Utilization management guide

BOOKLET 4:

Peer-to-peer conversations for Medicare Advantage plans

Humana

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Utilization management

Our utilization management (UM) program works to improve healthcare quality, reduce costs and improve the overall health of the population. It is a process that evaluates the efficiency, appropriateness and medical necessity of the treatments, services, procedures and facilities provided to patients on a case-by-case basis. Humana does not reward physicians, other individuals or Humana employees for denying coverage or encouraging under-use of services.

Peer-to-peer review process

Upon receiving an adverse determination, the provider seeking authorization may be given an opportunity to speak with a medical director or other appropriate reviewer about the services requested for the patient, along with the clinical basis for treatment.

Note: There are exceptions based on federal and state regulations—see below.

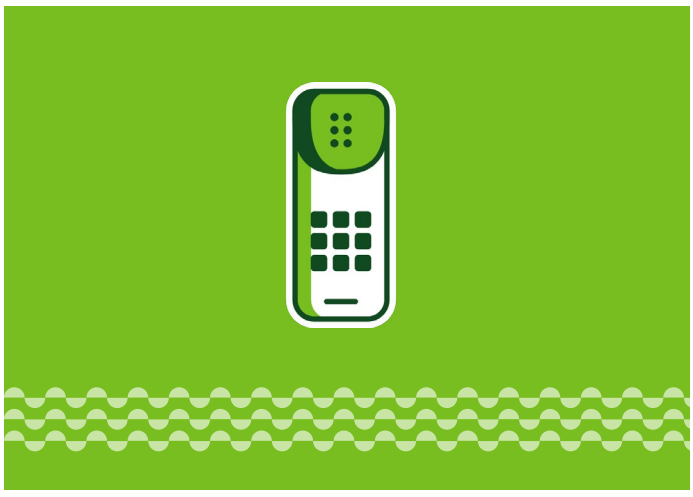
For Medicare Advantage (MA) plans, discussion must be completed prior to the adverse determination being rendered. Once an adverse determination has been made for urgent, concurrent and retrospective cases, participating providers are able to submit a dispute under the following circumstances:

- Physician/provider is contracted with Humana.
- Humana's adverse decision was based on evidence provided/supported at the time of the request.

Physicians/providers have 5 calendar days from notification of the denied authorization to request the pre-claim dispute.

A peer-to-peer (P2P) conversation may or may not be specialty matched. Not to be confused with a medical peer conversation, the P2P conversation is a telephone call between a licensed Humana physician and the physician or other healthcare professional requesting authorization for coverage.

For purposes of this discussion, doctors and medical directors are considered to be peers. A P2P conversation is not an appeal, not specialty matched and not intended to overturn a denial. However, it is an opportunity for the requesting physician to share critical clinical information that may have been omitted from the original request for services.



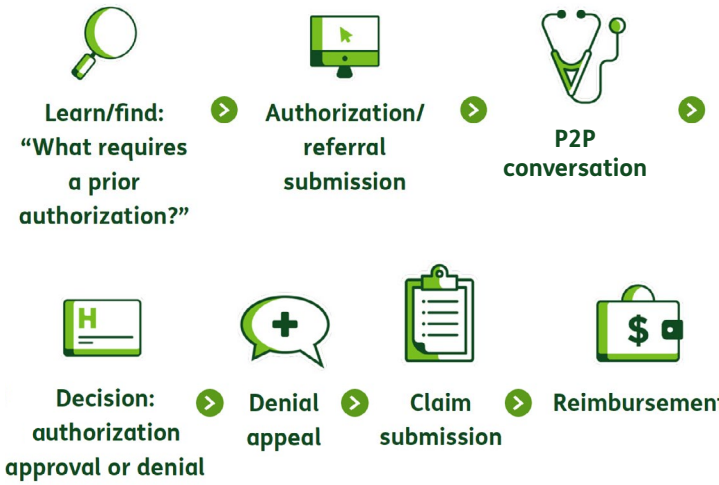
FREQUENTLY ASKED QUESTIONS

What is utilization management?

UM is a set of techniques used by or on behalf of purchasers of healthcare benefits to manage healthcare costs by informing patient care decision making through case-by-case assessments of the appropriateness of care prior to its provision.

How are authorization determinations made?

Most common scenario



Humana uses a variety of guidelines in making UM determinations, including CMS (Centers for Medicare & Medicaid Services) NCDs (National Coverage Determination), LCDs (Local Coverage Determination), and Manuals; MCG® care guidelines* and Humana Medical Coverage policies (limited to approvals only). The guideline that is used is dependent upon the service requested. The UM process is guided by a hierarchy of how to apply the various guidelines.

For Skilled Nursing Facility (SNF) and Acute Rehab (IRF) admissions, CMS Manuals for SNF and IRF Coverage Guidelinesare used.

* MCG Health is part of the Hearst Health network.

For most outpatient (OP) services, CMS NCDs and LCDs are used. Humana Medicare coverage policies may be used in the absence of any CMS coverage policies, but only for approval of a service that is not statutorily excluded as a Medicare-covered benefit.

Only an M.D. can render an adverse (denied) medical necessity determination.

Treating physicians are offered a P2P conversation prior to issuance of a preauthorization decision.

How does Humana establish UM guidelines?

We begin with evidence-based guidelines as the basis on which to define established standards of effective care. These guidelines are from a number of well-respected national sources. Condition/treatment-specific guidelines can be found here.

Note: The information contained within these guidelines is not a substitute for a physician or other healthcare professional's clinical judgment and is not always applicable to an individual. Therefore, the physician or healthcare professional and patient should work in partnership in the decision-making process regarding the patient's treatment. Furthermore, using this information will not guarantee a specific outcome for each patient. None of the information in the guidelines is intended to interfere with or prohibit clinical decisions made by a treating physician or other healthcare professional regarding medically available treatment options for patients.

What is a peer-to-peer review?

A P2P conversation is a telephone conversation between a board-certified, licensed Humana physician (medical director) and the physician or other healthcare professional requesting authorization for coverage. A P2P conversation is not specialty matched.

For purposes of this discussion, physicians, medical directors and reviewers are considered to be peers.

A P2P conversation is not an appeal, not specialty matched and not intended to overturn a denial. However, it is an opportunity for the requesting physician to share critical clinical information that may have been omitted from the original request for services.

What is the P2P process?

Prior to or at the time an adverse determination is communicated, the provider ordering services may be given an opportunity to discuss the services being requested for the patient and the clinical basis for treatment with a medical director or other appropriate reviewer through a peer-to-peer conversation.

Who can overturn a denial on appeal?

Humana medical directors and designated UM clinicians can overturn a denial on appeal.

Who is a Humana medical director?

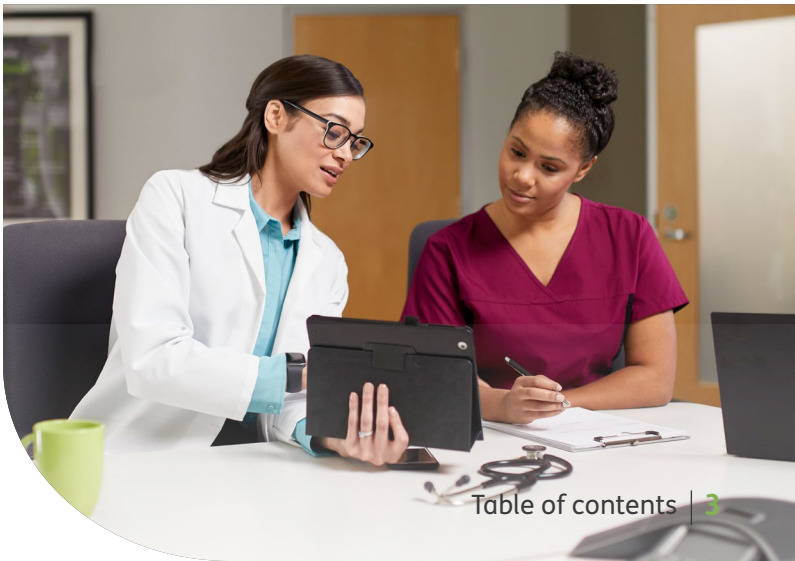
A Humana medical director is a board-certified, licensed physician versed in regulatory compliance, CMS policies, the National Committee for Quality Assurance (NCQA) guidelines, clinical reference materials and other sources of expertise.

How are authorization determinations made?

Humana uses a variety of guidelines in making utilization management determinations, including CMS NCDs, LCDs, and Medicare Manuals; MCG Care guidelines and Humana Medical Coverage policies (limited to approvals only). The guideline that is used is dependent upon the service requested.

How long does the appeal process take?

An appeal may take up to 30 days to process for Medicare Advantage cases. If you need us to expedite the grievance or appeal process, call us at **800-444-9137 (TTY: 711)**. Providers may find the reconsideration processes in the provider manual for physicians, hospitals and healthcare providers.



What is Availity Essentials?

The Availity Essentials Portal is a multipayer site where you can use a single user ID and password to work with Humana and other participating payers online. Availity Essentials is compliant with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations, and there is no cost to register. For select services on Humana's preauthorization list, providers now have the option to use preauthorization automation on the Availity Essentials Portal to get faster approvals by answering a few clinical questions. If all necessary guidelines are met, Humana will deliver an instant approval.

I often submit my preauthorization requests on my practice management system or phone. Is the preauthorization automation tool available for those request methods?

No. The tool is available only on the Availity Essentials Portal at this time.

- If you are not registered for the Availity Essentials Portal, please register here so you have access to the most up-to-date resources and tools for working with Humana.
- As reference, here also is a printable handout with Availity Essentials registration instructions.
- If you have the electronic funds transfer (EFT) information from a Humana check, you can register and start using Availity Essentials right away.

Who can I contact if I have questions about online tools on the Availity Essentials Portal?

If you have problems using the Availity Essentials Portal, call Availity Essentials Client Services at **800-AVAILITY (800-282-4548)**. Assistance is available Monday – Friday, 8 a.m. – 8 p.m., Eastern time, excluding holidays.

What is a retrospective review?

Retrospective review is the process of determining coverage after care is provided, usually after payment is made on the claim. This retrospective review process includes validation of various aspects of a claim against the medical records, and the difference between the payment made and the correct payment is calculated for recovery.

Retrospective reviews typically focus on coding/diagnosis-related group validation, appropriateness of setting, medical necessity and billing.

So, retrospective reviews are about post-treatment review and reconciliation (or claim appeal), whereas a dispute or an appeal typically occur before treatment is rendered and the provider or patient is denied a preauthorization request.

How do I request a retrospective review?

A request for retrospective review can be made by contacting the medical management department at **855-852-7005** and following the appropriate menu prompts, or by faxing the request to **888-527-0016**. Clinical information supporting the service must accompany the request.

Will Humana provide the specific criterion used to make the denial decision?

The denial notification will include the specific reasons for the denial. Providers may also obtain the guidelines used to make a specific adverse determination by contacting Humana.

Does Humana send a denial notification to both the patient and the provider?

Yes. A denial notification is sent to the patient or the patient's authorized representative every time Humana denies a service. The requesting provider and primary care physician are also generally copied. The denial notification contains the specific service that is being denied and the specific reasons for the denial.

What process should a provider follow when they disagree with an authorization decision?

Participating providers may find the reconsideration processes in the provider manuals for physicians, hospitals and healthcare providers. Visit here for information about medical claim payment reconsiderations and member appeals.

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Learn more at Humana.com/Provider