

## **MANAGED CARE PROGRAM**

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The State of South Dakota contracts with Health Management Partners (HMP) to provide managed care services and utilization review through a managed care program.

If the guidelines of the Managed Care Program are not followed, benefits payable under the Plan may be reduced or denied.

In addition, after reviewing medical services received by a Member, the Plan Administrator or its designee may find that healthcare services or prescription medications are being prescribed or received in a harmful quantity or manner, with harmful frequency, or that they are not Medically Necessary. If this is found to be the case, the Plan Administrator or its designee, after appropriate investigation, may terminate plan coverage for those services or prescription medications. The Plan Administrator may require the Member to select a single participating Physician, participating Hospital, participating pharmacy, or other participating healthcare provider for individual management and coordination of all future health services.

NOTE: The State reserves the right to regulate the choice of provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The member may choose a provider, service, or supply other than one approved by the State, but the member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved provider, service, or supply. The member is responsible for all remaining charges. These additional amounts will not apply to the annual medical Out-of-Pocket Maximum.

If a member chooses a facility other than one approved by the State, the member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved facility. The member is responsible for all remaining charges.

When non-DAKOTACARE or out-of-state providers are used and charges are more than these accepted amounts, the Plan will not cover the amount above the Usual, Customary, and Reasonable (UCR) or MAC amount, even if the Out-of-Pocket Maximum is met. The Member is responsible for paying the excess charges.

### ***PRE-AUTHORIZATION OR PRE-NOTIFICATION OF SERVICES-IN-STATE***

The Member or Member representative must call HMP before any non-emergency Hospital Admission and before receiving certain services to provide details of the proposed Hospital Admission, service, or treatment. The authorization should be made as soon as possible after the surgery or service has been prescribed or scheduled to allow HMP enough time to explore medical necessity and pricing alternatives. Approval of Plan benefits requires adequate timing for authorization and cooperation from the provider and/or the facility. To view the Pre-authorization listing, visit <http://benefits.sd.gov/Forms.aspx> and choose FY15 Pre-authorization listing.

In the case of an emergency admission, the authorization must be made within 48 hours, if possible, after such admission. Certain other services (such as emergency room services) may be authorized on a retroactive basis, after treatment is provided. A call to HMP will initiate the review process.

Pre-authorization is required for certain prescriptions to be covered under the Prescription Drug Plan. Providers can submit the pharmacy prescription pre-authorization request to [www.dkc-pa.com](http://www.dkc-pa.com).

The time limits described above may be waived if it is shown that:

- (a) It was not reasonably possible to provide such notification within the time limit which applies; and
- (b) Notification was provided as soon as was reasonably possible.

Pre-authorization does not guarantee coverage under the Plan. The services must fall within the South Dakota State Employee Health Plan provisions and the definition of covered services, and must not exceed Plan maximums. The Member receiving the service must also be eligible for coverage at the time the service is provided.

DAKOTACARE providers will initiate required Pre-authorization review processes for the Member.

If a Member visits a non-DAKOTACARE provider, the Member or a Member representative must contact HMP for review and Pre-authorization of services.

### ***PRE-AUTHORIZATION OF SERVICES OUT-OF-STATE***

For all Health Plan options, members are required to obtain Pre-authorization for any health care received outside the state of South Dakota (e.g., Mayo Clinic and University of Colorado).

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If a Member visits a non-DAKOTACARE provider, the Member or a Member representative must contact HMP for review and Pre-authorization of services.

## ***FAILURE TO MEET PRE-AUTHORIZATION REQUIREMENTS***

If a Managed Care Program notification requirement is not satisfied when a Member is admitted to a Hospital or receives certain medical services, the Plan Administrator may reduce or deny benefits in connection with the Hospital Admission or service.

If a Member elects to receive services even though the services have not been authorized, the Plan will not pay benefits for those services, or will provide benefits at a lower level, depending on whether the service is covered by the Plan.

For example, if HMP determines that a portion of a Hospital stay is not Medically Necessary or if any day is not authorized as appropriate for that condition or treatment, all charges for that day will not be considered a covered charge. No benefits will be paid for all charges for that day.

## ***SERVICES REQUIRING PRE-AUTHORIZATION***

### **Procedures Costing More Than \$25,000**

All procedures for which professional and/or facility charges will total (or are expected to total) more than \$25,000 will require Pre-authorization and/or a second opinion. Regardless of cost, the following services require Pre-authorization and/or second opinions.

#### **Admissions**

- (a) Assistant surgical services (whether performed inpatient or outpatient);
- (b) Hospice;
- (c) Mental health and chemical dependency, including partial or half-time residential treatment;
- (d) Non-emergency admissions to out-of-state Hospitals;
- (e) Observation services;
- (f) Out-of-network services;
- (g) Rehabilitation;
- (h) Skilled nursing;
- (i) Surgical, non-surgical (medical, mental health, substance abuse); and
- (j) Transplant services.

**NOTE:** Pre-authorization is not required for the minimum postpartum length of stay required by the Newborns' and Mothers Health Protection Act of 1996. Days in excess of the accepted length of stay require Pre-authorization.

## **Other Services**

- (a) Ambulatory infusion;
- (b) Cardiac catheterization;
- (c) Cardiac self-management training and education;
- (d) Chelation Therapy;
- (e) Chemical dependency and substance abuse treatment;
- (f) Approved Clinical Trial;
- (g) Colonoscopies (does not apply to preventive colonoscopies);
- (h) Genetic Testing;
- (i) Home health services, including home infusion, pain management, and Hospice;
- (j) Physical, occupational, or speech therapy;
- (k) MRI, MRA, CTA, CT, and PET Scans;
- (l) Observation services;
- (m) Out-of-network services;
- (n) Rehabilitation;
- (o) Maternity Ultrasounds;
- (p) Kidney Dialysis and related services;
- (q) Temporomandibular Joint Syndrome (TMJ) treatment;
- (r) Select drugs must be Pre-authorized by DAKOTACARE. To view the list for drugs that require Pre-authorization, visit <http://benefits.sd.gov/Forms.aspx> and click FY15 Pre-authorization Listing;
- (s) Select Durable Medical Equipment, services and supplies:
  - 1) Compression pumps;
  - 2) CGMS (continuous glucose monitoring system);
  - 3) CPAP, CPAP with humidifiers, Bi-PAP (continuous positive airway pressure);
  - 4) Continuous Positive Motion (CPM) machine;

- 5) Custom made braces over \$1,000;
  - 6) DME exceeding \$1,000;
  - 7) Electrical stimulation for urinary/bowel incontinence;
  - 8) Feeding pump (pump, tube, and kit);
  - 9) Hospital beds;
  - 10) Insulin pumps;
  - 11) Neuromuscular electrical stimulators;
  - 12) Negative pressure wound therapy pump;
  - 13) Osteogenic stimulator (bone growth stimulator) — authorization requires a Physician's documented history of poor bone healing and at least one risk factor (such as multi-level fusion, smoker, or diabetes);
  - 14) Oximeters;
  - 15) Oxygen (includes the oxygen carrier);
  - 16) Percussors;
  - 17) Pressure relief mattress;
  - 18) Prosthetics;
  - 19) SAD (Seasonal Affective Disorder) Lights;
  - 20) Speech Devices;
  - 21) Suction pumps;
  - 22) TENS (transcutaneous electrical nerve stimulator);
  - 23) Terbutaline pumps;
  - 24) Upper GI and Endoscopies;
  - 25) Uterine monitor;
  - 26) Ventilator; and
  - 26) Wheelchairs for purchase.
- (t) Surgical procedures performed in the outpatient department of ambulatory surgical centers, Hospitals, or specialty Hospitals; e.g. Vertebroplasty, Epidural Blocks, Kyphoplasty, SCS trial and implantation; and

(u) Transplant services.

If during the initial review, HMP finds the proposed treatment or admission to be inconsistent with treatment guidelines, the requesting provider or facility will be notified by faxed letter immediately. The requesting party will be given the opportunity to request a conversation with the HMP Physician to discuss the case. If the two Physicians are unable to negotiate an appropriate treatment plan, the denial will stand. The member and provider have the opportunity to appeal the determination.

Covered services received on an emergency basis outside the country do not require Pre-authorization.

NOTE: Outpatient surgery claims may be reviewed for medical necessity after claims are submitted. Outpatient surgeries or procedures performed solely for cosmetic reasons or that are not Medically Necessary will not be covered by the Plan.

### ***SECOND OPINIONS***

The South Dakota State Employee Health Plan covers Physician consultation services when Incurred as a result of voluntary second surgical opinions or other requirements of the Plan Managed Care Program. Voluntary second opinions are subject to the same Deductible and Coinsurance provisions that apply for any other surgical or medical procedures under the Plan.

The Plan Administrator may require second opinions for certain covered services (such as non-emergency surgical procedures) when HMP has cause to believe there is an effective and equivalent alternative to the original medical/surgical opinion. If member does not receive the required second opinion, the procedure will not be covered by the plan. Non-emergency surgical procedures may include, but are not limited to, gastric bypass, sinus surgery, or anterior/lateral disc fusion. Second opinions are also required for surgical procedures that must be redone due to the Member not following Physician instructions.

Services will be covered as follows when a second opinion is required:

- 1) The Plan will cover 100% of the required second opinion consultations, including Office Visits, pre-authorized tests, and mileage costs. In requiring a second opinion, the Plan Administrator will consider medical necessity, cost (e.g., procedures/services above \$25,000), location, diagnosis, and other related factors concerning the medical condition of the covered Member. If Pre-authorization review and/or the second opinion process indicate that a Medically Necessary procedure can be beneficially performed at an In-Network facility, payment will be limited to the contracted fee at that facility. If the Member chooses an Out-of-Network facility, benefit will be processed as Out-of-Network with the higher deductible, Coinsurance, and Out of Pocket Maximum. Any charges over Usual, Customary, and Reasonable will not apply to the annual medical Out-of-Pocket Maximum.
- 2) If it is determined during Pre-authorization review or the second opinion process that a procedure must be redone and is necessary because Physician instructions were not followed, the covered individual is responsible for 100% of the cost of the second procedure/surgery. The cost of this surgery does not apply to the annual medical Out-of-Pocket Maximum.

See “Services Requiring Pre-authorization” and “Services Requiring Second Opinions” for additional information about specific services.

## ***SERVICES REQUIRING SECOND OPINIONS***

The following services may require second opinions:

- Anterior / Lateral disc fusion;
- Gastric bypass surgery;
- Sinus surgery;
- Surgery that is redone because the Member didn't follow physician orders; and
- As determined by HMP, Plan Medical Management vendor.

## ***UTILIZATION REVIEW SERVICES***

### **Inpatient Services**

Once the Hospital admission has been reviewed, HMP will provide confirmation of the approval to the doctor, the Hospital, and/or the Claims Administrator. HMP will remain in contact with the facility throughout the Hospitalization to monitor Member progress, and may explore alternative treatment settings or the need for additional days in the Hospital.

### **Emergency Room Services**

Emergency Room (ER) Services will be retrospectively reviewed for appropriate utilization. Members who utilize the emergency room will receive contact from HMP for follow up including review of discharge instructions. Members may be subject to a reduction of ER benefits for inappropriate usage. Continued inappropriate ER usage may result in a 50% reduction in benefits or charges not being covered by the health plan. Reduced benefits and non-covered amounts are the responsibility of the member and not applicable to maximum out of pocket amounts.

## ***MEDICAL CASE MANAGEMENT***

Case management is a collaborative process that provides Members with health management support through a variety of coordinated programs. It is offered as a confidential and free program to Members who are experiencing complex health issues or challenges in meeting their health care goals. HMP provides case management for South Dakota State Employee Health Plan Members.

HMP case managers are registered nurses who provide Members with information and direction about health issues, Health Coverage, available community resources such as help with transportation, and much more. They can help make sure the Member is getting the best use of the covered services available to them.

Case Management is intended to support the Physician's plan of care. The case manager may contact the Member's Physician office to develop a rapport to support ongoing collaboration throughout the time the Member is in the program.

The case manager will:

- Review Member's current condition and history;
- Identify problems and offer education;
- Work with the Member to set goals that address problems;
- Suggest actions to reach goals;

- Measure progress towards goals; and
- Discharge the Member from case management when goals have been met.

Health conditions, which may be referred to a case manager, include but are not limited to:

- Active treatment of cancers or transplants;
- Depression or chemical dependency;
- Chronic diseases or chronic pain;
- Multiple sclerosis;
- Catastrophic events such as traumatic injuries;
- Readmissions to Hospital;
- High cost indications; and
- Neonatal Intensive Care Unit (NICU) admissions.

### ***INTENSIVE MEDICAL CASE MANAGEMENT***

Members dealing with complex medical conditions may be invited to participate in an Intensive Medical Case Management Program. Participation is encouraged as these programs have positive outcomes for members and providers. Members and their designee (if applicable) are provided access to a qualified Intensive Medical Case Manager that will offer assistance, additional education, and act as a liaison with the member and their treatment team to offer additional support and care facilitation.

DAKOTACARE provides Intensive Medical Case Management for South Dakota State Employee Health Plan Members.

### ***BARIATRIC SURGERY***

Bariatric surgery will be covered under the health plan when the Member meets the eligibility criteria and complies with the management plan. Guidelines to determine eligibility for bariatric surgery are as follows:

- The Member has a Body Mass Index (BMI) of 40 or greater or Member has a BMI of 35 or greater and a clinically serious condition exists (e.g., sleep apnea, diabetes, high blood pressure, arthritis).
- The Member must have failed non-surgical weight loss through a Physician-approved program with or without pharmacotherapy.
- No specifically correctable cause for obesity (e.g., an endocrine disorder) has been identified.
- Member has achieved full adult stature as determined by Physician.

Participation in the Bariatric Management Plan:

- Member must agree to participate in the plan's four-phase health management program for twelve months after bariatric surgery.
  - **Phase I** - Member must receive evaluation and treatment from a facility contracted for bariatric surgery.
  - **Phase II** - The Member must agree to participate in a multidisciplinary program for weight loss and weight management. Weight gain of more than five pounds from the



weight submitted during Phase I will be considered non-compliance and the Member will become ineligible for surgery.

- **Phase III** – Bariatric surgery approval and completion.
  - **Phase IV**- Members who successfully participate in the program will be eligible for 1 (one) skin reduction surgery twelve months after surgery and once a stable weight has been achieved and maintained.
- If a Member becomes ineligible for surgery due to non-compliance, they may reapply to the program after twelve months. However, any consultations done during the first time frame will have to be done again and none of the cost of the consultations will be covered by the plan.
  - The medical appropriateness of the type of surgery will be evaluated by the Medical Director.

To enroll in the program or for detailed information about the four-phase program, contact the Bariatric Management Program at Health Management Partners:

- Email: [weightloss@hmps.com](mailto:weightloss@hmps.com)
- Call toll-free: 1.866.330.9886