Provider Manual
Section 5.0
Utilization Management

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5.1 Utilization Management

Utilization Management is the evaluation of the medical necessity, quality, appropriateness, and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health plan benefits. “Medically necessary” or “medical necessity” means that the medical or allied care, goods, or services furnished or ordered must:

A. Meet the following conditions:
   i. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
   ii. Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient’s needs;
   iii. Be consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
   iv. Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
   v. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.
B. “Medically necessary” or “medical necessity” for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.
C. The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

Service-specific coverage requirements and medical necessity criteria can be found on the Provider Portal.

Participating providers are required to obtain authorization for any medically necessary service to enrollees under the age of twenty-one (21) years when the service is not listed in the service-specific Florida Medicaid Coverage and Limitations Handbook, Florida Medicaid Coverage Policy, or the associated Florida Medicaid fee schedule, or when the service is not a covered service of the plan; or the amount, frequency, or duration of the

service exceeds the limitations specified in the service-specific handbook or the corresponding fee schedule. Wellness, Well-Child, and EPSTD visits do not require prior authorization.

UM decision making is based only on appropriateness of care and service, existence of coverage, and available evidence-based criteria. Lighthouse does not reward providers or other individuals conducting utilization review for issuing denials of coverage or services. Lighthouse does not offer financial incentives for UM decisions and does not encourage decisions that result in under-utilization.

Services Requiring Prior Authorization	
Inpatient Acute Hospital Admissions: Medical Surgical	Notification required within twenty-four (24) hours of admission or next business day. Clinical updates required with continued stay
Admissions: Elective Procedures/Surgery LTAC, Rehabilitation, SNF Radiology Procedures Requiring Inpatient or Observation All Bariatric Procedures All Transplants, excluding cornea	All elective admissions Admission to any long-term acute care, rehabilitation or skilled nursing facility Observation Stays Extending Beyond 48 hours
OB Services	Induction of labor- if prior to thirty-nine (39) weeks gestation OB ultrasound over two (2) per pregnancy Stays over two (2) days for Vaginal delivery Stays over four (4) days for Cesarean delivery Termination of pregnancy
Outpatient Bariatric Procedures	
Home Health Services	*Determined by Coastal Care Services, Inc.*
Private Duty Nursing	Private duty nursing for children age twenty (20) or younger Personal care services for children age twenty (20) or younger Clinical updates required with continued review; incorporate review requirements during review process
Prescribed Pediatric Extended Care	Pediatric Day Care (Medically Fragile Children)

Services Requiring Prior Authorization	
Intensive Cardiac and Pulmonary Rehabilitation Services	Inpatient Outpatient
Home Infusion / IVT	
Outpatient Therapy	Physical / Occupational / Speech Therapies Prior authorization after initial evaluation up to twelve (12) visits.
Advanced Imaging:	CT/CTA MRI/MRA PET/SPECT Nuclear Medicine Studies Exclusions: Imaging rendered in the following settings DOES NOT require prior authorization: Emergency department Inpatient setting Observation unit
Durable Medical Equipment (DME)/External Prosthetic Appliances (EPA) and Supplies	*Determined by Coastal Care Services, Inc.*
High Dollar Medications and Pharmaceuticals (>$1,000)	Medications administered in office setting, otherwise through Pharmacy benefit
Outpatient Chemotherapy treatment	No Prior authorization if in a clinic or in an office setting; prior authorization is required if done in an outpatient hospital setting
All Potentially Cosmetic Surgery	
Any Experimental / Investigational	
Pain Management; Outpatient	
All non-participating providers (All OON services)	Inpatient Outpatient
Sleep studies	Facility based only
Molecular Diagnostics Testing/Genetic Testing	
Behavioral Health	*Determined by Access*
Pharmacy	

Transportation/Transfers	Non-emergent Ground Medical Transport Air Medical Transport
Dental Procedures	Those services that fall under the medical benefit (e.g. Orthognathic surgery)

All Lighthouse participating providers are required to obtain prior authorization from the Plan's UM department for inpatient services and specified outpatient services. Failure to submit a request for authorization may result in a denial.

Because of frequent changes in enrollee's eligibility for Medicaid coverage, providers should verify continued eligibility via the Plan's web site, www.lighthousehealthplan.com or by calling Provider Services at 844-243-5181.

5.1.1 Hours of Operation

The UM department is available Monday through Friday from 8:00 a.m. to 7:00 p.m., except holidays, Eastern Standard Time (EST). All requests for authorization of services may be received during these hours of operation. After business hours or on holidays, a provider can either fax the request or can call and leave a message and a representative will return the call the next business day.

Department	**Phone Number**	**Fax Number**
General Number Initial Inpatient Outpatient	844-824-8846	888-522-6490
Concurrent Review	844-824-8846	888-522-6490
Retrospective Review	844-824-8846	888-522-6490
Home Health	855-481-0505	855-481-0606
Home Infusion	855-481-0505	855-481-0606
DME	855-481-0505	855-481-0606

Lighthouse provides the opportunity for the provider to discuss a decision with the Medical Director, to ask questions about a UM issue, or to seek information about the UM process and the authorization of care by calling the UM Department at 844-824-8846.

5.2 Review Criteria

The UM Department utilizes InterQual® Criteria during the review process. In the event that InterQual® Criteria is not available for a specific request, the reviewer may use internal medical policies that are reviewed and approved by actively practicing providers in the community. The **Quality Improvement Committee (QIC)** approves the use of both InterQual Criteria® and Medical Polices.

Criteria for which a decision was based may be requested by a provider. Criteria are made available as allowed under copyright limitations and trademark considerations. To request the criteria for which a decision was based, you may contact the UM Department at. 844-824-8846

5.3 Authorization Requirements

All requests are subject to coverage, benefits, and eligibility.

5.3.1 Provider Notification Requirements

Providers must notify the UM department within the required times frames; failure to notify the UM department may result in an administrative denial of the request. An administrative denial may be appealed.

- Non-emergency: Prior to the elective / scheduled procedure / service
- Emergency:
- Urgent - Emergent Admission: Within one (1) business day of the admission

The UM Department will accept the hospital's or the attending physician's request for prior authorization; however, neither party should assume that the other has obtained prior authorization.

Providers may contact the UM Department by phone or by fax. Fax forms are available on the Lighthouse Website, and requests may be submitted using the Lighthouse fax forms or the Universal Fax form.

5.3.2 Information required for review

When requesting a review, at a minimum, documentation must include:

- The enrollee's name and Lighthouse ID number.
- The diagnosis for which the treatment or testing procedure is being sought.

- Other treatment or testing methods that have been tried, their duration, and any outcomes.
- Additional clinical information as applicable to the requested service.
- Applicable sections of the medical record.

Requests not meeting the established medical necessity criteria will be referred to Lighthouse's Medical Director for further review and evaluation.

5.3.3 Inpatient Authorization Exclusions: Maternity and Newborns

Normal Vaginal Delivery: If the inpatient stay is less than or equal to two (2) days, no authorization is required.

Authorization is required for:

- All Cesarean Sections
- All Scheduled inductions
- All Non-par providers, regardless of delivery type

An infant born by Normal Vaginal Delivery (NVD) does not require authorization until day three (3). If an infant born via NVD stays <= 2 days, authorization is not required.

An infant born by C-Section does not require authorization until day five (5). If an infant born via C-Section stays <= 4 days, authorization is not required.

5.3.4 Observation Stays

Observation at a participating facility does not require authorization, but observation stays extending beyond forty-eight (48) hours require authorization. If an enrollee is admitted following an observation stay, the date of the inpatient authorization begins on the date the inpatient order is written.

5.3.5 Durable Medical Equipment (DME)

For all DME prior authorizations or questions, please call Coastal Care Services, Inc. at 855-481-0505.

5.4 Retrospective Authorization

Retrospective review of inpatient services is performed when the patient was not an enrollee's of Lighthouse prior to or at the time of the service. Outpatient services do not require retrospective review by UM for enrollee's whose eligibility is determined retrospectively.

Providers have sixty (60) days from the notification of eligibility of retrospectively enrolled enrollees to submit medical records for review and an UM authorization request. A decision and written notification is provided within thirty (30) days of receipt of the medical

information for the retrospective review request. An administrative denial is issued for retrospective requests when the provider fails to request an UM review of the medical record within the timeframe specified.

The provider is notified of all decisions regarding retrospective reviews. In cases of denial, a written notification is provided.

Requests received beyond sixty (60) days from the card issue date or from the provider's documentation of the date when he/she was aware of the enrollee's eligibility will be administratively denied.

Send requests for retrospective review to:

Lighthouse Health Plan
PO BOX 211156
Eagan, MN 55121

The phone number for retrospective review is: 844-824-8846 or fax to: 888-522-6490

(for large chart review, please send records via mail).

5.5 Denials

An authorization request for a service may be denied for failure to meet guidelines, protocols, medical policies, or failure to follow administrative procedures outlined in the Provider Contract or in this Provider Manual. If pre-authorization criteria are not met resulting in a denied claim, enrollees must be held harmless for denied services.

A Lighthouse Medical Director renders all medical necessity denial decisions. Whenever a denial is issued, UM provides the name, telephone number, title, and office hours of the Medical Director who rendered the decision. The Lighthouse Medical Director is available to discuss any decision rendered with the attending provider.

An administrative denial is issued for those services that the provider did not follow the requirements set forth in the Provider Contract or in this Provider Manual. For example, an administrative denial may be issued for failure to prior authorize a non-emergent elective service, procedure, or admission. It may also be issued for failure to notify UM within one (1) business day of an emergency service, procedure, or admission.

A provider may appeal an administrative denial by submitting the appeal request in writing to:

Lighthouse Health Plan
PO BOX 211156
Eagan, MN 55121

To speak with the Medical Director or to the nurse reviewer regarding a denial, please contact Lighthouse's UM Department at 844-824-8846.

5.6 Prior Authorizations for Enrollees who ask for a Second Opinion

Lighthouse enrollees have the right to a second opinion, at no cost to the enrollee, regarding diagnosis and treatment of complex and/or chronic conditions and surgical procedures. If the enrollee requests a second opinion, then the PCP should complete a referral to a participating specialist. If there is not a specialist within the network, then the PCP must call Lighthouse's UM department at 844-824-8846 to request an authorization to a non-participating specialist.

In accordance with s. 641.51, F.S., if the enrollee elects to have a second opinion by a non-contracted Provider, Lighthouse will pay the amount of all charges which are usual, reasonable and customary in the community, but may require the enrollee to be responsible for up to forty percent (40%) of such amount. Lighthouse may require that any tests deemed necessary for a non-contracted provider will be conducted by a Lighthouse participating provider.

5.7 Prior Authorizations for Enrollees with Another Carrier

Prior authorization is not required for services that are listed on the prior authorization list when the enrollee has another carrier (e.g. Medicare or Tricare) as the primary payer and benefits under the primary payer have not been exhausted. This applies to both inpatient and outpatient services. When benefits are exhausted, or if the service is not a benefit covered under the primary payer, and Lighthouse becomes the primary payer, prior authorization requirements apply for both inpatient and outpatient services.

For enrollees who have exhausted their Medicare Part A inpatient lifetime reserve days, prior authorization of inpatient services must be obtained. If an enrollee's lifetime reserve days are exhausted during an inpatient hospitalization, notification to Lighthouse UM Department must be made within one (1) business day of the exhaustion of benefits by Medicare.

Authorization is required for enrollees who have another carrier as their primary carrier *except* for Medicare/Tricare.