Section (Primary Department) **Health Care Management – Utilization Management**		**SUBJECT (Document Title)** **Use of Board Certified Consultants (Medical/Behavioral Health) - Core Process**	
Effective Date 12/07/2010	**Date of Last Review** 02/28/2019	**Date of Last Revision** 12/18/2019	**Dept. Approval Date** 12/18/2019
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☒ Indiana	☒ Minnesota	☒ Tennessee
☒ **Medicare**	☐ California	☒ Iowa	☒ Nevada	☒ Texas
☒ **MMP/Duals**	☐ Colorado	☐ Kansas	☒ New Jersey	☒ Virginia
	☐ District of Columbia	☒ Kentucky	☒ New York – Empire	☒ Washington
	☐ Florida	☐ Louisiana	☒ New York (WNY)	☒ Wisconsin
	☒ Georgia	☒ Maryland	☐ South Carolina	☒ West Virginia

POLICY:

This P&P is also applicable to Medicare.

To establish procedures for requesting board-certified medical or Behavioral Health consultations or second opinions from board-certified specialists or subject matter experts individually or via Independent Review Organizations (IRO) to assist in making utilization management medical necessity determinations.

DEFINITIONS:

Board-Certified Consultant: A physician who has satisfied the requirements/standards of a nationally recognized specialty board and received the board's specialist certification.

Consultation: Written opinion or advice rendered by a consultant/specialist whose opinion or advice is requested by the health plan Medical Director, a Behavioral Health Medical Director, and/or the Medical Advisory Committee (MAC) for the further evaluation or management of the member by the attending physician.

Consultant/Specialist (Medical or Behavioral Health): A physician or non-physician who has an unrestricted medical or professional license and who meets one of the following criteria:

a) Has been declared board-certified by a member board of the American Board of Medical Specialists and currently retains that status;
b) Can demonstrate satisfactory completion of a residency program accredited by the Liaison Committee for Graduate Medical Education, or the appropriate Residency Review Committee of the American Medical Association;
c) Has been declared board-certified by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association;
d) Has been declared board eligible by a specialty board approved by the Advisory Board of Osteopathic Specialists;

e) Can demonstrate if a residency program was completed in a foreign country, that qualifications and training are acceptable for admission into the examination system of the appropriate American Specialty Board.
f) Non-physician reviewers can demonstrate current professional licensure applicable to review activities. Scope of review is based upon Current Procedure Terminology Codes grouped by utilization management service groups in the utilization management system.

Independent Review Organization (IRO): An entity that conducts independent external Medical or Behavioral Health reviews of medical necessity determinations and adverse health care treatment decisions and performs independent peer reviews.

Medically Necessary Services: Procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; **and**
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; **and**
- not primarily for the convenience of the covered individual, physician or other health care provider; **and**
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease

PROCEDURE:

1) Requests for board-certified consultations or second opinions may occur in, but are not limited to:
   a) Situations involving unusually complex cases when the facts are not clearly defined and there are alternative decisions that may be made based upon assessment of the clinical condition of the situation;
   b) Cases requiring special expertise in order to determine medical necessity and expertise is not readily available within the network of credentialed providers to provide a nonbiased and evidence-based review;
   c) Situations where conflicts of interest are identified with the current potential reviewers or associations with network facilities; or
   d) Situations involving discordance between the treating provider and the health plan Medical Director or a Behavioral Health Medical Director about a treatment plan or a medical necessity appeal decision, such that an external objective opinion is warranted to attest credibility of the process.

2) When the health plan Medical Director or Behavioral Health Medical Director determines

that such a consultation is needed, a board-certified consultant is selected from a list of available consultants or the contracted IRO is contacted.

a) The health plan Medical Director or Behavioral Health Medical Director verifies that the consultant or contracted IRO has no known conflict of interest with the initial reviewer or parties involved with the particular case.

3) The health plan maintains business associate agreements with all approved consultants and the contracted IRO, allowing for disclosure of Protected Health Information (PHI) or, in the absence of such an agreement, the appropriate Health Care Management (HCM) staff obtains the required consent from the member as per policies and procedures related to disclosure of PHI.

4) Designated HCM staff notifies the consultant or the contracted IRO of the pending referral and any questions to be addressed, and furnishes all necessary clinical information via an approved form of transmission to the external party.

5) Based on the medical information provided, the consultant or the contracted IRO will use the latest available knowledge to confirm the diagnosis, review the current treatment plan, define standards of care and identify deviations from or adherences to standards of care and recommend a treatment plan.

6) Within a specified timeframe, the consultant or the contracted IRO provides the results of the consultation to the referring health plan Medical Director, Behavioral Health Medical Director, or designees.

7) The referring health plan Medical Director, Behavioral Health Medical Director, or designees review the report of the consultant or the contracted IRO and makes a medical necessity determination, which is documented in the member's clinical record.

8) All applicable policies and procedures are followed in notifying the member and provider of the determination.

9) The health plan verifies through the credentialing and recredentialing process that the consultant is licensed and board-certified in one or more of the appropriate specialties. The IRO performs verifications through their credentialing and recredentialing process that the consultant is licensed and board-certified in the appropriate specialties.

10) Corporate HCM – Clinical UM Operations staff maintains the national list of board-certified consultants or contracted IRO for each health plan on the HCM SharePoint site.

a) Designated HCM health plan and Behavioral Health staff notifies UM Operations of updates to their consultants or contracted IRO.

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REFERENCES:

Iowa Health Link Contract Amendment 5
Kentucky Medicaid Managed Care Contract §1.0, 21.2
Kentucky Revised Statute 304.17A-005
Managed Care Resource Guide – DMAS April 2013NCQA Accreditation Standards and Guidelines: Appropriate Professionals
Revised Code of Washington 48.43.535
Texas Uniform Managed Care Contract- 1 T.A.C. §353.2 for Medicaid and 1 T.A.C. §370.4 for CHIP
Virginia 2016-2017 Medallion 3.0 Contract, Section 7.1.G & 7.1.N
Virginia Medallion 4.0 Contract, Section 8.2.GG & 8.1.Q
Washington Administrative Code 182-500-0070
Washington Administrative Code 284-43- 0140

Related Policies and Procedures:
Associates Performing Utilization Reviews – Core Process
Professional Competence and Conduct Criteria
Member Privacy Rights
Use of Board Certified Consultants (Medical/Behavioral Health) – Core Process - DC
Use of Board Certified Consultants (Medical/Behavioral Health) – Core Process - LA

Prior References:
Use of Board Certified External Medical Consultants – TN, MD & VA
Use of Board Certified External Medical Consultants – OH
Use of Board Certified External Medical Consultants (Medical Necessity Reviews) - Core Process

RESPONSIBLE DEPARTMENTS:

Primary Department:
Health Care Management - Utilization Management

Secondary Department(s):
Behavioral Health
Credentialing

EXCEPTIONS:

Kentucky:
Per Medicaid Managed Care Contract section 1.0: Medically Necessary or Medical Necessity means Covered Services which are medically necessary as defined under 907 KAR 3:130, meet

national standards, if applicable, and provided in accordance with 42 CFR § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

Per section 21.2: Physician consultants from appropriate medical, surgical and psychiatric specialties shall be accessible and available for consultation as needed.

Per Kentucky Revised Statute 304.17A-005 Health Care Service means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed.

Medically Necessary Health Care Services means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:
(a) In accordance with generally accepted standards of medical practice; and
(b) Clinically appropriate in terms of type, frequency, extent, and duration.

REVISION HISTORY:

Review Date	Changes
11/18/13	• Annual review by PPOC and MOC. Name changed from Use of Board Certified External Medical Consultants (Medical Necessity Reviews) - Core Process. Added VA & TX exceptions. Moved to MBU template. Removed OH language.
01/01/14	• Added Kentucky health plan.
04/01/14	• Added Wisconsin as applicable health plan and removed New Mexico. Deleted NM exception language
09/22/14	• Annual Review
11/13/14	• 2015 LA contract language added
05/20/15	• Remove LA as applicable market. Plan specific version created.
12/03/15	• Off-cycle edits to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016.
01/28/16	• Annual review by PPOC and MOC • Added CA, TX & VA MMP as applicable markets • Replaced Medical Necessity definition with Medically Necessary services • Revised KS, TX & VA exception language
03/23/16	• Off-cycle edits to WA exception language
09/22/16	• Off-cycle edits to added IN as applicable market and add IN exception language

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12/15/16	• Off-cycle edit to add NYW as an applicable market
02/23/17	• Annual review • Revised Clinical Ops to UM Ops • Revised WA & VA contract references; revised related P&Ps • Revised WA & VA exceptions
02/26/18	• Annual review • Updated References and Related P&Ps • Updated IN, KS, WA exception language • Added IA exception language
06/07/18	• FL Only - 2/15/18 - Off-cycle review by Simply Utilization Management Committee vote to adopt in FL Simply/Amerigroup/Clear Health Alliance to reflect legal rebranding of Simply, Better and Amerigroup to Simply and separate branding for Clear Health Alliance as Simply Healthcare Plans, Inc. dba Clear Health Alliance • Off-cycle review by Simply Utilization Management Committee vote to adopt for Simply Medicare Plan (FL) • No changes were made to the policy language
08/10/18	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
01/25/19	• Off-cycle edit to add AR as an applicable market. No content edits.
02/28/19	• Annual review • Added DC as an applicable market; removed KS • Revised References section • Revised IN, KY & WA exception language; added NY exception language; removed KS & MN exception language
12/18/19	• Off-cycle Review • Revised KY exception language