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External Medical Review (EMR)

Training Module Overview

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Purpose

The purpose of this training is to provide an overview of the external medical review (EMR) process.

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Talking Tip

MCO means managed care organization and dental contractor throughout this presentation.

Acronyms (1 of 2)

BTW

- BTW – Bring the Wheelchair
- BTW – By the way

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Acronyms (2 of 2)

Acronym	Full Name
DMO	Dental Maintenance Organization
EMR	External Medical Review
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
HCBS	Home and Community Based Services
HHSC	Health and Human Services Commission
ICF	Intermediate Care Facility
IID	Individual with an Intellectual Disability or Related Conditions
IMD	Institution of Mental Diseases
IRO	Independent Review Organization
MCO	Managed Care Organization
MDCP	Medically Dependent Children Program
NF	Nursing Facility
PDN	Private Duty Nursing
SB	Senate Bill
STAR	State of Texas Access Reform
TAC	Texas Administrative Code
THSteps	Texas Health Steps
TIERS	Texas Integrated Eligibility System
TMHP	Texas Medicaid Health Partnership

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Key Terms (1 of 12)

Dental Contractor

- A company or organization contracted with HHSC to provide Medicaid dental benefits to Medicaid Members.

Managed Care Organization (MCO)

- The company or organization contracted with HHSC to provide Medicaid benefits for Medicaid Members.

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Key Terms (2 of 12)

Independent Review Organization (IRO)

- A contracted entity responsible for completing EMRs when requested by Medicaid Members.

External Medical Review (EMR)

- An independent review of the relevant information the MCO used related to an Adverse Benefit Determination based on functional necessity or medical necessity.
- Also, includes review of a state decision based on functional and medical necessity.

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Key Terms (3 of 12)

HHSC Intake Team

- The HHSC team that assigns EMR requests to IROs and monitors for timely completion.

Level of Care (LOC)

- The type of care a person is eligible to receive in a nursing facility or IMD (Institute of Mental Disease) based upon an assessment of the person's need for care.

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Key Terms (4 of 12)

A Member is:

- Entitled to benefits under Title XIX of the Social Security Act and Medicaid
- In a Medicaid eligibility category
- Enrolled in the MCO's STAR, STAR Health, STAR Kids, STAR+PLUS

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Key Terms (5 of 12)

Medically Necessary

TITLE 1	ADMINISTRATION
PART 12	TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353	MEDICAID MANAGED CARE
SUBCHAPTER A	GENERAL PROVISIONS

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Key Terms (6 of 12)

Medical Necessity

- For Medicaid members birth through age 20, the following Texas Health Steps services:
  - Screening, vision, dental, and hearing services
  - Other health care services or dental services that are necessary to correct or ameliorate a defect or physical or mental illness or condition

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Key Terms (7 of 12)

Medical Necessity

- For Medicaid members birth through age 20, the following Texas Health Steps services (cont.):
  - A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
    - Must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole
    - May include consideration of other relevant factors, such as the criteria described in the following slides

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Key Terms (8 of 12)

Medical Necessity

- For Medicaid members over age 20, non-behavioral health services that are:
  - Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life

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Key Terms (9 of 12)

Medical Necessity

- For Medicaid members over age 20, non-behavioral health services that are (cont.):
  - Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
  - Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
  - Consistent with the member's medical need;

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Key Terms (10 of 12)

Medical Necessity

- For Medicaid members over age 20, non-behavioral health services that are (cont.):
  - No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency
  - Not experimental or investigative; and
  - Not primarily for the convenience of the member or provider.

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Key Terms (11 of 12)

Texas Medicaid and Health Care Partnership (TMHP)

- A group of contractors under the leadership of Accenture who administer certain Texas Medicaid activities on behalf of HHSC.
  - Some of these activities include:
    - Medicaid fee-for-service claims administrator
    - Process prior authorization requests for services in Medicaid fee for service programs
    - Texas Medicaid provider enrollment

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Key Terms (12 of 12)

Texas Medicaid and Health Care Partnership (TMHP)

- Some of these activities include (cont.):
  - Utilization of clinicians who review assessments and render determinations of medical necessity for eligibility for programs such as the Medically Dependent Children Program (MDCP) and STAR+PLUS Home and Community Based Services (HCBS) program.

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Legislation (1 of 10)

Senate Bill 1207

- Directs HHSC to contract with a third-party medical reviewer or Independent Review Organization (IRO) that provides objective, unbiased medical necessity determinations conducted by clinical staff.

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Legislation (2 of 10)

Senate Bill 1207

- Clinical staff reviewing determinations must have the same or similar practice area for which an independent review is sought and may only be determined by an appropriate physician, doctor, or other health care provider with appropriate credentials under §19.1706 of this title (relating to Requirements and Prohibitions Relating to Personnel) to determine medical necessity or appropriateness, or the experimental or investigational nature, of health care services.

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Legislation (3 of 10)

Senate Bill 1207

- Independent medical reviewers employed by the Independent Review Organization (IRO) will conduct EMRs and review:
  - The resolution of a Medicaid Member appeal related to a reduction in or denial of services on the basis of medical necessity for a managed care program.
  - A denial by HHSC of eligibility for a Medicaid program in which eligibility is based on a member's medical and functional needs.

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Legislation (4 of 10)

Senate Bill 1207

- The MCO may not have a financial interest in the medical reviewer with which HHSC contracts.
- The IRO must:
  - Be overseen by a medical director who is a physician licensed in Texas
  - Employ or be able to consult with staff with experience in providing private duty nursing and long-term services and supports.

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Legislation (5 of 10)

Senate Bill 1207

- The review must be conducted within a timeframe defined by HHSC, including a timeframe for expedited (**emergency**) reviews.
- This criteria must be consistent with state and federal law and HHSC medical policy as set forth in the TMPPM and other guidance.
- Medical necessity must be based on publicly available, up-to-date, evidence-based, and peer reviewed clinical criteria.

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Legislation (6 of 10)

Dental Example: Determinations based on:

- Valid and reliable clinical evidence
- Consensus of oral health care professionals in the **particular field**
- Practice guidelines consider the member needs, in consult with contracting oral health care professions, shared with the dental network for transparency.

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Legislation (7 of 10)

Dental Example: References

- Current dental contract with HHSC which references:
  - Chapter 32 of the Texas Human Resources Code referencing services or products for a member to diagnose, prevent, or treat orofacial pain, infection, disease, dysfunction, or disfiguration.

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Legislation (8 of 10)

Senate Bill 1207

- Reviews for service reductions or denials
  - The review occurs after the internal MCO appeal and before the State Fair Hearing.
- Reviews for eligibility denials
  - The review occurs after the eligibility denial and before the State Fair Hearing

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Legislation (9 of 10)

Senate Bill 1207

- The IRO's determination of medical necessity establishes the minimum level of services a Medicaid Member must receive, except that the level of services may not exceed the level identified as medically necessary by the ordering health care provider.

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Legislation (10 of 10)

Senate Bill 1207

- Requires the MCO/Dental Contractor to submit a detailed reason for the service reduction and include supporting documents.

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Implementation (1 of 2)

Phase I

- MCO/Dental Contractor service denials and reduction based on medical necessity for services provided by Managed care programs:
  - STAR
  - STAR+PLUS
  - STAR Kids
  - STAR Health
  - Dental

* Fee-for-service benefit reductions or denial determinations completed by TMHP are not subject to the EMR process.

Implementation (2 of 2)

Phase II

- A denial by the commission of eligibility for a Medicaid program in which eligibility is based on a Medicaid recipient's medical and functional needs.
- Applicable programs will be announced later in the year.

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MCO Responsibilities (1 of 12)

Step 1: Post MCO Internal Appeal

- When member contacts MCO regarding their decision, the MCO must fully educate member on their options to:
  - Request EMR and State Fair Hearing (SFH)
  - State Fair Hearing only
  - Not request an EMR and State Fair Hearing and accept MCO decision.
- Continue benefits through EMR and SFH process
- As a reminder, an oral request must be treated the same as a written request.

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MCO Responsibility (2 of 12)

Step 2: When a member requests an EMR, the MCO must:

- Enter the EMR and State Fair Hearing request in the Texas Integrated Eligibility Reporting System (TIERS) Portal.
- Indicate if the request is expedited

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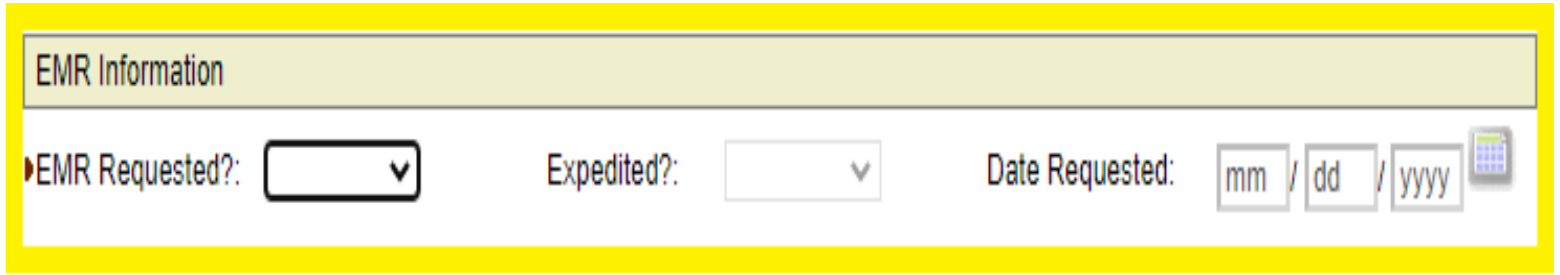
MCO Responsibility (3 of 12)

Step 2: When a member requests an EMR, the MCO must (cont.):



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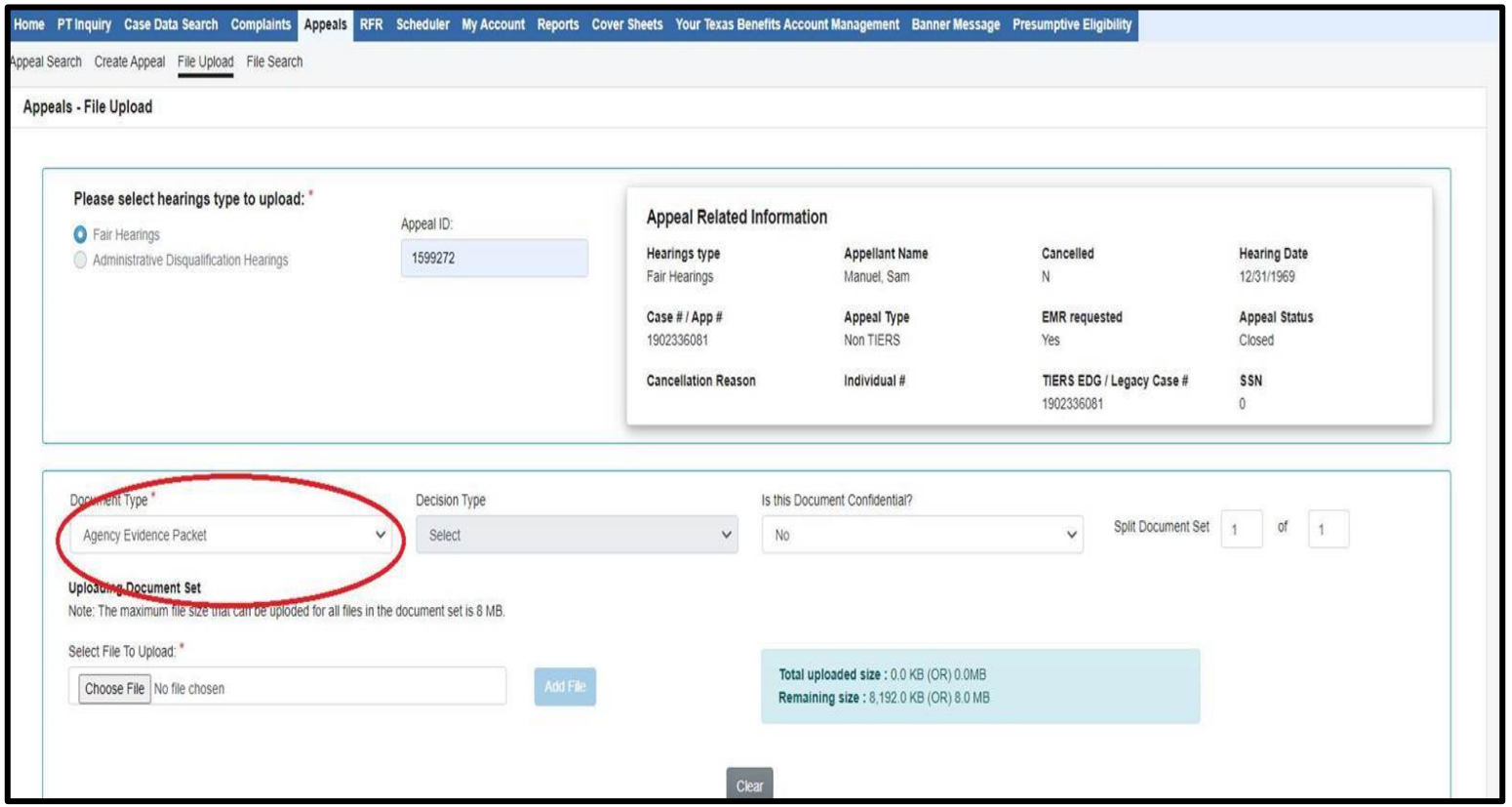
MCO Responsibility (4 of 12)

Step 3: When a member requests an EMR, the MCO must:



MCO Responsibility (5 of 12)

Step 3: When a member requests an EMR, the MCO must (cont.):

- Upload documentation to the state portal, if the EMR Request is received, anytime Monday through 3:00 p.m. on Friday, on days HHSC is open
  - Within three Days, if routine
  - Within one Day, if expedited
    - Unless received after 3:00 p.m. CST on a Friday, or any Day HHSC is closed for business, the Expedited EMR Request is due no later than noon the following Business Day

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MCO Responsibility (6 of 12)

Step 3: When a member requests an EMR, the MCO must (cont.):

- Types of documentation includes:
  - Cover letter identifying which information is uploaded
    - For External Medical Review: Exclusively used to determine MCO/DMO Internal Appeal.
    - For State Fair Hearing: Includes any new information
    - A reference to the predominant language of the member
- Service request (including prior authorization requests)
  - Supporting clinical documents
  - Letters requesting additional information

MCO Responsibility (7 of 12)

Step 3: When a member requests an EMR, the MCO must (cont.):

- Types of documentation includes (cont.):
  - Documentation of any phone calls or other information from the requesting provider
  - MCO staff name who conferred on the decision
  - Any names of peers or providers consulted regarding member's Expedited MCO Internal Appeal or MCO Internal Appeal
  - Member information, including predominant or preferred language

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MCO Responsibility (8 of 12)

Step 3: When a member requests an EMR, the MCO must (cont.):

- Within 72 hours of receiving the IRO decision, the MCO Must:
  - Implement partially overturned decisions if member did not request continued benefits during the appeal
  - Continue full benefits if benefits were continued through the SFH decision
  - Implement fully overturned decisions
  - Inform members of their right to continue to State Fair Hearing

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HHSC Responsibility (9 of 12)

Step 4: The EMR Intake team will assign the EMR to an IRO via round robin process by email

- Review IRO assignee for conflict of interest
  - If conflict, next IRO in rotation is assigned
  - If no conflict, IRO assignment email occurs

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HHSC Responsibility (10 of 12)

Step 5: The EMR Intake team will assign the EMR to an IRO via round robin process by email (cont.)

- Information provided will include:
  - Date of EMR Request
  - IRO decision due date
  - Member information
  - Authorized Representative information

HHSC Responsibility (11 of 12)

Step 5 : The EMR Intake team will assign the EMR to an IRO via round robin process and by email (cont.)

- MCO information IROs must use for the Member notice, including:
  - MCO name, address, phone number
- MCO documentation used to make adverse benefit determination, and
- Location of MCO Internal Appeal packet if unable to email due to file size
- HHSC Intake Team will call the member to inform them of the IRO's decision, if contact information is available

IRO Responsibility (12 of 12)

Steps 6 and 7: The IRO must:

- **Acknowledge receipt via email of:**
  - EMR assignment email
  - Supporting documentation
- **Return assignment to HHSC EMR Intake, if conflict of interest identified:**
  - **Standard Reviews -** Next business day
  - **Expedited –** within 3 hours

- **Return the EMR decision within:**
  - **Standard Reviews:** 10 days from the IRO's receipt of the information from HHSC
  - **Expedited Reviews:** Next business day

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Completion Timeframes

*MEMBER EMR AND STATE FAIR HEARING REQUEST		
Requirement	**Standard Request Entry and Document Upload Time Frame**	**Expedited Request Entry and Document Upload Time Frame**
MCO/ Dental Contractor to enter member EMR/State Fair Hearing request and upload determination information into TIERs	No later than three calendar days after receiving the EMR request from the Member, the Member's authorized representative, or the Member's LAR.	As soon as possible and no later than one calendar of receiving the EMR request, unless received after 3:00 p.m. CST on a Friday, or any day HHSC is closed for business. If the EMR Request is received after 3:00 p.m. CST on Friday, or on a day HHSC is closed for business, the Expedited EMR Request is due no later than noon the following business day.
HHSC EMR Intake Team to assign EMR request and provide MCO Internal Appeal documentation	No later than the next calendar day from receipt in TIERS of MCO Internal Appeal documentation	Same calendar day the EMR request and associated MCO documentation is received in TIERS from the MCO.
IRO to mail the decision letter to the member and copy the MCO and email HHSC Intake Team	Within 10 calendar days from receipt of MCO Internal Appeal documentation from the HHSC Intake Team	No later than the next business day from receipt of MCO Internal Appeal documentation from the HHSC Intake Team
*Note: EMR and SFH must be requested at same time, if member wants an EMR. Due dates is for **TIERS entry of the EMR request and documentation**. This allows for the 72-hour timeline for the State Fair Hearing expedited process		

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IRO Responsibility

Phase I IRO Decisions:

- Review the EMR
- Make a decision
- Inform all parties of its decision in at least one of these methods:
  - Mail
  - Email

Post IRO Decision (1 of 3)

- IRO decisions of "overturned" are considered final
- If benefits were not continued:
  - IRO decisions of "partially overturned," must be implemented by the MCO within 72 hours
  - If the member continues to a State Fair Hearing, the State Fair Hearing decision is final.
- If benefits were continued:
  - Member will continue to receive full benefits until the state fair hearing decision
- **Member must choose:**
  - To continue to a State Fair Hearing, or
  - To withdraw from the State Fair Hearing

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Post IRO Decision (2 of 3)

- **If member chooses to continue with State Fair Hearing:**
  - State Fair Hearing timelines continue to apply
- **Is Fair and Fraud Hearings informed of Decision?:**
  - Yes

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Post IRO Decision (3 of 3)

- **The MCO by contract must implement any partial or full decisions overturned by the IRO:**
  - As expeditiously as the Member's health condition requires
  - No later than 72 hours from the date it receives notice reversing the determination
- **The MCO must notify HHSC of the date the Member's services are resumed through our existing processes**

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IRO Payment Process (1 of 2)

- IRO invoices must be received by 10th of the month for the previous month's services
- Invoices are to be sent electronically to HHSC
- HHSC will pay the IRO
- HHSC will request payment from the MCOs
- MCO will pay HHSC
- Reminder: The MCO must not pass any IRO-related costs on to providers or Members.

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IRO Payment Process (2 of 2)

- HHSC will process payments to IROs, once the following has occurred:
  - IRO invoice received has the required elements
  - Invoice matches IRO monthly report
  - IRO decision was received timely

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EMR Withdrawal (1 of 2)

Member Withdrawal

- **Can a Member Withdraw an EMR Request?**
- Yes. Member must submit:
  - Request verbally or in writing to the MCO
- When the MCO receives an EMR Withdrawal:
  - MCO notify the HHSC EMR Intake Team the same day it is received
    - Phone or email
- Withdrawal requests cannot occur after an IRO has rendered an EMR decision.

EMR Withdrawal (2 of 2)

EMR Withdrawal Payment

- IRO payment is based on EMR assignment and work completed as follows upon notice of the withdrawal:
- HHSC will pay the IRO. Including:
  - Withdrawn EMRs, at a rate calculated by HHSC, for EMRs assigned to the IRO which the Member subsequently withdraw prior to or on the 10-Day due date of the IRO EMR decision.
- The MCO must:
  - Reimburse HHSC for all IRO costs within timeframes specified by HHSC.

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References (1 of 2)

- Uniformed Managed Care Contract (UMCC) see Sections 8.2.6.1 – 8.2.6.8
  Uniformed Managed Care Contract
- SB 1207 Legislation (see Sec 531.024164):
  SB 1207 Sec 531.024164 External Medical Review
- Texas Administrative Code (TAC) Title 1, Chapter 353
  Texas Administrative Code (TAC) Title 1, Chapter 353, Rule 2

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References (2 of 2)

- MEDICALLY NECESSARY COVERED DENTAL SERVICES Section 2.3.4

  Dental Services Contract (Operational 9/1/2020) (PDF
- Texas Human Resources Code/ Texas Dental Practice Act , Chapters 32 and 36 Texas Human Resources Code

  https://statutes.capitol.texas.gov/Docs/HR/htm/HR.32.htm
- Uniform Managed Care Manual 3.21

  MMC Notices of Actions Required
- Uniform Managed Care Manual 3.21.1

  Independent Review Organization Process

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Questions?

HHSC EMR Intake Team

EMR_Intake_Team@hhsc.state.tx.us

Question

Q: Who pays for the External Medical Review?

A: The MCO is ultimately responsible for payment.

- IRO invoices are to be sent electronically to HHSC by the IRO
- HHSC reviews and will reject or approve the invoice
- HHSC will pay the IRO for all approved invoices
- HHSC will request payment from the MCOs through our established processes with the MCO

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Question

Q: UMCM Chapter 3.21.1 talks about members going to a local HHSC office to request and EMR. What does the "local office" do?

A: When a member walks into a local HHSC office for assistance making an EMR and State Fair Hearing or just a State Fair hearing request, the local office staff person helping the member will call the "MCO local contact number" with the member present. The MCO will follow their processes for EMRs and State Fair Hearings or just State Fair hearings with receipt of the call.

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Question

Q: How does the Member or MCO ask for the IRO to attend the SFH?

A: Process for the MCO's request participation at the State Fair Hearing remains the same regardless if its request is made at the time of the Member's State Fair Hearing request or after the State Fair Hearing has been scheduled. Instructions for requesting that the IRO be named a party in the State Fair Hearing are located in the UMCM Member Handbooks, specifically in Chapters 3.4

The MCO must also send the request to::

- State Fair Hearing team at OCC_Appeals_FairandFraudHearings@hhsc.state.tx.us
- HHSC EMR Intake Team at EMR_Intake_Team@hhsc.state.tx.us.

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Thank you