MEDICAL POLICY DEVELOPMENT

AND APPLICATION OF CRITERIA IN UTILIZATION MANAGEMENT

Purpose

This document provides guidelines for the evolution and adoption of a medical policy.

Description

A medical policy or guideline is the standard by which coverage, decisions, and actions are determined. It is based on scientifically sound, current, reasonable, reliable, and comprehensive information and supplemented, when medically necessary, by expert opinion. Authoritative information used during development comes from a wide variety of sources, including, but not limited to, medical literature, medical consensus bodies, specialty societies, regulatory agencies, health care standards, database searches, evidence from national medical organizations, community physicians, state and federal government agencies and research organizations. Policies shall clearly identify, when applicable, experimental status, approval status, written research protocols, appropriate clinical application, efficacy, safety, research findings, and medical consensus regarding medical technology.

Policy

Medical policy is the primary basis of medical review decisions for prior authorization, concurrent review, retrospective review, case management, appeals, and claims adjudication. VCHCP uses several nationally developed protocols in the review process. Beginning in the fall of 2009, Milliman Care Guidelines was adopted as one of VCHCP's resources. Other guidelines utilized include UpToDate, other peer-reviewed medical and scientific literature, National Guideline Clearinghouse (http://www.guideline.gov) and additional Federal and state publications. VCHCP's own medical policies are developed to reflect the local characteristics of its membership and provider network, to augment the available national guidelines and they take precedence over the other review criteria (e.g., Milliman Care Guidelines) for determination of medical necessity. Medical policy primarily focuses on medical issues, however, it can also contain clarification on benefit interpretation and administrative policy.

Procedures for the Development of the Medical Policy

1. The physician authoring the policy, which is most frequently the Medical Director, completes the following steps:
    a. Performs a search of printed and online medical literature that includes professionally recognized guidelines, current evidence-based medicine, and community standards.
    b. Reviews the procedure or service to determine if it is considered investigational / experimental.
    c. Identifies issues of controversy and specific statutory requirement (e.g., Evidence of Coverage constraints are identified; Department of Managed Health Care (DMHC), Department of Health Services (DHS) and Medicare regulations are reviewed for position statements decisions and approval status)
    d. Identifies regulatory issues which are reviewed by legal counsel, when necessary
    e. Develops a draft policy

f. Requests departmental input, if indicated, from, but not limited to, the following:
   i. Claims
   ii. Member Services
   iii. Legal Counsel

2. The draft policy is brought to the Medical Policy Committee which is an ad hoc sub- committee consisting of network specialists and subspecialists who assist VCHCP in the development and evaluation of appropriateness of medical criteria.

   The following characteristics are to be met:

   a. Content based on empirically valid and clinically practical and reasonable medical evidence
   b. Care guidelines which result in consistently effective and safe outcomes of acute and chronic care services
   c. Content applicable to various populations and reflects local provider network and member characteristics.
3. The policy is reviewed, revised as necessary and adopted. The Committee also reviews the instructions for application of the criteria to assure consistency and appropriateness for Plan members and the local delivery system. The Medical Policy Committee similarly evaluates policies on new technology and procedures.
4. The VCHCP Medical Policy Committee includes the VCHCP medical director, VCHCP associate medical director, VCHCP Health Services Director and UM/QA/UM Managers.
5. The VCHCP Medical Policy Committee findings are reviewed first in the Utilization Management Committee, then in the Quality Assurance Committee.
6. The Utilization Management Department then makes approved policies available to network providers via newsletters and on the provider portal and maintains an audit trail of revised medical policies.

MEDICAL POLICY REVIEW

Purpose

Medical Policies are reviewed and updated on an annual basis to ensure that national standards of care are maintained, and that application of the policies are consistent and appropriate.

Policy

The VCHCP Medical Policy Committee reviews established national guidelines and internal VCHCP guidelines and makes recommendations for necessary revisions, additions, or both to the VCHCP Medical Policy Manual. The review may entail a formal literature review if further information is required or new information is available. The VCHCP Medical Policy Committee reviews all existing medical and administrative policies and technology assessments on a yearly basis and, when necessary, updates the policies. The date of review is indicated on each document. This annual review shall not interfere with policy revisions necessitated by new medical information.

In performing these reviews, the VCHCP Medical Policy Committee refers to evidence from the national

medical community, which may include, but is not limited to, one or more of the following sources:

1. National medical organizations
2. Peer-reviewed medical and scientific journals and publications
3. Publications and standards from professional medical organizations
4. Professional and Specialist Associations and Organizations
5. Expert consensus reports
6. Written protocols and consent forms used by the proposed treating facility or other facility administering substantially the same drug, device, or medical treatment
7. Federal and state publications
8. Federal and state statutes, court decisions
9. Ventura County Health Care Plan (VCHCP) adopted the Standards of Care developed by the World Professional Association for Transgender Health (WPATH) as guidelines for coverage of all services for members diagnosed with Gender Dysphoria. All listed services/procedures/surgeries described in the WPATH for gender dysphoria require prior authorization. Criteria for preauthorization is a diagnosis of Gender Dysphoria when making determinations in accordance with SB-855 (Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People).

The UM and QA committee reviews and approves all polices and changes at least annually.

APPLICATION OF MEDICAL CRITERIA

Utilization Review staff are charged with appropriate and consistent application of plan policies and procedures and any other accepted criteria in making authorization determinations. However, staff has also been given instructions to include with every referral, the evaluation of the needs of the individual and characteristics of the local delivery system. The following criteria are distributed to all staff via email on an annual basis and to every new hire during onboarding. Staff is encouraged to have the criteria available at their workspace for easy accessibility and are expected to refer to these guidelines regularly.

Examples of Individual characteristics to consider include, but not be limited to:

- Diagnosis
- Gender
- Availability of services such as Skilled Nursing Facilities (SNF), sub-acute, acute rehabilitation or home care in the service area
- Age
- Explanation of Benefits (“EOB”) or other coverage definitions Community standards
- Severity of illness Co-Morbidities
- Complications
- Home Environment, as appropriate
- Progress toward accomplishing treatment goals Cultural Factors, as they relate to the disease process Family Support
- Psychosocial needs
- Ability of hospitals to provide recommended services within the length of stay Availability of urgent care centers
- Access to tertiary and quaternary care, for specialist and sub-specialist care Assessment of coverage

of benefits for SNF, subacute care facilities or home care when needed

If any of the above factors indicate that the usual UM guidelines are not appropriate, the staff is directed to elevate the referral to the Director of Health Services, Medical Director or designee for discussion, review, and final decision.

INTER RATER RELIABILITY -Consistency in Applying Criteria

VCHCP has developed a mechanism for assessing the consistency with which physician and non- physician reviewers apply UM criteria.

On an annual basis, VCHCP utilizes the Milliman Care Guidelines Inter-Rater Reliability (IRR) Test and VCHCP Prior Authorization Drug Policies for Behavioral Health Drugs/Pharmacy reviewed in the Plan's Utilization Management Department.

In addition, the Plan conducts IRR testing covering all aspects of utilization review, including the application of WPATH SOC. The IRR testing includes measurements of consistency in utilization review decision making using the guidelines of coverage WPATH SOC and prior authorization criteria of the Medical Policy for Gender Affirming Procedures.

Methodology
A survey consisting of eight case studies followed by a series of questions pertaining to the studies was prepared. The survey was distributed to nurse reviewers electronically via the Survey Monkey. Milliman Care Guidelines most current edition are the guidelines presently being used by the Plan for medical management. In addition, VCHCP Prior Authorization Drug Policies are also utilized.

The case study topics are determined by:

1. VCHCP QA Nurse a selects specific case studies from the Milliman Care Guidelines IRR Administrator tool and from behavioral health pharmacy/drugs reviewed in UM. Selected case studies include three (3) ambulatory care related case studies, one (1) for authorization only inpatient case study and four (4) behavioral health pharmacy/drugs reviewed in UM
2. Review of high utilization guidelines
3. Review of guidelines with major changes
4. Key medical conditions as noted in medical journals
5. Review of blinded clinical data and case scenarios
6. Review of behavioral health pharmacy/drugs reviewed by UM

All MCG cases studies go through a multi-phased review by Milliman Care Guidelines to ensure they adhere to the intent of the guidelines and training standards.

Each Medical Management Nurse and Physician Reviewer performing Utilization Review activities is required to answer a total of 8 hypothetical case studies followed by 3-4 questions for each case. The scenario types include Outpatient/Ambulatory Care services, Inpatient care and behavioral health pharmacy/drugs reviewed in UM. Each scenario includes the following information:

- Outpatient Scenarios-Ambulatory Care
  1) Diagnosis
  2) Requested procedure or service
  3) Setting

4) Clinical History, status of patient, previous treatment

- Inpatient scenario-For initial authorization only
  1) Diagnosis
  2) Requested procedure or service
  3) Setting
  4) Clinical History, status of patient, previous treatment
- Behavioral Health Pharmacy/Drugs
  1) Diagnosis
  2) Requested procedure or service
  3) Setting
  4) Clinical History, status of patient, previous treatment

Nurses and Physicians are given one (1) hour of uninterrupted time to complete the IRR online testing via SurveyMonkey. Typically, it takes up to one hour of uninterrupted time to complete.

- Passing Score: 90% or better (this was increased from 85% in 2020)
  - The process is that if the benchmark is not reached, an immediate remediation is required where the reviewer retakes the test to correct the areas missed. Two scores will be reported for those reviewers who did not pass the first time.

Behavioral Health Clinical Criteria for UM Decisions

VCHCP delegates UM for Behavioral Health Services to OptumHealth Behavioral Solutions of California (OHBS-CA), our BHA. See Optum's appropriate policies for written criteria, applying criteria, availability of criteria and consistency in applying criteria. See the VCHCP Delegation Policy and the OHBS-CA delegation agreement for details including oversight activities.

These policies are reviewed at least annually by the QA committee which includes members from Optum.

The criteria are available to members and practitioners on Optum's website which can be accessed through the VCHCP website by an active link. The information regarding this availability is sent to members and practitioners in the same way VCHCP information is distributed.

A. Attachments:

- **VCHCP Medical Policy on Gender Affirming Procedures**

Gender Affirming Procedures 2022.1re

- **Standards of Care for the Health of Transsexual, Transgender, and Gender Non-Conforming People – The World Professional Association for Transgender Health (WPATH) and**

Gender Affirming Procedures WPATH

B. Review & Revision History:

Created by: Dr. Catherine Sanders & Dr. Albert Reeves
Committee Review: UM: August 08, 2013; QAC: August 27, 2013
Committee Review: UM: February 13, 2014; QAC: February 25, 2014
Committee Review: UM: February 12, 2015; QAC: February 24, 2015. No revisions.
Committee Review: UM: February 11, 2016; QAC: February 23, 2016. No revisions.
Committee Review: UM: February 9, 2017; QAC: February 28, 2017. No revisions.
Committee Review: UM: February 8, 2018; QAC: February 27, 2018. No revisions.
Committee Review: UM: February 14, 2019; QAC: February 26, 2019. No revisions.
Committee Review: UM: February 13, 2020; QAC: February 25, 2020. No revisions.
Committee Review: UM: February 11, 2021; QAC: February 23, 2021. No revisions.
Committee Review: UM: February 17, 2022; QAC: February 22, 2022. With revisions.

Revision Date	Content Revised (Yes/No)	Contributors	Review/Revision Notes
2/9/17	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/8/18	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/14/19	No	Catherine Sanders, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/13/20	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/11/21	No	Howard Taekman, MD; Robert Sterling, MD, Faustine Dela Cruz, RN	Annual review
2/17/22	Yes	Howard Taekman, MD; Robert	• Updated with gender

		Sterling, MD, Faustine Dela Cruz, RN	dysphoria language/prior authorization criteria to comply with SB-855 • Updated with Inter Rater Reliability information to comply with SB-855 Section 1374.721(e)(7) (pass rate and immediate remediation). • Updated with current IRR process to comply with SB-855 (coverage and prior authorization consistency using WPATH SOC and Medical Policy for Gender Affirming Procedures