

# 7 Medical Management

## MEDICAL MANAGEMENT OVERVIEW

Our medical management philosophy and approach focuses on providing high quality and cost-effective healthcare services to our members. Our Medical Management Program is designed to align our goals of member service, effective medical management and member and provider satisfaction.

Empire is committed to providing access for the delivery of quality medical care and services to its members. The Medical Management department shares the commitment by

- making utilization management decisions based only on the appropriateness of care and service, the existence of coverage, the provider of these services and the setting in which the services will be delivered.
- not rewarding our medical staff — or other people who perform medical management functions — for denials of coverage for medical care and services.
- having no financial incentives to encourage decisions that could result in underutilization.

## MEDICAL MANAGEMENT REVIEW PROCESS

When calling Medical Management, the physician should have the following member information available to give to Empire's service representative:

- Member's and/or patient's identification number
- Patient's name
- Scheduled/actual date of admission
- Type of admission (scheduled or emergent)
- Attending physician's name and telephone number
- PCP's name and telephone number
- Facility's name and telephone number

- Diagnoses (primary, secondary and any other co-morbidities)
- Requested procedure, service or plan or care

An Empire Medical Management Nurse, a specially trained registered nurse, will review each request for admissions, procedures or services for medical appropriateness of services and setting based on evidence-based criteria. If the criteria are met, the review nurse documents clinical data on the Medical Management system and authorizes the requested service. Approval letters are mailed to the member, the PCP, the hospital and the attending physician within one business day of the decision. If the review nurse determines that the criteria are not met, or there is insufficient information to complete a review, the request for service is referred to the medical director for review. As part of the medical director's review the attending physician may be contacted to discuss the case.

Whenever Empire makes a utilization review determination about the medical necessity of a service, procedure or admission for which the physician requests precertification, Empire will notify the physician by telephone and remind the physician to inform his/her patient of the decision.

Upon receipt of this notice, the physician must notify the patient by telephone of the determination. The call is a requirement of Empire's procedures and is considered part of the physician's professional relationship with his/her patient. Physicians must provide this notice to their Empire patient within 24 hours of receiving notice from Empire of its determination, regardless of whether precertification for the service, procedure or admission has been approved or denied.

In addition to Empire's telephone call, Empire will follow

up with a written notice to the physician, facility and to the Empire patient within three business days. If a third-party utilization review agent is providing precertification services, this agent will notify the physician by telephone of its determination. In this instance, it remains the physician's responsibility to notify his/her patient within 24 hours.

## **MEDICAL DIRECTOR AVAILABILITY**

Empire's medical directors are available to discuss medical necessity denial decisions with physicians. To speak to a medical director, refer to the denial notification. It includes information regarding how to contact the medical director.

## **LACK OF INFORMATION POLICY FOR MEDICAL MANAGEMENT REVIEWS**

### **Limited Clinical Information**

If limited clinical information is available for review, the nurse will contact the treating physician and/or the hospital Utilization Review department. If the nurse places an outgoing call to either of the above parties prior to 12:00 p.m. (noon), the nurse will notify the physician and/or Utilization Review department that additional clinical information must be received by 3:00 p.m. of that same day or the case will be referred to a Medical Director for denial.

### **No Clinical Information**

If no clinical information is available for review, the nurse will contact the treating physician and/or the hospital Utilization Review department. When placing an outgoing call to either of the above parties prior to 12:00 p.m. (noon), the nurse will notify the physician and or Utilization Review department that clinical information must be received by 3:00 p.m. of that same day or the case will be referred to the Case Manager for denial. For outgoing calls placed after 12:00 p.m. (noon), the nurse will notify the physician and/or Utilization Review department that clinical information is required by 3:00 p.m. of the following day or the case will be referred to a Medical Director for denial.

For outgoing calls placed after 12 noon, the nurse will notify the physician and/or Utilization Review department that clinical review information is required by 3:00 p.m. of the following business day or the case

will be referred to a Medical Director for lack of information denial.

## **Senior Plan, HMO and POS Contracts**

Services will be denied as of the last day approved, for example, if a nurse reviews an inpatient admission on Friday and approves services through Sunday, then determines on Monday that there is not enough information to approve any additional days. The nurse then will place appropriate calls to request additional clinical information. If no response is received, the nurse will refer the case to the medical director. If the medical director receives no response to his or her request for clinical information, the services will be denied as of 12 midnight Sunday.

## **RECONSIDERATIONS**

Physicians may request a reconsideration when an Empire medical director makes an initial denial decision without being able to speak to the requesting physician. The reconsideration decision is made within 1 day of the reconsideration request.

## **RETROSPECTIVE REVIEW OF SERVICES RENDERED**

A retrospective review is an evaluation done after services are completed. Empire's Medical Management Program reviews care retrospectively in certain situations where medical necessity must be established to approve the payment of the benefit. We will not retroactively deny reimbursement for services that were provided based on precertification for such services, except where there was a material misrepresentation or fraud in connection with the precertification request or the patient was not a member at the time of service.

## **EMPIRE'S MEDICAL POLICIES**

### **Medical Policy Review and Development**

Empire develops and/or adopts clinical and payment policies through a formal process that evaluates new developments in technology and new applications of existing technology. The review and decisions are based on a preponderance of expert opinion and published peer-reviewed medical literature proving that the technology is effective for its intended use.

We have stated that our primary source of information is CMS, but information from the FDA, research entities such as HAYES and ECRI and the BlueCross BlueShield Association Technology Evaluation Criteria are also

heavily considered. One of the factors considered is the potential effect of a new policy on members and physicians.

To view Empire’s Medical Policy, visit our website [www.empireblue.com](http://www.empireblue.com). Log in to Physician Online Services and click on the link to Empire’s Medical Policies.

For paper copies, contact your Network Maintenance Representative.

The following are examples of new technology and payment decisions. Some directly follow CMS while some follow CMS with some modification. The modifications may be more or less restrictive than CMS based on other evidence reviewed by the Empire’s Clinical Policy Committee.

## Technology-Related Policies

Policy	Source	Action	Effective Date
<b>Empire Directly adopted CMS policy</b>			
Upper Limb Myoelectric prostheses	CMS	Adopted CMS policy to allow.	May 2003
Immunologic fecal occult blood test	CMS	Adopted CMS policy to allow.	May 2004
Cardiac Rehab for stable angina	CMS	Adopted CMS policy to allow.	December 2003
PET scan for breast/esophageal CA	CMS	Adopted CMS policy to allow.	November 2003
PET scan for prostate, pancreatic, ovarian CA	CMS	Adopted CMS policy not to allow.	November 2003
<b>Empire Modified CMS policy</b>			
Drug-eluting coronary stents	Empire, CMS	Adopted CMS policy to allow.	September 2003
Laparoscopic gastric bypass	Empire, CMS, BCBSA	Allowed with more rigorous criteria than CMS.	January 2004
IVIIG	BCBSA, ECRI, other insurers	Allowed with more rigorous criteria than CMS.	June 2004
Allergy testing	BCBSA, ECRI, other insurers	Allowed with more rigorous criteria than CMS.	June 2004
Allergy immunotherapy	BCBSA, ECRI, other insurers	Allowed with more rigorous criteria than CMS.	June 2004
<b>CMS policy not adopted by Empire</b>			
PET scan sarcoma/thyroid CA	BCBSA, ECRI, other insurers	Empire does not allow. CMS allows.	November 2003
Radiofrequency ablation of liver tumors	BCBSA, ECRI, other insurers	Empire allows. CMS does not allow.	April 2004
Frequency limit on lipid testing	Empire, BCBSA	Empire allows unlimited. CMS allows with limits.	2001
<b>Empire Policies unrelated to CMS (CMS has no policy)</b>			
Cryoablation of liver tumors	BCBSA, ECRI, other insurers	Not allowed.	June 2004
Rhinomanometry	BCBSA, ECRI, other insurers	Not allowed.	November 2003
Light therapy for seasonal affective disorder	BCBSA, ECRI, other insurers	Allowed.	August 2003
Amevive for psoriasis	BCBSA, ECRI, Drug Compendia	Allowed.	October 2003
Humira for rheumatoid arthritis	BCBSA, ECRI, Drug Compendia	Allowed.	June 2004
Fuzeon for HIV	BCBSA, ECRI, Drug Compendia	Allowed.	October 2003

## Payment-Related Policies

Policy	Source	Action	Effective Date
<b>Empire Directly adopted CMS policy</b>			
Component – profile lab procedure bundling	CMS	Adopted CMS policy .	May 2003
Strabismus (eye muscle) surgery bundling	CMS	Adopted CMS policy .	January 2004
Arthroscopy Procedure Bundling	CMS	Adopted CMS policy .	August 2003
Modifier –59	CMS	Adopted CMS policy to allow.	April 2004
Anesthesia supervision	CMS	Adopted CMS policy to allow.	April 2004
Digital mammography	CMS/Other insurers	Adopted CMS policy to allow.	April 2004
<b>Modified CMS policy</b>			
Assistant surgeon	CMS/Empire	Empire allows procedures in addition to those allowed by CMS.	February 2004
<b>Empire did not adopt CMS policy</b>			
Pregnancy ultrasound	Empire	Empire pays separately from global fee. CMS does not.	August 2003
Routine foot care	Empire	Empire allows ingrown nail removal. CMS does not allow.	August 2003
Colorectal cancer screening testing	ACS	Empire covers screening. Screening not covered by CMS.	July 2003
Anesthesia with GI procedures	Empire	Monitored anesthesia covered in office without CMS diagnosis restrictions.	January 2003
Lab test diagnosis restrictions	Empire	Allow lab tests without CMS diagnosis restrictions.	June 2003
Cardiology test diagnosis restrictions	Empire	Allow cardiology tests without CMS diagnosis restrictions.	2001
Telemedicine	Empire	Not covered.	January 2003
<b>Payment policies unrelated to CMS policy</b>			
Physical therapy	Empire, other insurers	Payment covered under global fee.	August 2003