

Utilization Management (UM) Handbook



March 2023

Trillium Community Health Plan's (Trillium) Utilization Management (UM) practices promote fair, impartial, and consistent UM decisions for all health plan members. Trillium follows and adheres to the Oregon Health Authority (OHA) rules, regulations and criteria when making UM decisions.

→ **Trillium's UM practices serve to:**

- Ensure confidentiality of personal health information
- Initiate process improvement activities to enhance UM practices
- Make evidence-based decisions that take into consideration medical necessity, appropriateness and availability of benefits
- Objectively and consistently monitor and evaluate the delivery of high quality and cost-effective services

→ **Trillium does not discriminate in the provision of services based on an individual's race, color, national origin, sex, age or disability, including to:**

- Deny, cancel, limit or refuse to issue or renew a Trillium insurance plan or other Trillium health coverage
- Deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage
- Exclude or limit categories of services related to gender transition
- Use discriminatory marketing practices or benefit designs

→ **Compensation or incentives is prohibited by any Trillium staff, subcontractor, vendor, provider or entity performing UM activities on behalf of Trillium-**

Examples are:

- Amount or volume of adverse determinations
- Reductions or limitations on lengths of stay, benefits or services
- Frequency of telephone calls or other contacts with health care practitioners or patients

MEDICAL RECORDS AND INFORMATION

Trillium requests and reviews only the minimum health record information necessary to authorize services and meets appropriate utilization control requirements as defined by State and Federal rules per Trillium policy: *OR.MM.125 Supporting Documentation for Authorization Determination*

Trillium has established written UM policies, procedures and criteria for covered services. These UM procedures are consistent with appropriate utilization control requirements of 42 CFR Part 456, which includes minimum health record requirements in 42 CFR §456.111 and 42 CFR §456.211 for hospitals and mental hospitals, which are:

- Identification of member;
- Physician name;
- Date of admission, dates of application for and authorization of Medicaid benefits if application is made after admission;
- Plan of care (as required under §456.180 [mental hospitals] or §456.80 [hospitals]);
- Initial and subsequent continued stay review dates (described under §456.233 and §465.234 [for mental hospitals] and §456.128 and §456.133 [for hospitals]);
- Reasons and plan for continued stay if the attending physician determines continued stay is necessary;
- Other supporting material the committee believes appropriate to include; and
 - ➔ For non-mental hospitals only:
 - Date of operating room reservation; and
 - Justification of emergency admission if applicable.

MEDICAL NECESSITY DETERMINATIONS

- Trillium does not deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition, subject to the Prioritized List of Health Services;
- All medically appropriate covered services are furnished in an amount, duration and scope that is no less than the amount, duration and scope for the same services furnished to members under Fee-for-Service per 42 CFR §438.210 and §438.210(a)(5)(i) to reasonably be expected to achieve the purpose for which the services are furnished and include the following:
 - The prevention, diagnosis and treatment of a disease, condition or disorder that results in health impairments or disability;
 - The ability to achieve age-appropriate growth and development; and
 - The ability to attain, maintain or regain functional capacity.

FINANCIAL INCENTIVES

- To ensure UM decisions are based on appropriateness of care and service and existence of coverage, Trillium's Medical Management, Behavioral Health and Provider Network Management, adhere to Trillium's policy: CC.UM.64 **Affirmative Statement about Financial Incentives**. Trillium does not reward practitioners, providers, or employees who perform utilization reviews, including those of the delegated entities for issuing denials of coverage or care. UM decision making is based only on appropriateness of care, service, and existence of coverage.
 - Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Denial decisions are based on lack of medical necessity or lack of covered services and benefits.
 - Trillium and its delegated health plan partners have utilization and claims management systems in place to identify, track, and monitor care provided and to ensure appropriate healthcare is provided to members.
- Trillium **does not**:
- Offer, pay, solicit, or receive remuneration to induce referral of business reimbursable under Medicaid and Medicare contracts
 - Engage in practices incentivizing over- or underutilization
 - Sanction or offer reduced rates for care or services not having stringent payment or utilization constraints
 - Engage in or condone practices resulting in fraud, waste, or abuse
 - Make decisions regarding hiring, promoting, or terminating an individual based on the likelihood the individual will support denial of benefits
 - Offer member incentives to use a particular provider, practitioner, or supplier
 - Specifically reward providers, practitioners or other individuals for issuing denials of coverage for care or services
- Trillium adheres to the following measures and practices to ensure appropriate utilization of health care:
- Processes to monitor for under and overutilization of services and take the appropriate intervention when identified
 - Systems in place to support the analysis of utilization statistics, identification of potential quality of care issues, implementation of intervention plans and evaluation of the effectiveness of the actions taken
 - Processes to support continuity of care across the health care continuum
 - Affirmative Statement about Incentives is distributed and signed by Trillium UM staff annually
 - Affirmative Statement about Incentives is distributed to practitioners and providers upon contracting and annually thereafter
 - Affirmative Statement about Incentives is distributed to members annually via Member Newsletter

UTILIZATION MANAGEMENT HANDBOOK

REFERENCES | DEFINITIONS | REVISION TRACKING

DEPARTMENTS: Medical Management- Utilization Management Provider Network Management (PNM)	PRODUCT TYPE: OHP/MEDICAID
EFFECTIVE DATE: 1/1/2020	REVISED DATE: 3/2/2023

REFERENCES: 42 CFR §438.210(a)(5)(i) 42 CFR §456 §456.111 §456.128 §456.133 §456.180 §456.211 §456.233-234	OR.MM.125 Supporting Documentation for Authorization Determination CC.UM.64 Affirmative Statement About Financial Incentives OR.MM.159 Covered Benefits and Services
OAR 410-120-0000 - Definitions	

DEFINITIONS: Covered Services: Those medically necessary health care services provided to members, the payment or indemnification of which is covered under the State contract. Fee for Service: A method in which doctors and other health care providers are paid for each service performed. Medically Appropriate: Health services, items, or medical supplies that are: (a) recommended by a licensed health provider practicing within the scope of their license; (b) safe, effective and appropriate for the patient, based on standards of good health practice and generally recognized by the relevant scientific or professional community based on the best available evidence; (c) not solely for the convenience or preference of member or a provider of the service item or medical supply; and (d) most cost effective of the alternative levels or types of health services, items, or medical supplies that are covered services that can be safely and effectively provided to a member; (e) all covered services must be medically appropriate for the member but not all medically appropriate services are covered services.
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DEFINITIONS (cont.):

Medically Necessary: Health services and items that are required by a member to address one or more of the following:

- (a) The prevention, diagnosis, or treatment of a client or member's disease, condition, or disorder that results in health impairments or a disability;
- (b) The ability for a client or member to achieve age-appropriate growth and development;
- (c) The ability for a member to attain, maintain, or regain independence in self-care, ability to perform activities of daily living or improve health status; or
- (d) The opportunity for a member receiving Long Term Services & Supports (LTSS) as defined in the rules to have access to the benefits of non-institutionalized community living, to achieve person centered care goals, and to live and work in the setting of their choice;
- (e) A medically necessary service must also be medically appropriate. All covered services must be medically necessary but not all medically necessary services are covered services.

Member: An individual becomes a Member as of the date of enrollment with the Plan, on which date, the Plan will provide all covered services applicable to their member benefit package. If a person becomes a Member on the same day they are admitted to the hospital or, for children and adolescents admitted to Psychiatric Residential Treatment Services (PRTS), the Plan is responsible for said services.

Utilization Management (UM): Evaluating and determining coverage for and appropriateness of medical care services, as well as providing needed clinical assistance to member, in cooperation with other parties, to ensure appropriate use of resources.

REVISION LOG

REVISION:	DATE:
Annual Review. Updated Financial Incentives policy OR.UM.105 to mapped corporate policy CC.UM.64. Minor grammatical edits throughout document. Verification of all regulation references, i.e., ORS, CFR's, P&P's.	3/2/2023