

XIII. MEDICAL MANAGEMENT

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XIII. MEDICAL MANAGEMENT

The Missouri Care Medical Quality Management (MQM) Department is comprised of the operations used to manage the medical services provided to members and to evaluate and monitor the quality and continuity of their care. MQM’s key activities include utilization management (concurrent review and retrospective claims review), prior authorization, and coordinated care (case management).

MQM incorporates prior authorization, utilization management, case management, and the Chief Medical Office (CMO) into a close-knit system with the purpose of using medical resources efficiently and cost effectively.

13.1 UTILIZATION MANAGEMENT

Utilization Management (UM) is performed through Missouri Care's network of concurrent review nurses and medical directors.

Concurrent Review Process

Concurrent review nurses and medical directors review and evaluate hospital admissions concurrently using nationally recognized criteria. Initial reviews are conducted within twenty-four (24) hours or the next business day after admission. Subsequent reviews are conducted regularly and always prior to the expiration of the assigned length of stay.

At each review, the member’s medical record is evaluated to determine:

- Medical Necessity and appropriate level of care
- Probable length of stay (based on optimal recovery guidelines for the diagnosis)
- Member’s discharge needs, such as:
 - home health care
 - durable medical equipment
 - rehabilitation therapy
 - case management
- Other payors, and
- Indications of potential quality, risk, or utilization issues

If according to review criteria, the member's condition has changed, the number of authorized inpatient days may be modified. If continued stay criteria are not met, the Missouri Care CMO or designee notifies the attending Provider(s) of the impending end of Missouri Care's financial responsibility. The CMO reviews all potential denials and is responsible for issuing denials related to a member’s inpatient stay.

Denial Reconsideration

Missouri Care has established an informal mechanism for Providers to request reconsideration of a decision regarding authorized stay days. Concurrent review nurses and the CMO are available to discuss additional documentation or information provided by the attending health professionals. Formal grievances are also available (see Chapter XII).

Chief Medical Officer

Missouri Care's CMO participates in concurrent review by reviewing and making final authorization determinations. The CMO is available 8:00 a.m. to 5:00 p.m., Monday through Friday (except for designated State holidays) at Missouri Care's office. During evenings or weekends, medical directors are available via phone for problem solving through the Prior Authorization Unit.

Committees

The committees discussed below support Missouri Care's medical management program. Providers who wish to participate on a committee should contact the CMO or inform their Provider Relations Representative.

Medical Quality Management Committee

The Medical Quality Management Committee, chaired by the CMO or designee, assists the CMO in the oversight, maintenance, and support of Missouri Care's QM, credentialing, utilization management, and technology review processes. The committee's responsibilities include:

- Reviewing and identifying opportunities to improve the care and services provided to Missouri Care members and recommending alternative solutions
- Assisting in the development of action plans for Missouri Care, or reviewing and approving action plans submitted to the committee from other sources
- Reviewing and approving studies, standards, practice parameters, indicators, and outcomes
- Performing peer review and investigating quality of care or service issues, making recommendations to the CMO, and requesting follow-up
- Conducting credential/recredential reviews and recommending contract decisions to the CMO

- Evaluating utilization issues, data and infrastructures interacting with QM.
- Analyzing and evaluating information obtained through utilization activities
- Recommending studies to evaluate medical care
- Assisting in the development of standards of care and practice parameters
- Recommending, reviewing and approving medical review criteria
- Reviewing cases as requested by the CMO.

Members of the committee include representatives from the MQM Department, the CMO or designee, and at least four (4) participating primary care Providers (PCPs), and four (4) participating specialist physicians (PSPs) from both rural and urban areas. The committee meets at least bi-monthly. Written minutes are provided to the Quality Management Oversight Committee (QMOC) and the Operating Board.

Case Management Committee

The Case Management Committee meets weekly with Case Management (CM) personnel to review and approve members' cases that are presented. Committee participants may recommend that Covered Services, community resources, or a combination of services be used to manage a member's care. The CMO or designee must approve recommendations for non-covered services. To ensure an interdisciplinary approach, standing members of this subcommittee may include:

- Chief Medical Officer
- Manager, Medical Management
- Case Management nurses
- Concurrent Review nurses (optional)
- Prior Authorization nurses (optional)

13.2 PRIOR AUTHORIZATION

Prior Authorization is the primary contact for Providers requesting authorization to perform a medical service. Primary care Providers (PCPs) initiate and coordinate requests for services; however, specialists and ancillary Providers may request prior authorization for services within their specialty areas. (See Chapter IX for an explanation of prior authorization requirements.)

Prior authorization nurses are available twenty-four (24) hours a day, seven (7) days a week to receive requests by mail, fax, or telephone.

The PA Unit will:

- A. Evaluate Provider requests for:
 - 1. Medical Necessity
 - 2. Appropriate service location
 - 3. Benefit coverage
 - 4. Member enrollment in Missouri Care
 - 5. Provider participation

- B. Refer members to case management as necessary

PA staff includes licensed nurses with a support staff of data technicians and clerks. The nursing staff represents clinical knowledge in specialties such as labor and delivery, home health, long-term care, operating room, orthopaedics, pediatrics, and emergency room services.

PA nurse staff functions include:

To process Providers' requests for authorization more efficiently, Missouri Care's nurses coordinate requests for routine services for the medical director's review. Missouri Care's standard for processing routine requests is two (2) business days. Requests for urgent medical services are processed within twenty-four (24) hours.

Missouri Care has established an informal mechanism for Providers to request reconsideration of a prior authorization decision. Medical directors are available to consider additional documentation or information provided by the requesting health professionals. Formal grievance procedures are also available (see Chapter XII).

13.3 CASE MANAGEMENT

The Case Management (CM) Department consisting of licensed skilled nurses identify, assess and provide interventions to members based on identified risks and unmet needs.

Special Case Management Programs include but are not limited to:

- Pregnancy
- Special needs
- Elevated lead
- Disease management

The Case Manager performs a health risk assessment to determine members medical status. Case Managers collaborate with the member, member's family, PCP's and specialists to achieve cost effective quality care. Case Managers direct use of community resources as cost-effective alternative services.

Prenatal Case Management

The Prenatal Case Manager utilizes the **Pregnancy Notification and Risk Screening** form to identify pregnant members for case management. Members are stratified as high, moderate or low based on their identified risks. Interventions by the Prenatal Case Manager are determined by the member's risk level. The goal of the Prenatal Case Management program is healthy, term infants and healthy moms. The Prenatal Case Manager works closely with the obstetrical provider to increase early and regular prenatal care, and compliance with postpartum follow-up care.

Lead Case Management

The Lead Case Manager educates families on the effects of lead toxicity and importance of follow-up care for lead screens. The Lead Case Manager collaborates with the member's family, PCP, LPHA and Division of Medical Services to meet CDC's guidelines for screening children for lead poisoning.

Special Needs Case Management

Special Needs Case Management includes members with complex medical conditions. The Special Needs Case Manager facilitates coordination of health care services based on the severity of member's condition. The Special Needs Case Manager provides support to families with children with special needs to ensure compliance with complex specialty medical services.