An Eating Recovery Community

UR: Knowledge is Power

Chelsey Sorensen, National Director of UR

Agenda

- Who is UR?
- What is UR?
- UR Terminology
- Peer Review
- Medical Necessity

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ALSANA

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What is Utilization Review (UR)?

- An Alsana UR Specialist advocates for client's care by articulating medical necessity to payors who will determine whether the treatment is *appropriate, justifiable* and *reimbursable*.
- The skillset gained popularity within the health insurance industry, mainly due to growing research about medical necessity, misuse, and overutilization of services. Therefore, health plans began to review claims for medical necessity, and the length of stay (LOS).
- UR Specialists are the behind the scenes treatment team member advocating for the client's full dose of treatment!

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UR terminology

- Pre- certification: the initial review completed by Alsana UR with clt's payor who will determine if clinical presentation meets medical necessity for admission
  - Policy dependent on WHEN UR can call this in
- Concurrent review: Every subsequent review between a UR Specialist and payor Case Manager
  - UR builds concurrent reviews based on documentation from every discipline
  - Specialized knowledge of payor criteria to help re-frame the work to insurance
- Peer review: When a CM doesn't feel there is enough evidence for continued stay and needs a payor physician to complete a review with an Alsana therapist or MD to determine continued authorization or denial
- Case consult: Complex client presentation requiring payor physician to speak with Alsana tx team
- Appeal process: A further attempt at receiving continued authorization after a denial was issued during peer process
  - Expedited appeal (EA)
  - Standard appeal

Not all policies have internal appeals, know your policy

UR terminology cont.

- **Case Managers:** are licensed clinicians or registered nurses who complete concurrent reviews for the payor to measure a client's current clinical presentation vs. payor medical necessity to determine on going authorization or need for physician review. A CM is the provider's resource on the payor side.
- **Care Managers** or Care Advocates: are professionals who work with families and individuals with complex medical or social situations. They may also interact with other health care providers to ensure the patient is aware of the services available to them. They are a liaison or between the member and insurance.

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Peer Review

- A peer review can occur for the following reasons:
- The client has been in treatment for a set allotted time per their policy, leaving the Case Manger unable to authorize additional days without involving a doctor from the insurance company to override policy.
- The client does not clearly meet the criteria for medical necessity and a doctor must use his or her clinical expertise/ discretion to determine if the level of care being requested is warranted.
- The client may be meeting medical necessity criteria, but not demonstrating progress or motivation requiring a physician to determine if on going treatment is beneficial at this time.

Primary therapist to complete peer review, unless payor requires MD

UR schedules first available time offered for peer

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Medical Necessity: Cigna

Medical Necessity Criteria – Residential Eating Disorders Treatment

Criteria for Admission

All of the following must be met:

1. All elements of Medical Necessity must be met.
2. The individual is expressing willingness to actively participate in this level of care
3. The individual has a documented diagnosis of Anorexia Nervosa, Bulimia Nervosa, or Other Specified Eating Disorder, per the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.
4. If there are medical issues, they can be safely managed in a residential level of care.
5. The individual is able to function with some independence, participate in structured activities in a group environment.
6. As a result of the interventions provided at this level of care, the symptoms and/or behaviors that led to the admission can be reasonably expected to show improvement such that the individual will be capable of returning to the community and to less restrictive levels of care.
7. For individuals under 18 years, the individual's family is willing to commit to active regular treatment participation.
8. There is evidence that a less restrictive level of care is not likely to provide safe and effective treatment.

Criteria for Continued Stay

All of the following must be met:

1. The individual continues to meet all elements of Medical Necessity.
2. **One or more of the following criteria must be met:**
   A. The treatment provided is leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, but the individual is not sufficiently stabilized so that he/she can be safely and effectively treated at a less restrictive level of care.
   B. If the treatment plan implemented is not leading to measurable clinical improvements in the acute symptoms and/or behaviors that led to this admission and a progression toward discharge from the present level of care, there must be ongoing reassessment and modifications to the treatment plan that address specific barriers to achieving improvement when clinically indicated.
   C. The individual has developed new symptoms and/or behaviors that require this intensity of service for safe and effective treatment.
3. **All of the following must be met:**
   A. The individual and family are involved to the best of their ability in the treatment and discharge planning process.
   B. Continued stay is not primarily for the purpose of providing a safe and structured environment.
   C. Continued stay is not primarily due to a lack of external supports.

Medical Necessity: New Directions RTC

family or group counseling

7. There are active biomedical complications that require 24-hour care, including, but not limited to:

	Adults	Children/Adolescents
Pulse	<40	<50
Blood Pressure	<90/60	<80/50
Serum glucose	<45 mg/dl	<45 mg/dl
Orthostatic changes: BP AND pulse **Supine to standing measured with 3-minute wait**	systolic: > 20-point drop diastolic: >10-point drop pulse: > 20 bpm	systolic: > 20-point drop diastolic: >10-point drop pulse: >20 bpm
Sodium	125 meq/l	130 meq/l
Potassium	<3 meq/l	Hypokalemia
Magnesium/Phosphate	Below normal range	Below normal range
Body Temperature	<96 °F or cold blue extremities	<96 °F or cold blue extremities

8. Must have either a. or b.:
   a. A body weight that can reasonably lead to instability in the absence of intervention as evidenced by one of the following:
      i. Less than 85% of IBW or a BMI less than 16.5
      ii. Greater than 10% decrease in body weight within the last 30 days
      iii. In children and adolescents, greater than 10% decrease in body weight during a rapid growth cycle
   b. Persistence or worsening of compensatory eating disorder behaviors despite recent (with the last three months), appropriate therapeutic intervention in a structured eating disorder treatment setting. If PHP or IOP is contraindicated, documentation of the rationale supporting the contraindication is required. One of the following must be present:

What can YOU do?

- Advocate for family/support sessions with your loved one
- Identify with the primary therapist how you would like to be notified of authorizations while ensuring it does not inhibit your loved ones process
- Payors care more about what YOU have to say then the provider (Alsana)
  - Have your loved one enroll in Case Management and sign a ROI to take point on advocation for continued stay if clinically indicated
  - If it is your policy, contact HR and see what they can do to help discuss the lack of benefits/support in authorization