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.

UTILIZATION MANAGEMENT			
	ASPIRE HEALTH PLAN	**Effective Date** 01/01/2014	
		Policy # AHP ASO-HS027	
	UTILIZATION REVIEW CRITERIA	**Review Date** 10/17/2022	**Applicable to:** ☑ Medicare Advantage ☑ Commercial ☑ Anthem HMO ☑ Blue Shield Trio
	Approver's Name & Title	Eva Balint, MD – Chief Medical Officer	

1.0 PURPOSE

1.1 This policy and procedure addresses how Aspire Health Plan (AHP) uses written criteria based on appropriateness of medical and pharmacy services and sound clinical evidence to make consistent utilization decisions, and specifies procedures for appropriately applying criteria that are objective based on medical evidence.

2.0 POLICY

2.1 The utilization review criteria used by AHP to determine whether to authorize, modify, or deny health care and pharmacy services (when delegated by health plan partner to make pharmacy decisions) are developed with involvement from actively practicing health care providers and consistent with sound clinical principles and processes.

2.2 AHP will adopt and consistently apply utilization review decisions which will rely on the consistent and appropriate application of evidence-based guidelines.

2.3 AHP will evaluate the consistency with which health care professionals involved in Utilization Management (UM) apply criteria in decision making and acts on opportunities to improve consistency if applicable.

3.0 DEFINITIONS

3.1 Refer to AHP Definitions Manual.

4.0 PROCEDURE

4.1 Medicare Criteria Hierarchy

4.1.1 Evidence of Coverage

4.1.2 Medicare National Coverage Determination (NCD)

4.1.3 Medicare Local Coverage Determination (LCD)

4.1.4 AHP medical policy or specific contract language, MCG ® Care Guidelines are used.

4.2 Anthem Hierarchy

4.2.1 Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

4.2.2 Anthem Medical Policies

4.2.3 Anthem Clinical UM Guidelines, including 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.

4.2.4 Other guideline sets adopted by Anthem

4.2.5 After considering Anthem Clinical Guidelines and Medical Policies, may adopt third party guidelines such as AIM, IngenioRx or mcg.

4.2.6 AIM guidelines—may use other guidelines, as applicable, including imaging and sleep study guidelines.

4.3 Blue Shield Hierarchy

4.3.1 BSC Medical Policy

4.3.2 MCG Guidelines

4.3.3 Applicable National Imaging Associates (NIA) Policies

4.3.4 Applicable American Specialty Health (ASH) Policies

4.3.5 MG/IPA Policy (HMO LOB only)

4.4 Criteria Review and Approval

4.4.1 The Medical Director or physician designee will validate that all utilization review criteria and guidelines are evidence based.

4.4.2 The organization reviews it's UM criteria and procedures against current clinical and medical evidence and updates them, when appropriate. If new scientific evidence is not available, a designated group may determine if further review of a criterion is necessary

4.4.3 The Medical Director confers with practitioners with clinical expertise in the area being reviewed. These practitioners have the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria.

4.4.4 AHP gathers relevant clinical information consistently to support non-behavioral health UM decision-making. In doing so, the UM process requires that staff collect relevant medical information to allow for evidence-based review and determination.

4.4.5 AHP recognizes that it is not delegated for behavioral health (BH) reviews and refers cases for commercial members to the appropriate delegated BH provider as determined by contract.

4.4.6 AHP recognizes that it is not delegated for review of traditional Pharmacy requests for commercial members and would provide education to any requesting provider and notification to the member if a non-delegated pharmacy request were to be received.

4.5 Criteria Application

4.5.1 Reviewers apply utilization review criteria after determining the requested services are covered benefits under the circumstances requested.

4.5.2 The UR nurse reviewer applies the review criteria to service requests needing authorization prior to the authorization determination.

4.5.3 The UR Nurse reviewer documents the criteria used to make the review determination in the patient file.

4.5.4 If the requested services do not appear to meet the criteria or there is question about meeting the criteria, the UR nurse reviewer refers the case to the Medical Director or physician designee When review criteria are not appropriate for an individual patient's condition or circumstances, the physician reviewer must take into consideration the following factors when reviewing service requests:

4.5.4.1 Age

4.5.4.2 Co-Morbidities

4.5.4.3 Complications

4.5.4.4 Progress of treatment

4.5.4.5 Psychological situation

4.5.4.6 Home environment

4.5.4.7 Availability of alternate levels of care within the local delivery system

4.5.4.8 (e.g., Skilled Nursing Facility, home health)

4.6 Provider Request

4.6.1 When a provider calls to request criteria, the reviewer responds by either providing a copy of the specific criteria or verbally giving the information to the provider over the phone.

4.7 Evaluation of consistency

4.7.1 AHP will assess the consistency with which the Medical Director or physician designee and UR nurse reviewers apply UR criteria, and evaluates interrater reliability using hypothetical UR test cases, or using a sample of UR determination files.

4.8 Non-Delegated Services

4.7.1 AHP only maintains and reviews utilization review criteria that pertain to those services for which it is delegated. At this time, AHP is not delegated prescription or behavioral health services.

5.0 TRAINING

5.1 Training for employees will occur within 90 days of hire, and upon updates to the policy.

6.0 REVIEW PERIOD

6.1 N/A

7.0 REGULATORY REQUIREMENTS AND REFERENCES

7.1 Medicare Managed Care Manual, Chapter 4, Section 90, Chapter 6, section 20.1

7.2 CA Health and Safety Code 1363.5 (a)&(b); 1367.01 (b); 1363.5

7.3 NCQA page 245

7.4 Anthem page K(1)-4

8.0 POLICY VIOLATION

8.1 Any AHP associate or contractor who fails to abide by this policy may be subject to disciplinary action, up to, and including termination. Please refer to AHP's Disciplinary Guidelines and Enforcement Policy for further details.