PROVIDENCE HEALTH PLANS
MEDICAL MANAGEMENT PROGRAM SUMMARY

1.0 PROGRAM PURPOSE

The purpose of the Medical Management Program (MM) is to maximize health outcomes and provide quality of care to our members through appropriate use of health care services and resources. The Medical Management Program is designed to promote collaboration and coordination between primary care providers, providers of specialty care, and Health Plan clinicians through fair and consistent decision making. Continuity of care is preserved through a team approach to medical management activities.

2.0 PROGRAM GOALS AND OBJECTIVES

The GOAL of the Medical Management Program is to promote optimal management of health care services through thoughtful planning, careful stewardship of resources, and continual improvement of our healthcare delivery system.

The OBJECTIVES are to:
♦ Facilitate the delivery of efficient and effective medical care.
♦ Adopt and implement interventions that promote effective management and outcomes of care, including encouraging prevention and early detection of disease.
♦ Ensure that members have equitable access to care across our healthcare delivery system. Establish guidelines and policy through education and research, which support consistent and equitable allocation of medical services.
♦ Meet or exceed the expectations and standards of Federal and State regulatory bodies, accrediting organizations, and our contracted Provider network and members.
♦ Ensure delegated Providers/sites have adequate systems and resources to meet quality of care and service demands of our members in cost-effective and efficient ways.

3.0 PROGRAM SCOPE

The Medical Management Program is a component of the Quality Management Program of Providence Health Plans, and reflects both delegated and non-delegated activities. The Program serves the membership and populations within the service areas of Providence Health Plan, and Providence Preferred Provider Organization (PPO). The scope of the MM Program includes the following processes:
♦ Referral management
♦ Prior authorization of selected services
♦ Concurrent review and discharge planning
♦ Retrospective review, which may include claims review
♦ Care coordination and case management
♦ Technology assessment
♦ Identification of clinical quality of care issues
Data analysis, profiling, and dissemination of information

4.0 AUTHORITY AND RESPONSIBILITY

The Medical Management Program is an integral part of the Quality Management Program, and as such reports to the Providence Health Plan Board through the existing QM structure. The Chief Medical Officer is the senior executive responsible for the Medical Management Program. The Administrative Quality Council is the body responsible for oversight of the Quality Management Program. (See Quality Assessment filing)

The ongoing oversight for the Medical Management Program is through the Analysis and Program Committee (A&P Committee). This committee reviews relevant data and information and hears direct reports from sub-committees. Subcommittees of the A&P Committee include the Technology Assessment Committee, the Utilization Review and Policy Committee, the Pharmacy Committee and the Mental Health Program Committee. The A&P Committee reports to the Quality Improvement Team through the Chief Medical Officer.

The Chief Medical Office (CMO), the Director of the Quality and Medical Management Department, and the Director of Medical Management are responsible for the day to day oversight, implementation, and improvement of the MM program and processes.
5.0 PROGRAM STAFF

The MM Program is supported by physician and professional staff who have knowledge and skills needed to evaluate working diagnoses and proposed treatment plans. Additional operational support is provided by non-clinical staff. Specific personnel responsibilities and requirements are provided in job descriptions.

Chief Medical Officer

Chief Medical Officer (CMO) is the senior executive responsible for the Medical Management Program. The CMO is a licensed Doctor of Medicine or Doctor of Osteopathy. The CMO is responsible for ensuring fair and consistent decision making through the use of medical policy and criteria; for evaluation of new technologies; and for delegated MM functions. The CMO is assisted by Medical Directors and Physician Advisors who have program and function responsibilities.

The principal accountabilities of the CMO include the day to day oversight, implementation, and improvement of the quality and medical management programs, the counseling of practitioners in the principles of managed care, and the promotion of a positive relationship between the Health Plans and practitioners, including delegated providers/sites.

Clinical Staff

Professional Clinical Reviewers (RN’s) and Masters of Social Work (MSW’s), knowledgeable in managed care systems, facilitate and promote medical management through a Primary Care Physician (PCP) based care management model; through specialized case management programs; and through prospective, concurrent, and retrospective medical appropriateness review.

A Registered Professional Pharmacist manages the pharmacy program and provides oversight, direction, implementation, and improvement of drug utilization and provider education activities.

Additionally, clinical staff provide identification of potential clinical quality of care issues, and provide resource support to Medical Groups and delegated entities for medical management activities.

Non Clinical Staff

Medical technicians coordinate and triage incoming requests; provide assistance to callers, and manage day to day activities under the supervision of a licensed professional. Technicians are Accredited Record Technicians (ART) or have equivalent experience.

6.0 MEDICAL MANAGEMENT REVIEW CRITERIA

Both nationally and locally accepted indicators of medical appropriateness (criteria) are used in review process and decision making. Criteria as a normative standard provide a
Plan Developed Medical Policy and Criteria

Plan Medical Policy and Criteria used for authorizing care is developed by the appropriate specialty representation through a systematized high level process. Policy and criteria formulation is based on reasonable medical evidence. All policies are reviewed annually and updated as needed. Final review and approval of Plan developed medical policy and criteria is provided by the Analysis & Program Committee.

Length of stay is based on medical need and is determined by the attending physician. Planning optimal care and discharge planning is managed collaboratively by the Milliman and Robertson established criteria provide guidelines for optimal care and are used to facilitate care. Milliman and Robertson (M&R) Guidelines for review of lengths of stay and concurrent review activities are provided by the Health as well as the PAS Western Region Length of stay. Medicare Coverage for Skilled Nursing serves as a guide for assessing appropriate skilled level of care.

New technology assessments and coverage decisions are evaluated and recommended for coverage by the regional Technology Assessment Committee. Coverage is established by experts in the field. Health Plan decisions are based on information from multiple sources; consensus of expert opinion; proven health benefit, efficacy and safety.

MEDICAL MANAGEMENT DECISION PROCESSES

MM decisions are supported by approved definitions, criteria, and medical policies which decision making in specialized cases, or in cases where medical appropriateness is unclear. MM policies and procedures define processes, standards, and expectations.

Utilization Management decisions are made by individuals licensed in the appropriate medical field, using national or Health Plan criteria; the accepted standards of care in the Administrative Rules and Regulations. All available clinical information is collected and used to make the coverage decision; including co-
impairment or exacerbate the primary condition for which treatment is being sought.

Timeliness of Review

Medical review decisions are made within standard timeframes to assure that there are no delays in access to care and that practitioners and members have timely rights of appeal of an adverse opinion. Timeliness standards are monitored quarterly.

Expediting Review

A member or provider has the right to request an expedited review for time sensitive pre-service requests or for situations in which care has been discontinued. Time sensitive situations are those in which the time frame of the regular decision making process could seriously jeopardize the life or health of the member or seriously jeopardize the member's ability to regain maximum functioning. A request from a physician is automatically expedited. Expedited reviews are completed within 72 hours.

Communication with Members and Providers

Correspondence regarding medical review decisions is generated in a timely manner, clearly outlines the medical decision process and the review decision. Policies and procedures are in place which govern the content and the timelines for generation of correspondence to members and to providers/practitioners.

8.0 QUALITY IMPROVEMENT

The MM Program staff support the Clinical Quality Management Program through identification of potential quality of care issues. Identified quality of care issues are referred to the Quality Management Program for investigation and follow up. Identification may occur at any point in the review process and may be initiated at any level of review.

9.0 CONFIDENTIALITY

All staff and providers, including committee members, involved in Medical Management activities are required to maintain confidentiality. The MM Confidentiality Policy is reviewed and approved by the A&P Committee. Delegated entities must follow the MM Program Confidentiality Policy and Procedure.

Information related to medical review activity is confidential. No information is shared unless a person has an identifiable need to know. All medical information referred for outside chart review is redacted, i.e., void of all identifiable provider or patient specifics. No report with patient characteristics may be issued to an employer or payor unless stipulated by contract, or allowed by Oregon Insurance Code. The MM Program has a policy further defining confidentiality.

10.0 DELEGATION OF MEDICAL MANAGEMENT SERVICES

The Medical Management Program is accountable for approval and oversight of
delegated MM activities to ensure compliance with regulatory and accreditation

be met by the delegated entities medical management function and processes. The Health Plan views delegation as a collaborative process, and coordinates and supports the

services are formally delegated to another agency, clinic or panel of doctors [PODs], a pre-delegation assessment, based on accreditation and regulatory body standards, is

mentors the delegated Provider/site, offering collaborative support for corrective action plans.

IPA’s, letters of agreement, and/or written memoranda of understanding [MOU].

The Health Plan retains the responsibility for oversight of delegated activities to ensure

approval of program documents and policies. This process verifies and validates the delegates’ ability to administer a Medical Management program. Revocation of

Revocation of delegation is recommended by the Analysis & Program Committee, and is referred to the Administrative Quality Council.

MEDICAL MANAGEMENT PROGRAM EVALUATION

The Medical Management Program is evaluated annually. The evaluation is prepared by

collaboration with Health System program staff and physician leadership.
Relevant information from the 1998 Medical Management Program Evaluation follows:

A. Inter-rater reliability audits

*Physician*

clinical review. They review all cases determined not to meet established medical criteria and facing a potential denial, complex clinical cases, or those cases for which established

An audit was done to validate the consistency of medical decision making. The review sample consisted of ten randomly selected cases reviewed by each physician for a total of

*Clinical (pre-authorization) Reviewers*

Inter-rater reliability audits were conducted during first and second quarter 1997 to assess appropriateness and consistency of applying medical criteria, contract benefits, and monitoring documentation standards.

The ongoing audits show 100% compliance, with no interventions recommended.

*Clinical (Concurrent) Review*

Audits were begun in 1995. These audits review the performance of the nurses and how they consistently apply criteria for decision making. The ongoing audits show an improvement over the baseline in 1997.

B. Timeliness Audits

Timeliness audits were conducted on a semi-annual basis beginning in 1995. A random sample of five cases is pulled per reviewer of quarterly review activity. The audit is conducted by peer review.

Improvements have been made since the baseline year 44% in 1995 with average performance in 1997 of 85%. Improvements over time are attributed to staff and practitioner education and a refinement of the standard for obtaining additional information.

C. Member/Practitioner Satisfaction with UM Program

Annual Member Satisfaction surveys include questions to measure satisfaction with PHP’s utilization management program. As part of the Grand Analysis of Member Satisfaction, issues surrounding PHP’s administrative processes to document specialty referrals were identified in both Member and Practitioner Satisfaction Surveys. In response, PHP commissioned a quality improvement project to identify existing internal and external performance barriers and develop recommendations to improve the current referral entry process. It is anticipated that identified interventions will be implemented mid-1999.
D. Practitioner Involvement

Participating physicians continued to support the Health Plan through committee membership and involvement in clinical quality improvement activities. Physician committee participation is demonstrated by the percentage of physicians attending committee meetings as reflected on the chart by committee name. The number of physicians represented on each committee is also reflected in the chart legend.