

Subject: Clinical Criteria for Utilization/Referral Decisions (Page 1 of 2)

Objective:

- I. To ensure that when making utilization decisions, Tuality Health Alliance (THA) uses objective criteria that are established from sound clinical evidence.

Policy:

I. *Member and Service Area Criteria*

- a. Utilization Management (UM) criteria are not absolute, but are designed to be used in conjunction with good clinical judgment while assessing the needs of the individual patient/member. Accurate and appropriate UM decisions require that relevant facts pertaining to member care be gathered from appropriate providers. Such relevant facts/information about the member include:

- Age;
- Treatment progress;
- Psychosocial factors;
- Home environment;
- Co-morbidities;
- Health complications

Pertinent clinical documentation from a member's current medical record is utilized in making referral, pre-authorization, and inpatient review determinations. This information is reviewed utilizing specific health plan criteria or national guidelines when indicated.

- b. THA also considers characteristics of the local healthcare delivery system in making utilization decisions for specific patients; such characteristics include:
 - Availability of service area skilled nursing facilities, sub-acute care facilities or home care to support the patient after hospital discharge;
 - Coverage of benefits for skilled nursing facilities, sub-acute care facilities, or home care, as needed; and
 - The ability of local healthcare delivery system facilities to provide all recommended services within the member's estimated length of stay.

II. *Clinical Criteria*

- a. THA utilizes McKesson InterQual and health plan-specific criteria for making UM determinations; health plan-specific criteria includes:
 - Medicare Standards, as applicable;
 - Oregon Health Plan Policies and Administrative Rules, as applicable.
- b. Clinical criteria are reviewed for currency and relevance by the THA Medical Management Team on a yearly basis; suggestions to change or update criteria are sent to the THA Quality Management Committee for evaluation.

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III. *THA Quality Management Committee Oversight of Criteria*

The THA Quality Management Committee (QMC) consists of a variety of physicians in varying specialty areas that review UM criteria when a change in the criteria is requested. This review process allows for providers with professional knowledge or clinical expertise in the area being reviewed to advise or comment on the development or adoption of the criteria and on instructions for applying the criteria.

IV. *Provider Access to UM Criteria*

Providers may make a verbal or written request for a copy of UM criteria as used in THA utilization determinations. Criteria requests shall be made directly to the THA Medical Management Team, which makes all UM determinations. Medical Management staff may share criteria in the following ways:

- A copy of the criteria is mailed, faxed, or emailed to the practitioner;
- Criteria are read over the phone to the practitioner;
- Criteria are physically housed at THA for practitioner review; or
- Criteria are available on the Internet/THA website.

References:

42 CFR 438.210(d)
2013 NCQA Standard UM 2 Clinical Criteria
OAR 410-141-0420
Oregon Health Authority Health Plan Services Contract
THA Policy V-18: Second Opinion

Formulated:	February 2002
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