - 3. Instructions on First-level Appeal rights, including urgent appeal rights when appropriate. The instructions are to include a description of the appeal rights and an explanation of the appeal process.
 - 4. A statement of the right of the member and the treating clinician to request a copy, free of charge, of the relevant sections of the guidelines or the benefit plan provisions used in making the determination.
 - 5. Information on the product's external review process.
 - 6. The right of the treating clinician, facility, member or authorized representative to submit written comments, documents or records relating to the claim or request.
 - 7. The name and credentials of the reviewer.

Letters will be sent by the Health Services Department when the determination is made or within 7 working days of the decision.

- L. If there is additional clinical information which was not available for review that may alter the decision, the provider has the option for reconsideration. For a valid reconsideration request, the member or

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provider must contact the Health Plan and submit the additional information within 60 days.

- M. The status of a medical necessity case can be verified by accessing CareOne, the clinical information system.
- N. As a full risk Health Plan we will maintain documentation regarding the provision of CEAs including patient-identifying information, service type and cost, and justification. A report compiling such data will be made available to TennCare upon request.

IV. RELATED DOCUMENTS:

SOP HS UM 1 UM Decision Making/Medical
SOP HS UM 2 UM Decision Making/Behavioral

V. ATTACHMENTS:

Attachment A: TennCare Cost Effective Alternative Services

REFERENCE:

- A. TennCare Contractor Risk Agreements
- B. Medicare Managed Care Manual, Chapter 11 – Medicare Advantage Application, Procedures and Contract Requirements
- C. Contract for Health Care Services Under the Healthy and Well Kids In Iowa Program

VI. APPROVED BY:



Chief Medical Officer

10/23/2008
Date

2.4 Medical Necessity Review
2.6 Cost Effective Alternative Services
11.1.3 UM P&P

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Fortenberry, Elizabeth M

From: Fortenberry, Elizabeth M
Sent: Monday, June 28, 2010 2:01 PM
To: Avery, Connie G; Bagley, Gabrielle Z; Campbell, Mary A; Field, Victoria R; Kovach, Deborah F; Lane, Donna T; Legenzoff, Linda; Stevens, Sharon; Wilson, Carol H; Woodard, Selina H
Cc: Woodard, Selina H
Subject: Mandatory re-education on policy HS UM 1
Importance: High
Attachments: HS UM 1 Medical Necessity Review.doc

Tracking:

Recipient	Response
Avery, Connie G	✓
Bagley, Gabrielle Z	✓
Campbell, Mary A	✓
Field, Victoria R	Yes: 6/28/2010 2:26 PM ✓
Kovach, Deborah F	
Lane, Donna T	✓
Legenzoff, Linda	- STD
Stevens, Sharon	✓
Wilson, Carol H	✓
Woodard, Selina H	Yes: 6/28/2010 2:28 PM ✓
Woodard, Selina H	
<i>Jette Jernage - SICK</i>	

All ICMs,
 I need each of you to review this policy on Medical Necessity. Pay close attention to the timelines. See highlighted in RED.

**** Please note the reply button for a response upon completion.

Thank you all!

Elizabeth "Beth" Fortenberry, RN, BSN,CCM
 Associate Director Medical Clinical Ops
 AmeriChoice by UnitedHealth Care
 8 Cadillac Drive, Ste 410
 Brentwood, TN 37027
 Phone (615) 493-9607

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6/28/2010

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Fortenberry, Elizabeth M

From: Campbell, Mary A
Sent: Monday, June 28, 2010 2:23 PM
To: Fortenberry, Elizabeth M
Subject: RE: Mandatory re-education on policy HS UM 1

completed

Mary Campbell RN, MSN

Utilization Care Manager, Inpatient Care
AmeriChoice Tennessee
8 Cadillac Drive, Suite 410
Brentwood, TN 37027
phone: 615-493-9626
fax: 877-690-7052

Help our members avoid unnecessary Emergency Room usage by calling our Nurse Line for assistance with health related questions 24/7 at 1-866-263-9168
Please share this resource with our membership. Thanks!

The information transmitted in this email including any attachments is intended solely for the individual or entity to which it is addressed and may contain confidential and/or privileged material. If you have received this email in error please contact the sender and delete the material from your system immediately.

From: Fortenberry, Elizabeth M
Sent: Monday, June 28, 2010 2:01 PM
To: Avery, Connie G; Bagley, Gabrielle Z; Campbell, Mary A; Field, Victoria R; Kovach, Deborah F; Lane, Donna T; Legenzoff, Linda; Stevens, Sharon; Wilson, Carol H; Woodard, Selina H
Cc: Woodard, Selina H
Subject: Mandatory re-education on policy HS UM 1
Importance: High

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**** Please note the reply button for a response upon completion.

Thank you all!

Elizabeth "Beth" Fortenberry, RN, BSN, CCM
Associate Director Medical Clinical Ops
AmeriChoice by UnitedHealth Care
8 Cadillac Drive, Ste 410
Brentwood, TN 37027
Phone (615) 493-9607

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6/28/2010

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Fortenberry, Elizabeth M

From: Lane, Donna T
Sent: Monday, June 28, 2010 2:20 PM
To: Fortenberry, Elizabeth M
Subject: RE: Mandatory re-education on policy HS UM 1

completed.

*Donna Lane, RN
Utilization Case Management
AmeriChoice ~ United Healthcare
8 Cadillac Drive, Suite 410
Brentwood, TN 37027
ph: 615~493~9548
fax: 1~866~761~9148
donna_lane@uhc.com*

~~HAVE A NICE DAY~~

From: Fortenberry, Elizabeth M
Sent: Monday, June 28, 2010 2:01 PM
To: Avery, Connie G; Bagley, Gabrielle Z; Campbell, Mary A; Field, Victoria R; Kovach, Deborah F; Lane, Donna T; Legenzoff, Linda; Stevens, Sharon; Wilson, Carol H; Woodard, Selina H
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Importance: High

All ICMs,
I need each of you to review this policy on Medical Necessity. Pay close attention to the timelines. See highlighted in RED.

**** Please note the reply button for a response upon completion.

Thank you all!

Elizabeth "Beth" Fortenberry, RN, BSN,CCM
Associate Director Medical Clinical Ops
AmeriChoice by UnitedHealth Care
8 Cadillac Drive, Ste 410
Brentwood, TN 37027
Phone (615) 493-9607

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6/28/2010

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Fortenberry, Elizabeth M

From: Field, Victoria R
Sent: Monday, June 28, 2010 2:26 PM
To: Fortenberry, Elizabeth M
Subject: Yes: Mandatory re-education on policy HS UM 1

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6/28/2010

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Fortenberry, Elizabeth M

From: Woodard, Selina H
Sent: Monday, June 28, 2010 2:28 PM
To: Fortenberry, Elizabeth M
Subject: Yes: Mandatory re-education on policy HS UM 1

From:
To:
Subject:

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Fortenberry, Elizabeth M

From: Avery, Connie G

Sent: Tuesday, June 29, 2010 1:26 PM

To: Fortenberry, Elizabeth M

Subject: Yes: Mandatory re-education on policy HS UM 1 RESPONSE REQUIRED DUE TODAY

6/30/2010

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Fortenberry, Elizabeth M

From: Bagley, Gabrielle Z

Sent: Tuesday, June 29, 2010 1:26 PM

To: Fortenberry, Elizabeth M

Subject: Yes: Mandatory re-education on policy HS UM 1 RESPONSE REQUIRED DUE TODAY

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Fortenberry, Elizabeth M

From: Stevens, Sharon

Sent: Tuesday, June 29, 2010 2:47 PM

To: Fortenberry, Elizabeth M

Subject: Yes: Mandatory re-education on policy HS UM 1 RESPONSE REQUIRED DUE TODAY

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6/30/2010

CONFIDENTIAL

Fortenberry, Elizabeth M

From: Wilson, Carol H

Sent: Wednesday, June 30, 2010 5:28 AM

To: Fortenberry, Elizabeth M

Subject: Yes: Mandatory re-education on policy HS UM 1 RESPONSE REQUIRED DUE TODAY

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Fortenberry, Elizabeth M

From: Jernigan, Jetta L
Sent: Thursday, July 01, 2010 8:42 AM
To: Fortenberry, Elizabeth M
Subject: Yes: Mandatory re-education on policy HS UM 1

7/1/2010

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Fortenberry, Elizabeth M

From: Kovach, Deborah F

Sent: Thursday, July 01, 2010 1:23 PM

To: Fortenberry, Elizabeth M

Subject: Yes: Mandatory re-education on policy HS UM 1 RESPONSE REQUIRED DUE TODAY

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7/1/2010

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New Denial Letter Tasking Process

Previously when the TN Notification Coordinator was “tasked” a notification to send a Grier/Denial letter, the Integrated Care Managers (ICMs) did not check the box “return task upon completion” therefore when the letter was sent the ICM was not aware.

Presently when tasking the TN Notification Coordinator the ICM is checking the box “return task upon completion” and are also tasking the notification to their personal queue to follow up for discharge date and any discharge planning needs. If they have a case in their queue and notice they do not have a task from the TN Notification Coordinator they can follow up on why the letter has not been completed.

Start tasking a request for denial letter as seen below.

1. Task "Letter"
2. Check box "Return task upon completion"

This will help ID when letter is completed.

The screenshot displays a web-based notification system interface. On the left is a vertical navigation menu with categories: General, Providers, Contact Information, Bed Details, Discharge Planning, Reviews, Notes, and CR History. The main content area is titled 'Notification Information' and contains several fields: Notification # (redacted), External #, Notification Status (Anticipated Admission), Status Reason (AN Completed - Awaiting Admission), Category (Hospital Admit), Admit Reason (Elective), Admit Type (SURGICAL), Date Notified (7/1/2010 4:19 PM), Notification Source (Fax), and Adv. Notification Date (7/1/2010 4:19 PM). A modal dialog box titled 'Assign Task' is overlaid on the screen. It prompts the user to 'Create a task for the selected user to complete/review the notification.' The dialog includes fields for Notification # (redacted), Group (TN Notification Coordinator), Task Description (Letter), Due Date (8/4/2010), and Priority (Normal). A checkbox labeled 'Return Task Upon Completion' is checked. The dialog also has 'OK' and 'Cancel' buttons.

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May Audit Scores

Connie Avery: 100%, 100%

Gabrielle Bagley: 100%, 100%

Mary Campbell: 94%, 94%, 94%, 94%, 100%

Vikki Field: 100%, 100%

Debbie Kovach: 94%, 94%

Donna Lane: 100%, 94%, 100%, 94%, 94%

Sharon Stevens: 88%, 100%

Carol Wilson: 88%, 94%, 100%, 94%, 100%

June Audit Scores

Connie Avery: 94%, 100%

Gabrielle Bagley: 100%, 100%

Mary Campbell: 94%, 94%, 94%, 88%, 89%

Vikki Field: 100%, 94%

Debbie Kovach: 100%, 94%

Donna Lane: 94%, 94%

Sharon Stevens: 95%, 94%

Carol Wilson: 82%, 82%, 89%, 88%, 94%