FILING NOTICE: Revisions to this policy require filing with the CA Department of Managed Healthcare. Notify the Compliance Department of any edits made to this policy.

ASPIRE HEALTH PLAN

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION 2021-2022

LAST UPDATED 3/09/2022

Utilization Management Program Description

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I. Program Definition

Aspire Health Plan (AHP) operates a multi-dimensional Utilization Management ("UM") Program (the "Program") to direct and monitor inpatient and outpatient health care services provided to members. The UM Program involves prospective, concurrent and retrospective evaluation of services provided to members. The Program involves the cooperative participation of AHP staff, clinicians contracted hospitals, ancillary providers and members to ensure a timely and effective program.

The UM program is structured to ensure that medical decisions are made by qualified individuals, professionally licensed where required, using evidence-based criteria. AHP monitors both over and under-utilization for our members. AHP does not conduct economic profiling in any evaluation of a contracted provider based on cost or utilization of services associated with the medical care provided or authorized by the provider. Economic profiling is not used in utilization review, peer review, incentive or penalty programs or in provider retention/termination decisions. The UM program also ensures that contracted clinicians are not penalized for recommending appropriate medical and/or service referrals, and receive no incentive to deny appropriate care of service.

The UM Program is designed to promote the provision of medically appropriate care, and to monitor, evaluate, and manage resource allocation, cost effectiveness and quality of the health care delivered to our members through a multidisciplinary, comprehensive, consistent approach and process. AHP upholds the integration of utilization management through quality improvement, risk management, disease management, and care management activities. Sentinel events and potential quality of care and service issue are identified and referred to the appropriate quality department for tracking, trending, investigation, and peer review. The UM Program supports the Aspire Health Plan corporate mission, vision and value statements.

The UM program consists of three (3) main documents which are submitted to each contracted Health Plan and regulatory authority, as required, on an annual basis:

- Utilization Management Program Description
- Annual UM Work Plan
- Annual Year-End UM Work Plan Evaluation

The above documents are written to meet all contractual, regulatory, and accreditation standards including:

- NCQA Utilization
- CMS requirements
- DMHC-specific requirements
- Reporting requirements as defined by AHP contracts with each Health Plan, and as mutually agreed upon with the respective Health Plan Delegation Agreements

Reference: NCQA UM1: Element D

The UM Program is further delineated and supported by UM Policies and Procedures. The UM Policy and Procedures apply to all products and programs. Where a specific product or program has unique requirements, a separate Policy and Procedure will address those requirements. At least annually, these documents are reviewed and approved by the UM Committee including the Chief Medical Officer.

Where this UM Program does not specifically address a regulatory organization's requirements, a separate program document or policies and procedures will address those requirements. Any such documents will be presented to the Chief Medical Officer at least annually, for review and approval.

II. Aspire Health Plan's Commitment to Members

Practitioners are not prohibited from advocating on behalf of the member and are expected to do the following:

- To educate members regarding health needs,
- To share findings of medical history and physical exams,
- To discuss potential treatment options (including those that may be self-administered) and the risks, benefits and consequences of treatment or non-treatment,
- To discuss the side effects and management of symptoms (without regard to plan coverage), and
- Recognize that the member has the right to receive sufficient information, to be able to provide input into the proposed treatment plan and has the final say in the course of action to take among clinically acceptable choices.

Members have the right to be represented by parents, guardians, family members or other conservators for those who are unable to fully participate in their treatment decisions.

Members are not discriminated against based on race, color, ancestry, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, such as ESRD, sexual orientation, marital status, gender identification, claims experience, medical history, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information or source of payment or any other applicable protective classes.

AHP recognizes that members may have distinct patterns of health beliefs, values and behaviors. Linguistic and cultural issues can significantly affect patients' ability to synthesize program content and to understand the services they are receiving. AHP is dedicated to supporting cultural diversity, providing equitable and understandable services and delivery of care in a culturally and linguistically competent fashion. All services offered and provided to members, both clinical and non-clinical, ensure that members have the right to care, i.e. TTY, translation services, etc.

III. Program Purpose

The purpose of the Utilization Management Program is to develop and implement an integrated member care delivery process that actively controls and monitors the appropriateness, timeliness, and effectiveness of the medical care and service that is provided to our members across the continuum of care. This includes pre-service, concurrent and retrospective review of inpatient, outpatient services and durable medical equipment.

Activities designed to support the UM scope ensure processes are in place to meet the program goals and objectives. These activities may include the following:

- Monitoring and assessing the delivery of care, including review and evaluation of medical necessity and appropriateness, under- and over- utilization of services, continuity and Management of care, timeliness, cost effectiveness, and quality of care and service.
- Leverage the utilization review process to scrutinize prior authorization and concurrent review cases to identify potential or actual quality issues and report findings to the AHP and provider/provider QI departments.
- Ensure identification of root causes for any identified quality issues and follow any associated corrective action plans to closure.
- Ensure compliance with accrediting and regulatory agency standards related to care management processes.
- If applicable, maintain qualification and performance standards for clinical review of sub-vendor relationships that are consistent with AHP standards.
- Comply with contracted Health Plans' Utilization Management Delegation reporting requirements as agreed in the contract or Delegation Agreement for each Plan.
- Maintain written policies and procedures that govern all aspects of the UM process.
- Continuously improve the ability to implement effective, efficient and innovative UM methods that promote quality of care and decrease the rate of health care expenditures.
- Provide continuous education, training and feedback to our network clinicians regarding utilization management strategies.
- Maintain the delegation status of UM by ensuring appropriate and effective policies and procedures are in place in accordance with contracted Health Plan delegation agreements.
- Implement provisions for contracted Health Plans that allow them to adequately perform their oversight of delegated UM activities.
- Cooperate with Health Plans in any external/independent review process involving the care requested or provided to one of our patients.

Ensuring Appropriate Utilization:

- Utilization Management decision making is based solely on appropriateness of care and service as well as existence of coverage.
- AHP does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care.
- Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.
- Annually, AHP distributes a statement to all its practitioners, providers, and employees affirming the above.

IV. Program Goals and Objectives

The program goals and objectives reflect the scope of the services and activities provided by AHP, and endeavor to promote the delivery of high quality care in all settings in the most cost effective manner for members, and thus contribute to the achievement of the AHP's mission.

- Provide for the timely determination of medical necessity for members and ensure that all pertinent clinical information is reviewed prior to member and clinician notification of denial or modification;
- For all lines of business, provide members and clinician notification letters in language that is clear, concise, and easily understandable.
- Provide a high standard of customer service to our members and their families;
- Provide materials to members and families in their primary language;
- Provide timely response to health plan appeals requests;
- Adopt or develop evidence-based criteria for medical necessity;
- Perform interrater reliability review at least annually to audit the consistent and impartial application of criteria;
- Facilitate communication and develop positive relationships between members, providers, and Health Plans by providing education related to appropriate utilization;
- Identify members with chronic/high risk illnesses or special needs, and refer to the appropriate care management or high risk programs. This will reduce overall health care expenditures by providing effective preventive care and health promotion programs;
- Identify actual and/or potential quality issues during review activities, and refer to the QI Department;
- Ensure compliance with accrediting and regulatory agency standards related to care management processes;
- If applicable, maintain qualification and performance standards for clinical review of sub-vendor relationships that are consistent with AHP standards;
- Comply with contracted Health Plans' Utilization Management Delegation reporting requirements as agreed in the contract or Delegation Agreement for each Plan;
- Maintain written policies and procedures that govern all aspects of the UM process;
- Continuously improve the ability to implement effective, efficient and innovative UM methods that promote quality of care and decrease the rate of health care expenditures;
- Provide continuous education, training and feedback to our network clinicians regarding utilization management strategies;
- Maintain the delegation status of UM by ensuring appropriate and effective policies and procedures are in place in accordance with contracted Health Plan delegation agreements.
- Implement provisions for contracted Health Plans that allow them to adequately perform their oversight of delegated UM activities; and
- Cooperate with Health Plans in any external or Independent review process involving the care requested or provided to one of our patients.

V. Program Structure

Reference: NCQA UM1 Element A. 1

Aspire Health Plan is an organization focused on patient-driven care. AHP supports its providers by offering tools, competencies and resources to physicians in a high-performing network.

AHP has a process-oriented structure, organized into teams. The infrastructure promotes the ability to use information and technology to quickly respond to member needs, contracted health plan expectations, and market demands.

The structure of AHP is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of our health care delivery.
Additionally, the structure is designed to enhance communication and collaboration on issues that affect entities and multiple disciplines within the organization.

The UM Program describes the following entities within Aspire Health Plan

A. The UM Committee
B. Chief Medical Officer
C. Board Certified Specialists (Consultants)
D. Utilization Management Department
E. Appeals and Grievance Department
F. Quality and Compliance Departments
G. UM Licensed Staff of AHP
H. UM Non Licensed Support Staff of AHP

The Organization Chart and the Program Committees reporting structure accurately reflect Aspire leadership, Care Management /UM departments, as well as committee reporting structures and lines of authority. Position job descriptions and Committee policies/procedures define associated responsibilities and accountability.

A. UM Committee

Membership and Structure

- Chaired by the Chief Medical Officer
- Operating Group Leaders/Medical Directors
- Director, Utilization Management
- Health Plan Representatives, upon request
- Quality Improvement
- Meets quarterly and ad hoc for urgent issues

Committee Role and Responsibilities

- Governance over the UM program with a specific focus on the overall quality of the UM program;
- Oversight over how the UM program interacts and communicates with the various departments within the organization;
- Central link for AHP clinical services and support services;
- Oversight and policy-making body for the annual review and approval of the Utilization Management and Quality Improvement Programs, Work Plans and Annual Evaluations;
- Ensure corrective actions are taken when areas for improvement are identified;
- Review, recommend and approve guidelines/criteria used in medical and behavioral health decision-making review process. Reviewed for approval annually;

- Support the communication of accurate, useful utilization and quality data to the individuals in the organization with a need to have it;
- Make recommendations, when applicable, to promote optimum outcomes;
- Provide information on the risks and liabilities of utilization management;
- Assure the organization is positioned to respond effectively to changing demands from health plans, regulatory agencies, and other external agencies for quantifiable evidence of quality; and
- Maintain a forum for the exchange of ideas, information, and education on optimum management of care and utilization of resources.

Reporting and Accountability

- Reports directly to the Chief Medical Officer who is accountable for disseminating appropriate information to the Aspire leadership team on a regular basis. Reports are made to Aspire leadership no less than quarterly.

B. Chief Medical Officer

Reference: NCQA: UM1 Element B

Roles and Responsibilities

- As the senior level physician, the CMO is responsible for the development, implementation, supervision, oversight and evaluation of the UM Program;
- Ensures that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with all provisions of the California Health & Safety Code, including, but not limited to Section 1367.01.
- Approves UM policies and procedures;
- Supervises program operations;
- Reviews and decides UM cases;
- Supervises all UM decisions;
- Has authority to deny, delay, or modify requests for care or service based on medical necessity;
- Has an advisory role to the UM Physicians and may provide input for medical coverage issues that arise;
- Review consistency of applying UM decision criteria and implement corrective actions when needed;
- Participates in UM Committee meetings;
- Has an unrestricted license to practice medicine in the State of California;
- Annually reviews and updates the UM criteria and the procedures for applying them; and
- Directing the oversight and implementation of the Quality Improvement process.

C. Board Certified Specialists (Consultants)

Roles and Responsibilities

- Are physicians (MD or DO) with current, unrestricted licenses in the state of California;

- Reviews cases and makes a recommendation for medical necessity determinations, as the organization makes the final decision;
- Available by phone to conduct peer reviews (upon request) with requesting practitioners or attending physicians; and,
- Provide administrative support to the UM Department professional staff.

D. Director, Utilization Management

Role and Responsibilities

- Registered Nurse with a current, unrestricted license in the State of California;
- Responsible for the development and implementation of all UM Program components;
- Interfaces directly with AHP clients, UM staff, network practitioners, contracted vendors and other department leads;
- Provides a leadership role in assuring compliance with accrediting and regulatory bodies;
- Facilitates ongoing and annual review and revision of the UM Programs;
- Provides leadership in implementation of UM processes with consistency;
- Prepares documents for annual and ad hoc audits and responds to corrective actions;
- Participates in Joint Operations Committee (JOC) meetings with contracted Health Plans
- Provide day-to-day supervision of assigned UM staff;
- Participate in staff training;
- Monitor for consistent application of UM criteria by UM staff, for each level and type of UM decision;
- Monitor documentation for adequacy; and
- Available to UM staff on site or by telephone.

E. UM Licensed Staff

Role and Responsibilities

- Registered Nurses (RNs) with current, unrestricted licensure in the state of California;
- Provides for coordination of daily UM Department functions and operations as assigned;
- Performs Utilization Review functions with application of approved medical necessity review criteria and guidelines;
- Directs requests that do not meet medical criteria, or that do not have criteria for nurse level review to Chief Medical Officer or UM Physicians; and
- Facilitates communications and personalized approach to development of a treatment plan to meet individual member needs

All licensed staff receives ongoing user training in all the electronic referrals, and medical record systems. They receive additional training in Centers for Medicare & Medicaid Services CMS criteria, Health Plan criteria and evidence based criteria such as, Milliman Care Guidelines (MCG).

F. UM Unlicensed Support Staff

Role and Responsibilities

- Performs data entry of UM information;

- Support the UM programs in various duties as outlined in individual Job Descriptions;
- Collects data for pre-authorizations and concurrent reviews;
- Verify member benefits/eligibility using established policies, procedures and guidelines, answers UM Department phone lines and works closely with UM nurses on cases that require additional information;
- May contact provider offices to clarify, verify and/or obtain clinical information;
- May approve (but not deny) services outlined on the administrative approval list, vetted and approved by the UM Committee Provides administrative support to the UM Department professional staff;
- Serves as the initial point of contact for members and providers to the UM process, responding to inquiries and requests for information;
- May work closely with both internal and external stakeholders in developing, implementing, training and maintaining AHP's automated referral system;
- UM Support Staff without clinical licensure cannot use evidence based criteria, such as MCG guidelines; and
- Any services requiring clinical judgement must be referred to a licensed UM team member.

All support staff receives ongoing user training in all the electronic referrals, and medical record systems.

G. Health Plan Client Representative

The review process conducted by each entities' QIC/UM Committee will be carried out by participating physicians who will be the only voting members on the Committee. However, a Health Plan client representative (e.g., Anthem, Blue Shield) may attend any meeting of the QIC/UM Committee that deals with utilization of services provided to client's members. The client representative will generally be a member of the client's Delegation Oversight Staff or Medical Director who will contact the entities to request attendance at the meeting. The representative will monitor the process used by the entities to conduct review, provide technicalassistance, and provide data summaries or other information as needed to facilitate the operation of the QIC/UM Committee. In the event that specific case discussion is required, only cases involving members of the health plan representative can be reviewed as per HIPAA requirements.

VI. Program Monitoring and Evaluation

The effectiveness of the program is formally evaluated annually. The annual UM evaluation is reviewed and reported to the Chief Medical Officer. The report is submitted to each of the contracted Health Plans for review and comment.

- At a minimum, annually evaluating the effects of the UM Program by utilizing data which may include:
  - Clinical Criteria used to make UM decision
  - UM Program Description
  - UM Policy & Procedures
  - Member denials and appeals trends

- Member satisfaction surveys
- Provider satisfaction surveys
- Utilization data and program-specific data
- IRR (Interrater Reliability)
- Member and provider complaints
- Internal process audit

Monitor UM Data

Ongoing monitoring and evaluation activities will include, but are not limited to assessment monitoring and evaluation of internal activities, as well as any delegated activities for the following processes:

- Use of clinical criteria used for making medical management decisions;
- Turnaround times for the processing of routine and urgent referrals;
- Written and verbal (when applicable) member and provider communications regarding coverage decisions;
- Appropriate communication of adverse determinations including: appeal rights, appropriate clear and concise denial language, peer-to-peer consultations, and obtaining decision criteria;
    - For all line of business, provide members and clinician denial notification letters in language that is clear, concise, and easily understandable.
    - Denial letters are drafted with clear, concise language at an 8th grade reading level *(Anthem only)*.
    - AHP provides written notification which includes a complete explanation of the grounds for the denial, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand.
- Tracking and analyzing all complaints and respond in a timely manner;
- Gathering and analyzing information from members and practitioners regarding their experiences with the UM process;
- Addressing opportunities for improvement identified from information gathered from members and practitioners about experience with the UM process based on member data
- Oversight of consistency of UM decision making (Inter-rater Reliability) for physicians and non-physician reviewers;
- Coordination of discharge planning with hospital and health plan for timely and appropriate assurance of required appeal notices; and
- Trends of under-and-over utilization.

Data Sources

Data sets are systematically collected and organized so that those responsible for monitoring utilization management functions can determine when future evaluation is required. Aspire utilizes numerous data

sources in the development, monitoring and evaluation of program activities. These sources include, but are not limited to the following:

- Prior Authorization
- Inpatient Utilization
- Turn Around Time
- Telephone Management
- Denial Process
- Practitioner and Patient Satisfaction Survey Results
- Complaint (Grievance) tracking process
- Case audits or other performance measures

The UM Program's monitoring and evaluation methods are based on the use of both clinical and service indicators. Indicators are determined through an analysis of data including demographic, utilization and service analyses. Many indicators allow for comparisons across similar organizations in the industry, or to the local, state or national benchmarks. Indicators are monitored by UM Director. Utilization related indicators are categorized in several ways including: network availability, inpatient care, ambulatory care, behavioral health and quality.
Indicators are evaluated on an annual basis for inclusion and exclusion.

Specific utilization indicators focus on the following areas:

- Inpatient, ED and sub-acute days per thousand
- Inpatient, ED and sub-acute admission rates
- Average length of stay (ALOS)
- Timeliness of authorizations
- Access to UM services
- Approval rates for UM decisions

Clinical Criteria for UM Decisions

Reference: NCQA UM1 Element A Factors 5 & 6
NCQA UM2 Element A Factor 5

UM Licensed Staff and Physician Reviewers use explicit and objective decision support tools to remain consistent and impartial during evaluation of individual cases. Specific clinical criteria are used to determine if services are medically necessary, rendered at the appropriate level of care, and that care meets professionally recognized industry standards. AHP aligns decisions for coverage of services with state and federal required benefits.

The following clinical parameters, evidence based criteria, benchmarks and guidelines are utilized by the UM staff, physician reviewers and CMO as resources during the decision-making process:

- Medical necessity review criteria and guidelines
- Length of stay criteria and guidelines
- Clinical Practice Guidelines
- Policies and Procedures
- Consideration of provider access and location

- Consideration of member's current clinical condition

Medical necessity is determined using scientifically based medical evidence, and through the review of the individual member's medical record/information submitted by the member's treating and/or consulting physician(s). AHP decision protocols are developed under the leadership of the CMO along with physician reviewers. Protocols or guidelines are developed using national guidelines and medical literature and are not overly burdensome for the member, the practitioner of the health care delivery staff.

Medical necessity determinations may include:

- Decisions about covered medical benefits defined by the organization's Evidence of Coverage or Summary of Benefits
- Decisions about care or services that could be considered either covered or not covered, depending on the circumstances
- Decisions about dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the member's medical benefits.

Benefit determinations are decisions on requests for medical services that are specifically excluded from the benefits plan or that exceed the limitations or restrictions stated in the benefits plan.

CMS requires the use of published Medicare criteria or plan criteria, in the following order of preference:

1. Plan Eligibility and Coverage;
2. National Coverage Determination (NCD);
3. Local Coverage Determination (LCD);
4. Local Coverage Medical Policy Article;
5. Medicare Benefit Policy Manual;
6. Health Plan criteria (e.g. Coverage Summary, Medical Policy);
7. Evidence based criteria MCG; and
8. Other evidence-based resources such as Hayes or evidence based literature including, but not limited to, the Academies of Family Practice, Pediatrics, and Cardiology, the American Board of Internal Medicine, American Psychiatric Association, AGOG, HEDIS, and the US Task Force on Preventive Health.

Commercial plan products may use the same or similar criteria, depending on the Health Plan.

Anthem HMO requires: Anthem Medical Policies

1. Anthem Clinical UM Guidelines,
2. Applicable AIM Clinical Guidelines and Behavioral Health criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty. (not delegated BHS at this time)
3. Other guideline sets adopted by Anthem
4. After considering Anthem Clinical Guidelines and Medical Policies, may adopt third party guidelines such as AIM, IngenioRx or MCG.

Blue Shield HMO requires:

1. BSC Medical Policy

2. MCG Guidelines
3. Applicable National Imaging Associates (NIA) Policies
4. Applicable American Specialty Health (ASH) Policies
5. MG/IPA Policy (HMO LOB only)

These guidelines are intended for use by qualified licensed nursing and physician review staff as references, resources, screening criteria and guidelines with respect to the decisions regarding medical necessity of health care services, and not as a substitute for important professional judgment.

The criteria hierarchy is determined by the Health Plan and CMS. The UM Committee reviews the criteria and procedures against current clinical and medical evidence and updates them when appropriate. This may include, but is not limited to consistent use of current CMS website and the Health Plan's website for published criteria. If new scientific evidence is not available, the UM Committee may determine if further review of criteria is necessary. The evidence is provided through reviewing, updating, and approving the above hierarchy and the Utilization Decision Responsibility and Criteria policy by the CMO and UM Director at least annually.

Upon request by members or providers, UM will distribute criteria by mail or fax as requested. Practitioners are notified of the availability of written UM criteria through the "Provider Manual" distributed annually.

The criteria/guidelines used are applied on a case-by-case basis, considering age, co- morbidities, complications, home environment when applicable, progress of treatment, the psychosocial situation, and the accessibility of the local delivery system. Also considered is the local delivery system: the availability and coverage of benefits for skilled nursing facility, sub- acute or home care in the service area, the ability of local hospitals to provide recommended services within the estimated length of stay, and services to support the member after discharge.

Providers can obtain a copy of criteria/guidelines used in the decision process by contacting the UM Department by telephone. Upon request, UM will distribute criteria by mail or fax as requested.

VII. UTILIZATION MANAGEMENT

Scope

The scope of the program incorporates prospective review, concurrent management, discharge planning, retrospective review, and to accomplish program objectives.

Aspire arranges for the provision of medical care to health plan members through a network of physicians, nurses, ancillary care providers and other facilities. Care is comprehensive, providing for acute and chronic conditions. All services are offered in the context of participants' benefit plans.

Oversight of Health Delivery Organizations/Sub-Delegation

Aspire ensures that all contracted entities are in good standing with regulatory bodies and are accredited by an appropriate accrediting body before contracting with them. These contracted entities are re-evaluated through the credentialing process, no less than every three (3) years. AHP does not sub-delegate utilization management function to any contracted agency.

Referral Management

In managing referrals, the CMO assesses referral patterns and works with specialists to identify issues regarding over- and under-utilization. The CMO determines which specialists can be accessed within the network via direct referrals and approves any proposed changes to the prior authorization list as necessary.

Appropriate Professionals

Reference: NCQA UMJ Element A Factor 3

The senior-level physician (CMO) develops and implements the UM policies and procedures, and supervises program operations. The UM criteria is reviewed and updated annually along with the procedures for applying them. In addition to oversight of the clinical review process for all requests for medical care, all UM decisions are supervised by the CMO. The CMO attends and participates in UM Committee meetings for the review of data regarding Inter-rater Reliability findings and implements UM-related Quality Improvement corrective actions when necessary.

Licensed, qualified professionals directly review and decide UM cases. Non-licensed support staff may not deny or make decisions that require clinical judgment. UM Physicians review and decide all UM cases where a denial, delay, or modification would be based on medical necessity. Where clinical judgment beyond the scope of the reviewing physician is indicated on medical necessity determinations, a board-certified specialist from the appropriate specialty area may be included in the review process. All network board-certified specialists may be consulted for assistance with a request related to his/her area of specialty. The final decision as to the necessary and appropriate medical treatment for AHP members remains the responsibility of the member's physician and the member.

The physician reviewers evaluate cases including supporting documentation and clinical information and, when necessary, consultation with the treating physician that do not meet review criteria/guidelines, and is responsible for all determinations.

For behavioral health issues requiring clinical review, a psychiatrist, doctoral level clinical psychologist, or certified addiction medicine specialist may be consulted as appropriate.

The UM Licensed and Support Staff receive orientation and training on the job specific responsibilities and functions of the position. Review staff is properly qualified, supervised, and supported by UM Supervisors and adheres to explicit UM Policies and Procedures.

Inter-rater Reliability (IRR) Review Process

The interrater reliability review process will evaluate the consistency with which UM criteria are applied in decision-making by physician and UM licensed professionals. The interrater reliability review process will occur at least annually and will include the following:

- Consistency in the application of clinical guidelines and criteria
- Evaluation of the reviewers' ability to identify potentially avoidable utilization
- Evaluation of reviewer's ability to identify quality of care issues
- Identifying specific areas in need of improvement
- Identifying areas where additional training is needed

A sample of AHP UM determination files are used to perform IRR testing or the mcg Guideline online IRR tool is used if available. UM licensed professionals must receive at least a 90% passing score. Any areas identified for improvement are addressed to improve consistency, with additional training, assigned learning modules and auditing as needed to achieve the required level of consistency.

The UM department will act on identified opportunities for improvement through the interrater reliability review process, if applicable.

Timeliness Standards

There are established timeliness standards for clinical determinations concerning routine, urgent, and emergent services. When a determination results in a denial, notification to members/ providers complies with regulatory (i.e. CMS or DMHC) requirements. The timeliness standards are based on established industry standards and are consistent with NCQA, CMS, DMHC and contracted health plan requirements.

VIII. REFERRAL PROCESS

Referral Verification

It is the policy of the AHP UM Department to verify eligibility prior to issuing an authorization for service. This process includes:

- Verifying member eligibility
- Verifying member benefits coverage
- Verifying physician/hospital contract status
- Ensuring that requested facilities and referral physicians/vendors are network participants for AHP and the specific region
- Coordinating requests for care outside of the referral network, where necessary and appropriate
- Coordinating care for transitioning members for transfers both into and within AHP provider network
- Obtaining relevant clinical information required to make medical necessity determinations

If AHP requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan requests only the information reasonably necessary to make the determination.

IX. REVIEW PROCESS

Urgent review

A 72-hour urgent review and/or expedited appeal may be requested by the member, physician, or advocate acting on behalf of the member. Urgent referrals are processed according to the CMS timeliness guidelines. Health plan - specific timeliness requirements are used if they differ from CMS guidelines, including but not limited to DMHC required timelines.

Prospective Review

Prospective Review (prior authorization) is the process of reviewing requests for coverage of health care services before the services are rendered. AHP utilizes a Prior Authorization Requirements List to determine if a service requires prior authorization by the Health Plan. Requests are reviewed for eligibility, benefit interpretation, determination of medical necessity and appropriateness of services or levels of care. Additionally, staff members assist with coordination of care when needed. Examples of coordination of care include internal referrals between Care Management staff and UM staff for patient needs related to discharge planning and prior authorization of planned outpatient health care services.

Pre-service review is performed by licensed professional nurses or clinicians who function under the direction of a Chief Medical Officer or Physician Reviewer. Nurses, physicians and behavioral health practitioners use nationally recognized guidelines and Medicare coverage guidelines. Nurses or behavioral health practitioners approve coverage for services that explicitly meet guidelines. Medical Directors or Physician Reviewers review all requests for cases that may not meet criteria and cases that do not yet have established criteria. AHP Medical Directors or Physician Reviewers review for medical necessity within the context of benefits and services requested.

Board-certified physicians for appropriate specialty areas are utilized to assist in making determinations of medical necessity as indicated. Appropriately licensed health professionals initially review all cases.

Concurrent Review

Concurrent Review is the process of evaluating inpatient admissions for continuing care needs on a regular basis by reviewing the medical records and conferring with Attending Physicians, Inpatient Care Managers, Hospitalists and Medical Directors. Staff use nationally recognized guidelines to facilitate reviews. The concurrent review process allows UM licensed staff to assist interdisciplinary teams in evaluating the need for the current level of inpatient care. This provides a mechanism to monitor quality of care issues and opportunities for improvement.

Ongoing concurrent reviews are performed on all admitted members on a schedule consistent with acuteness of condition and care being provided, and are based on medical necessity.

Concurrent Reviews are performed on members admitted to:

- Acute care hospitals
- Skilled Nursing Facilities
- Acute Rehabilitation facilities or units
- Mental health facilities or units
- Intensive outpatient and residential behavioral care facilities

Retrospective Review

A retrospective review may be triggered by claims, deficiency in the prior authorization process, quality issues and/or to make utilization approval determination. Retrospective reviews include review of the medical records, communication with the involved provider and the health plan/payer.

Retrospective review may be conducted for the following unanticipated and/or unauthorized services:

- Hospital admissions
- Emergency Room visits
- Out of Area (OOA)/Out of Network (OON) admissions or services
- Procedures, tests and/or provider visits
- Skilled Nursing Facility admissions
- DME
- Home Health

Denials

All denial or proposed denial decisions related to medical necessity are reviewed by licensed physicians. Member confidentiality is strictly protected and compliance programs are in place to ensure adherence of procedures to maintain confidentiality.

For adverse decisions (denials, delays or modifications), the CMO or Physician Reviewer is available to requesting practitioners to discuss determinations and alternative treatment plans. All utilization adverse decisions are communicated telephonically or by fax to practitioners, and in writing to both the members and physicians in adherence with applicable timeliness standards. The provider may contact a physician reviewer to discuss the determination by phoning the UM Department or the physician reviewer at the contact number provided with the denial notification form. The name of the physician reviewer or an expert whose advice was obtained about a determination may be given to a member upon request.

The review criteria and/or guidelines utilized to assist with authorization decisions are clearly documented by the UM staff. If a member, member representative, or person acting in the interest of a member, or provider should question a medical necessity determination, any criteria, standards, or guidelines applied to the individual case supporting the determination may be provided in hard copy format for reference.

Appeals

Requests for appeals may be made by members or by individuals advocating on behalf of members, including practitioners. If AHP is not delegated for client's appeals, the denial letter language directs members to their respective health plans' appeal process.

All members are entitled to and are notified of their right to standard or expedited appeals of adverse decisions. When the standard processing time would seriously jeopardize the life or health of members or their ability to regain maximum functioning, the expedited appeal process is activated.

AHP adjudicates member appeals in a thorough, appropriate, and timely manner and ensures a full and fair process.

The timeliness of AHP's appeal process for preservice, post-service, and expedited appeals occur within the following timeframes:

- Preservice appeals are resolved within 30 calendar days of receipt of the request
- Post-service appeals are resolved within 60 calendar days of receipt of the request
- Expedited appeals are resolved within 72 hours of the request

For Medicare, AHP may provide a 14-day extension on post-service appeals upon member request.
For Medicare, if AHP provides verbal notification for an expedited appeal, and additional 3 calendar days may be used to provide the electronic or written notification. Within the notification to the member, the member is notified that they are entitled to receive reasonable access to and copies of all documents, free of charge, upon requests. The member also receives a description of the next level of appeal, either within AHP or to an independent external organization, as applicable, along with any relevant written procedures.

Communication

AHP UM process facilitates communications of approval and denial decisions for every determination. Members and Requesting Providers are informed of approval decisions through written notification in compliance with individual health plan requirements, and federal, State, and NCQA guidelines.

Members are informed of adverse decisions and denials of coverage through written communications that include appeal rights. Requesting Providers are notified of adverse decisions and denials of coverage through electronic and/or written communications that include instructions on requesting a direct Peer-to-Peer consultation with the deciding Physician Reviewer. Notifications of adverse determinations are standardized in accordance with health plans, federal, State and NCQA standards and guidelines.

Type (Medical and Behavioral)	**Decision turn-around-time, upon receipt**	**Notification to Provider and Member of the UM decision**
Urgent Pre-service	**72 hours**	Time, date and who notified must be documented. Provider: Within 24 hours of the decision.

		Member: Written notification no later than 2 business days after receipt of the request. Document date and time of oral notifications.
Urgent Concurrent	**72 hours**	Within 24 hours of the decision.
Non-urgent Preservice	**5 business days for Commercial/14 days for Medicare**	Within 24 hours of the decision.
Non-urgent Concurrent	**5 business days for Commercial/14 days for Medicare**	Within 24 hours of the decision.
Retrospective	**30 days**	Within 30 days from the date of receipt.