Community Care Plan

The Health Plan with a Heart

Utilization Management

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Overview

The Utilization Management (UM) program ensures fair and consistent care coordination for health plan members. It focuses on safeguarding member confidentiality, improving UM practices through process enhancements, making evidence-based decisions based on medical necessity and appropriateness, and delivering high-quality, cost-efficient services

Non-Discriminatory Policy

We are committed to providing services without discrimination based on race, color, national origin, sex, age, or disability. This includes not wrongfully denying or limiting coverage, imposing extra costs, or restricting services, especially those related to gender treatment, in line with State and Federal laws. Additionally, we avoid discriminatory marketing practices or benefit designs.

Clinical Practice Guidelines

Our Utilization Management (UM) decisions are guided by clinical practice guidelines to ensure appropriate care. These include:

- Change Healthcare InterQual® Criteria as a screening tool
- Florida Medicaid Coverage and Limitations Handbooks for medical necessity
- American Society of Addiction Medicine (ASAM) guidelines for substance use treatment

Utilization reviews follow these guidelines and Rule 59G-1.010 but consider special circumstances for deviations. The guidelines are reviewed by the quality improvement committee, updated every two years, or when new scientific evidence or national standards change.

Emergency Services

Key Responsibilities:

- Providers must deliver emergency care 24/7 without prior authorization.
- Perform medical screenings to determine emergencies; provide stabilizing treatment or arrange safe transfer.
- Reimbursement is still provided even if no emergency is found, for screenings and evaluations.

Post-Emergency Coordination:

- Notify the health plan within 2 business days of emergency admissions or document attempt.
- Non-participating facility care is covered until safe transfer is possible, as determined by the attending physician.
- Coordinate ongoing care with the member’s PCP and healthcare team.

Compliance & Member Support

Provider Obligations:

- Ensure accurate documentation and billing practices.
- Educate members about their emergency care rights.
- Maintain compliance with emergency service requirements non-compliance may lead to corrective action.

Health Plan Role:

- Monitors provider adherence to emergency care guidelines.

Prior Authorization

- Providers should consult the Services Requiring Prior Authorization listing to determine if a specific service needs prior authorization. Requests for authorization can be made through the secure provider portal, PlanLink

- Prior authorization involves submitting a formal medical necessity request to the health plan before delivering the service
- "Medical Necessity" refers to goods or services that align with accepted medical standards and are essential to alleviate a terminal condition or prevent, diagnose, treat, or manage a condition that threatens life, causes pain, or results in illness

- For Medicaid reimbursement, the agency is the final authority on medical necessity

Submitting Prior Authorization

PlanLink Portal Use:

- All standard prior authorization (PA) requests must be submitted through the PlanLink Secure Provider Portal. Faxed requests are only accepted if the portal is temporarily down or if the provider lacks internet access.

Check Requirements First:

- Most Behavioral Health Outpatient Services do not require PA. Use the Pre-Auth Check Tool to confirm if a service needs authorization.

Special Submission Cases:

- Residential Treatment & State Inpatient Psychiatric Program: Submit via fax.
- DME & Home Health (post-hospital discharge): Fax to Coastal Care Services.
- Home Health Services: Must be ordered by the attending physician or PCP and coordinated with contracted agencies.
- EPSDT (members under 21): PA required if services exceed coverage limits or aren’t listed in Medicaid guidelines.

Prior Authorization Timeframes

- **Non-emergent services** Submit within 7 days before the service date
- **Urgent/emergent inpatient admission** Submit within 2 business days or 24 hours after behavioral health admissions
- No prior authorization is required for urgent or emergent stabilization services
- Hospice requests outside business hours must be submitted the next business day

Thank You

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