Policy Name	Texas- Consistency of Application of Clinical Criteria and Decision Making
Policy Number	455A.02
Department	Utilization Management
Subcategory	Operations
Original Issue Date	03/18/2018
Committee Approval Date	01/20/2021
Effective Date	04/23/2019

Company Entities Supported (Select All that Apply):
_X_ Superior Vision Benefit Management
_X_ Superior Vision Services
___ Superior Vision of New Jersey, Inc.
_X_ Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
_X_ Davis Vision
(Collectively referred to as 'Versant Health' or 'the Company')

DEFINITIONS:	
Term	**Definition**
CMS	**C**enters for **M**edicare and **M**edicaid **S**ervices
Utilization Management (UM)	The evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan

PURPOSE:

The purpose of this policy is to ensure that licensed health care professionals, utilizing criteria to make determinations of medical necessity and assess the need for services appropriately.

SCOPE:

This policy applies to all utilization management staff who render medical necessity decisions

POLICY:

It is the Company policy to consistently apply utilization management protocols and criteria in utilization management determinations. The Company routinely performs inter-rater reliability assessments in order to ensure consistent application of criteria and management of cases.

The study is based on the selection of a statistically relevant and randomly selected sample of previously determined pre-authorization service requests from a universe of requests identified during a period of time 30 days prior to the audit. The selected sample is blinded for the prior determination and provided to each licensed professional. Each professional will determine and record their decision on the selected request forms. The completed authorizations are tallied, scored in house and discussed by reviewers to achieve consensus and understanding for future decisions.

The Company maintains a minimum threshold reliability score of 90% for matching decisions within the group. Failure to reach the minimum threshold will require a review of criteria by all professional staff reviewers and a repetition of the original study elements for re-scoring of the study.

The final study is reported to the Chief Medical Officer and Vice President of Clinical Operations and results are shared at the UM Committee, Medical Policy Council meeting, and subsequently reported to the Quality Improvement Committee.

Cases selected are consistent with the licensure limitations of the clinical professional being assessed.

1) Conducting the Inter-Rater Study

a) The study will require each licensed professional staff to review identical randomly selected Prior Authorization (PA) Requests received by the Company prior to the audit.

b) Each reviewer will determine and record their decision on the Request for Prior Approval form, following the established Company criteria and processes for PA Requests.

c) The completed requests will be collected and reviewed and a report will be developed on each individual rater results to provide a comparison of the results within the reviewer group.

d) Failure to reach the minimum threshold reliability score will result in a review of the report within 30 days of receipt of the findings by the team of Company licensed professionals participating in the Prior Authorization determinations. A joint review and training session will be held covering the established criteria for making the determinations. Tracking documents will be maintained that confirm the date and names of professionals attending.

e) Upon completion of the re-training an additional sample will be provided for re-review of the sample and the re-study of the results with reporting as previously discussed.

f) The final passing results will be reported to the Chief Medical Officer and the Vice President of Clinical Operations for presentation to the UM Committee and Medical Policy Council meeting, and subsequently reported to the Quality Improvement Committee

2) IRR Case Sampling

Sampling for IRR case review is determined by the Chief Medical Officer utilizing the previous month Corrective Action Plan. New policies that are effective the previous month are used for case sampling. Sampling can be selected from 1st and 2nd level review source conducted by the Clinical Reviewers and Medical Directors.

3) Case Review Structure

Case selection is redacted and forwarded to the Clinical Reviewers and Medical Director for review and noting source of determination

4) IRR Data Analysis

All IRR results are required to have a result determination under the Versant Health/NDC's or Reference material. Data analysis is aggregated to a dashboard for the Chief Medical Director to review and approve. All final approvals require submission to the Utilization Management Committee.

5) Corrective Action Plan

The Chief Medical Director implements the Corrective Action Plan based off of the adverse decisions from both the Clinical Reviewers and Medical Directors. The Corrective Action Plan is submitted to the Utilization Management Committee.

DISCLAIMER, LIMITATIONS AND EXCLUSIONS:

Applies to the Clinical Reviewers and Medical Directors

RELATED POLICIES AND PROCEDURES	
Policy Number	**Policy Name**
451A.01	Determination of Medical Necessity Policy

Document History:		
Date	***Revision***	***Version***
4/22/2019	Updated into current format, assigned new ID and version number, previous Audit Control Number: 409.00	.01
11/30/2020	Updated to reflect 2020 NCQA UM 2 Standards.	.02

Compliance Source(s):

Texas Insurance Code

Tex. Ins. Code § 4201.153 (LexisNexis, Lexis Advance through the most recent legislation which is the 2019 Regular Session, 86th Legislature, and the 2019 election results)

Texas Administration Code

28 Tex. Admin. Code § 19.1705(a-c) (Lexis Advance through all regulations in effect as of September 30, 2020)

NCQA Standards

NCQA Standards UM 2 (2020)