Arizona Priority Care

2017 UTILIZATION MANAGEMENT PROGRAM

Approval Signature

2/2/17

Date

Utilization Management Program

TABLE OF CONTENTS

PHILOSOPHY

The philosophy of Arizona Priority Care is to provide continuous quality improvement and appropriate utilization of resources to its members.

UM 1: UTILIZATION MANAGEMENT STRUCTURE

Arizona Priority Care (AZPC) will have the Utilization Management infrastructure necessary to provide ongoing monitoring and evaluation of delegated medical management activities to address over/under utilization and coordination of medical resources, to support continuum-based case management activities, continuity-of-care, and to maintain a systematic process for the education of staff and providers regarding Utilization Management.

The Arizona Priority Care Utilization Management Program is designed to achieve congruence with the following services:

- Quality Healthcare
- Care Management
- Utilization Management
- Efficient and Effective Healthcare
- Resource Management
- Customer Satisfaction
- Provider Orientation and Update Regarding Utilization

AZPC shall participate in a policy setting and interactive education role. AZPC's interest is to ensure that systems and resources meet the quality of medical care and service demands of its members in a cost effective manner. AZPC's Utilization Management Program will ensure compliance with regulatory and accreditation agency standards and appropriate data collection and reporting to meet the needs of contracted health plans and any other external customers.

All Utilization Management (UM) decision-making will be based on appropriateness of care and service.

AZPC will distribute the approved UM Program and relevant policies and procedures to all Arizona Priority Care practitioners and contracted providers at least annually to ensure that all are advised of services requiring Utilization Management pre-service determinations such as:

- Ambulatory
- Inpatient
- Skilled Nursing
- Home Health
- Rehabilitative Services (such as physical, occupational and speech therapies)
- Pharmaceuticals, when delegated
- Medical Equipment and/or Supplies, when delegated

As well as services that do NOT require pre-service determinations such as:

- Emergency
- Family Planning and Sensitive Services
- Preventive Services (including immunizations)
- Basic Prenatal Care (in-network)

- Sexually Transmitted Disease Services
- HIV Testing/Counseling
- Language Assistance Programs/Interpretation services
- Hospice

AZPC providers are not restricted in advocating on behalf of a member or advising a member on medical care. This includes, but is not limited to:

- Risks, benefits, and consequences of treatment or non-treatment
- Member's right to refuse medical treatment and self-determination in treatment plans.

PROGRAM OVERSIGHT

Governing Body

The Executive Committee (Governing Body) shall have ultimate authority and responsibility for the Utilization Management Program. It shall establish and maintain an effective and efficient UM Program.

The Executive Committee will ensure that Arizona Priority Care providers receive and comply with all aspects of the UM Program.

The Executive Committee will review, evaluate and make any necessary revisions to the UM Program at least annually.

The structure and responsibilities of the Executive Committee are outlined in the Executive Committee Charter and made available to its committee members.

Utilization Management Committee

The Utilization Management Committee (UMC) and any ad-hoc committees or subcommittees of the UMC will report to the Executive Committee via the UMC. The UMC reports to the Executive Committee at least biannually.

The Utilization Management Committee will meet at least quarterly to review, evaluate and provide the Executive Committee with recommendations for revisions to the Utilization Management Program. For urgent issues that require immediate updating, these will be addressed separately by the designated ad-hoc committee meeting (either virtual or in person) utilizing appropriate practitioners (3 physicians) and/or subcommittee.

Minutes and records are kept of all UMC activities for which the UMC is responsible. Such materials are considered confidential and are maintained in locked quarters and, therefore, are only available to the appropriate staff, as well as contracted full service health plan directors, auditors or designees for annual review or follow up.

Each attendee, including guests, at each Committee meeting will sign confidentiality and conflict of interest statements.

The composition of the Utilization Management Committee shall include, but is not limited to:

- Chief Medical Officer
- Medical Directors
- Vice President of Clinical Services
- Vice President Value-Based Care Initiatives & Network Management
- Director of Clinical Operations
- Director of Care Management
- Other AZPC clinical staff as appropriate
- Additional personnel, clinical or technical experts as requested by the Utilization Management Committee or Executive Committee

The UMC responsibilities shall include:

- Evaluation of AZPC's capacity to perform UM activities
- Review and approval of the UM Program annually
- Review of utilization reports
- Evaluation of AZPC's activities to ensure they are being conducted in accordance with expectations and regulatory standards
- Ensuring all member information is confidential and protected from unauthorized dissemination

Designated Physician

AZPC shall employ or designate a Medical Director who holds an unrestricted license to practice medicine in the state of Arizona.

The Medical Director is fully credentialed by AZPC and is the designated physician who is involved in the UM Program development and evaluation, facilitates all Utilization Management activities, supports the various committees, ensures appropriate staff and resources are available, and makes recommendations based on various analyzed clinical care and administrative data.

Designated Behavioral Healthcare Practitioner

When delegated, AZPC may contract with but not delegate Utilization Management responsibilities to their respective Behavioral Healthcare (BH) Provider Organization. The Medical Director of AZPC's contracted Behavioral Healthcare Organization shall be a behavioral healthcare physician or a doctoral level behavioral healthcare practitioner. The Behavioral Healthcare (BH) Medical Director is the designated physician who is involved in the behavioral aspects of the UM Program development and evaluation.

The BH Medical Director shall be available for assisting with member behavioral health UM procedures and processes, complaints, development of behavioral health guidelines, making recommendations on service and safety, providing behavioral health UM statistical data, following up on identified issues and attending the UMC meeting at least semi-annually and when needed.

Utilization Management Department

AZPC may employ clinical and non-clinical persons in the UM Department to process requests for medical services for their respective members. AZPC shall employ or designate a Medical Director who holds an unrestricted license to practice medicine in the state of Arizona to provide primary oversight of the UM Department. The UM staff may consist of licensed physician reviewers, licensed nurse reviewers and non-clinical support staff.

Term of membership is two years with an automatic renewal of membership possible.

Note: Only physicians having voting rights and a quorum consisting of three (3) members is needed.

Arizona Priority Care will maintain a current department organizational chart identifying all key UM positions, decision makers and department/staff oversight.

PROGRAM SCOPE AND PURPOSE

Utilization Review Program Responsibilities

AZPC will provide policies and procedures that are needed to support UM decisions.

AZPC policies and procedures will meet all Arizona health and safety codes and regulations.

The AZPC Chief Medical Officer will ensure that these policies and procedures are reviewed and adopted by the UMC and that all clinical and non-clinical staff responsible for UM activities are educated on the most current policies and procedures.

Medical decisions are to be made by credentialed, qualified medical providers, unhindered by fiscal and administrative management, using objective criteria based on medical evidence, consistent with AZPC approved policies and procedures and utilizing evidence of coverage and benefit limitations, as well as approved clinical criterion, medical review guidelines and policies and in accordance with all state and federal regulations:

1. Senior licensed physician will supervise all UM staff responsible for making Utilization Management determinations.
2. Licensed physician reviewers may approve or deny any services based on benefit coverage and medical necessity.
3. Licensed nurse reviewers may approve any services, deny benefit driven services and provide recommendations to physician reviewers for medical necessity denials.
4. Non-clinical staff may verify benefit coverage, retrieve information necessary for clinical review, approve limited services as assigned and deny benefit driven services as assigned.
5. The Medical Director will be responsible for all final decisions to deny any and all services based on medical necessity.
6. Determinations of coverage and medical necessity for behavioral health services will include involvement of a behavioral health practitioner.

AZPC may utilize contracted healthcare professionals and specialists to assist with clinical reviews and/or recommendations but may not delegate or sub-delegate UM activities to any other entity.

The clinical information utilized to make UM determinations may include, but is not limited to, the following:

- Office and hospital records
- A history of the presenting problem
- A clinical exam
- Diagnostic testing results
- Treatment plans and progress notes
- Patient psychosocial history
- Information on consultations with the treating practitioner
- Evaluations from other healthcare practitioners and providers
- Photographs
- Operative and pathological reports
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

AZPC may not rescind or modify an approved service authorization after the provider renders the healthcare service in good faith for any reason, including, but not limited to, subsequent rescissions, cancellations or modification of the member's contract or when AZPC did not originally make an accurate determination of the member's eligibility. All Utilization Management information must be kept on file for at least 36 months.

Program Goals and Objectives

The UM Program will be implemented and directed by the AZPC Utilization Management Committee. The goal of the UM Program is to ensure that AZPC practitioners provide quality care in the most cost-effective manner.

Objectives

A. To evaluate the utilization of services, member benefits and resources related to the provision of care by reviewing requests for services prior to authorization, conducting concurrent review, discharge planning, retrospective review and providing care management.

B. To ensure that all members receiving inpatient and skilled nursing facility care will have a completed continuity-of-care plan developed prior to discharge to a lower level of care.

C. To encourage effective, efficient use of services and resources through communication and education of employees, providers, patients and their families.

D. To ensure all practitioners and UM reviewers have access to and are utilizing the most current criteria, guidelines and policies as approved by the AZPC Utilization Management Committee.

E. To develop systems to ensure that criteria and physician/non physician reviewer decisions are applied consistently and that services delivered are medically necessary and consistent with the patient's diagnosis and level of care required.

F. To monitor and improve the coordination of medical and behavioral healthcare.

G. To target and care manage patients with complex healthcare needs across the continuum of community and facility-based services to assure that the goals of health, promotion, risk reduction and the prevention of illness complications are met.

H. To communicate and interact effectively with the primary care physicians, specialists and other contracted services through committee meetings, newsletters, verbally, correspondence and education forums.

I. To work in conjunction with the Quality Improvement Committee in referring those issues which require a quality interface/review.

J. To develop Corrective Action Plans, if necessary, to improve practice or system issues.

K. To work with contracted health plans in disseminating information related to their Language Assistance Programs (LAP) for Limited English Proficient (LEP) members, when and where appropriate.

L. To identify utilization issues and problems in the utilization management process and to use the Continuous Quality Improvement process to develop interventions to continuously improve the utilization management process.

M. To ensure a process by which members and practitioners are informed of their rights and the process to appeal a determination.

UM Program achievements will be measured by the Utilization Management Committee through the evaluation of the UM work plan, annual program evaluation and other utilization activity reports.

The AZPC Utilization Management Committee will routinely review and monitor the services that are provided by AZPC including, but not limited to:

A. Prospective Hospitalization Review

1. Necessity of admission determined according to review criteria.

2. Appropriateness of workup on all elective cases - Medical Director or designee.

3. Assign a specific number of days

4. Complete written authorization process.

5. Automatic authorizations are approved according to AZPC policies and procedures.

6. Prospective review is accomplished daily by the Medical Director or designee.

7. When delegated, prospective review of psychiatric and substance abuse admissions are conducted daily by the Medical Director and/or designee with involvement of behavioral health professional(s).

8. Referral to Behavioral Health Assessment Team/disease management, where available, when appropriate.

B. Concurrent Hospital Review

1. Performed daily by Care Managers

2. Concurrent review of psychiatric and substance abuse admissions are conducted daily by Care Managers and/or designee with involvement of behavioral health professional(s).
3. Care Managers, social services or designees, discharge planners, inpatient physicians and Medical Director will review daily to determine medical necessity of continued stay, level of care, intensity of service, diagnostic studies, treatment plans, identify barriers to discharge and the quality of care being rendered.

4. Referral to telephonic or complex care management or AZPC Home Program, when appropriate.

5. Documentation of review will be maintained by the Clinical Services Department.

6. AZPC staff that performs onsite review is expected to follow all applicable facility policies and/or procedures, i.e. safety, confidentiality, scheduling of visits, awareness of facility rules, wearing facility issued identification badges and/or maintaining any other form of identification as required by facility.

7. Care shall not be discontinued until the member's treating provider has been notified of the plan's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient.

C. Retrospective Review - Hospitalizations

Review of inpatient admissions for:

a. Appropriateness of admission and disposition
b. Severity of illness and intensity of service
c. Patient outcome
d. Proper documentation
e. Complications of patient care
f. Appropriateness of the length of stay
g. Delays of service

D. Emergency Room/Ambulance Service

Services necessary to screen, stabilize and transport members without preauthorization of emergency services will be covered in cases where a prudent layperson, acting reasonably would have believed that an emergency medical condition exists.

Retrospective claims, primarily consisting of emergency room/ambulance services, are reviewed only in an effort to track utilization criteria for improved patient care and/or PCP availability to patient population. The delegated personnel for these reviews consist of claims reviewer/auditor and appropriate clinical staff.

E. Post Stabilization Transfer

Post stabilization services require prior authorization. No person needing emergency services and care may be transferred for any non-medical reason unless certain conditions are met, i.e., a provision that the person is examined and evaluated by a physician and/or surgeon prior to transfer. A patient is considered stabilized when, in the opinion of the treating provider, the patient's medical condition is such that within reasonable medical probability, no material deterioration of the patient's condition is likely to result from or occur during a transfer of the patient.

F. Prospective and Retrospective Review - Outpatient Services

All prospective and retrospective prior authorizations will be reviewed by the Medical Director or designee for:

1. Medical indication for prior authorization.

2. Specific number of visits or services specified on the form.

3. Sufficient clinical information is documented so that the consulting provider has all known significant information relating to the requested services.

4. Correct coding – level of care

5. Contractual arrangements

G. Out of Network/Non-Contracted Provider Referrals

Contracted providers will be utilized whenever possible. If a contracted provider is not available, then a prior authorization for an out of network or non-contracted provider will be reviewed for medical necessity by the Medical Director or designee. For services determined to be medically necessary and not available in network, a Letter of Agreement will be generated by AZPC's designated staff prior to the member's visit.

All out of network or non-contracted provider prior authorizations will be reviewed by the Medical Director or designee.

H. Home Health Agency Care

When a member is referred to a home health agency, the attending physician must order the evaluation and then approve the treatment plan submitted by the home health agency. The treatment plan must then be approved by the UM Department or designee. If there are any questions regarding approval, the Medical Director will be consulted. Continued home healthcare must be concurrently approved by the UM Department, Care Manager or designee.

I. Behavioral Healthcare Review

When delegated, AZPC will contract with Behavioral Healthcare Provider Organizations to provide behavioral health services for their members.

AZPC requires that:

1. Only licensed practitioners make decisions that require clinical judgment.

2. Staff that makes clinical decisions is supervised by a licensed master's level practitioner with five years of post-master's clinical experience.

3. A licensed psychiatrist or a licensed doctoral-level clinical psychologist will oversee triage and prior authorization decisions.

4. Protocols for behavioral healthcare triage and prior authorization address all relevant mental health and substance abuse situations. Protocols also address the level of urgency and appropriate setting. The protocols should be reviewed at least annually and as needed.

5. The designated behavioral healthcare practitioner will:
   - Be involved in the implementation of the behavioral healthcare aspects of the Utilization Management Program and policy development;
   - Participate in Utilization Management Committee meetings; and
   - Review behavioral health Utilization Management cases as needed.

K. Second Opinions

A member's request for a second opinion from a qualified healthcare professional will be covered at no cost (with the exception of standard copays and deductibles) to the member.

1. AZPC will not deny a member's request for a second opinion with a contracted, qualified health professional.

2. Requests for second opinions by a non-contracted provider will be reviewed for availability of a contracted qualified health professional prior to issuing authorization to the non-contracted provider.

L. Over and Under-Utilization Review of Services

The AZPC UM Committee will regularly monitor utilization data of high volume care (i.e., specialists, outpatient services, inpatient hospital care and skilled nursing facility care) to detect potential adverse utilization patterns (practice-specific and/or provider-specific) and/or other barriers to the authorization process.

Corrective action and/or other appropriate intervention will be implemented based on Committee's findings. The Committee will allow sufficient time to elapse prior to evaluating effectiveness of the corrective action(s). Comparisons will be made with the previous findings.

M. Reporting Requirements

1. Annual Initial Work Plans - AZPC will complete and submit an annual initial work plan to the UMC during the first quarter of each new year.

The Annual Initial Work Plan is to include:

a. Utilization management goals and objectives, program scope, areas of program focus and the specific utilization related activities and studies that are to occur
b. Planned monitoring of utilization data, including tracking statistics over time
c. Planned annual evaluation of the UM Program
d. Action steps which include target dates for completion and responsible party

2. Quarterly Work Plan Evaluations – AZPC will update and submit a quarterly work plan to the Utilization Management Committee. Based on regulatory and plan contracting requirements, quarterly work plan evaluations are due to the UMC by 15 February, 15 May, 15 August, and 15 November, unless otherwise noted.

   Quarterly work plan updates must include:

   a. UM activities completed
   b. The organization's performance in utilization management should be trended
   c. An analysis of whether there have been any demonstrated improvements in the UM Program
   d. A description of how these improvements were meaningful to the organization's population should be included

3. Monthly/Quarterly/Semiannual/Annual UM Reports are submitted based on regulatory and plan contracting requirements (e.g. NOMNC, Part C Reporting, ESRD Log, etc.)

4. 1st Semi-Annual report - AZPC will complete and submit to UMC by 15 August.

5. Final Work Plan Evaluation/2nd Semi-annual report - AZPC will complete and submit a final work plan evaluation to the Utilization Management Committee by February 15 of each new year.

The final assessment will include a full review and analysis of each component as listed on the UM Work Plan and an overall evaluation summary in each section as to the attainment to written goals and any additional strategies and clarifications as necessary.

UM 2: CLINICAL CRITERIA FOR UTILIZATION MANAGEMENT DECISIONS

The UM review process uses a wide range of criteria, guidelines and reference tools to assist in determinations of benefit coverage, behavioral health needs and medical appropriateness. Supporting clinical and benefit information relevant to each particular case will be reviewed when making medical necessity coverage determinations.

AZPC maintains written policies addressing the application of objective and evidence-based criteria in making UM determinations while taking into account the local delivery system, individual circumstances and the member's needs such as age, comorbidities and complications, progress of treatment, psychosocial situation and home environment, when applicable.

AZPC will assist with a member's transition to other care, if necessary, when medical necessity is not met or benefits end while a member still needs care.

AZPC shall offer to educate the member (or the member's designated representative) about alternatives for continuing care and how to obtain care and/or access to community resources as appropriate.

Annual Review of Criteria

1. Materials are reviewed, approved and/or updated/modified as needed but not less than annually.
2. Only appropriate clinical and behavioral health practitioners with relevant experience are involved in the development, adoption and review of the criteria.
3. Criterion complies with Medicare local and national coverage determinations and relevant Medicaid requirements.
4. Upon final approval, all materials are made available to UM staff and practitioners in writing either by mail, fax or e-mail or on the AZPC website according to AZPC standard communication/dissemination processes.

Availability of Criteria, Guidelines, Policies

Upon request, AZPC will make available all criteria, clinical review guidelines and medical review polices utilized for decision making to members and practitioners. With each determination made by AZPC, members and providers are notified in writing of the process for requesting a free copy of the criteria guideline or policy used to make the determination.

Additionally, all criteria, guidelines and polices utilized will be maintained and made for review at all times.

Consistency in Applying Criteria, Guidelines, Policies

To ensure case review consistency and uniformity in decision making among the physician and non-physician reviewers, Inter-Rater Reliability audits will be conducted at least annually by AZPC.

Utilizing the "8/30" methodology, randomly selected authorization requests shall be reviewed by a same level staff (physician, nurse, non-clinical) who was not responsible for the initial decision.

At a minimum, the Inter-Rater Reliability survey shall contain the following elements:

Outpatient Services

1. The case was completed within the line of business standard timelines.
2. The reason for the prior authorization delay was clearly documented, if applicable.
3. There was sufficient clinical documentation to support the decision.
4. The files were correctly categorized.
5. The appropriate utilization management criteria or benefit provision was applied.
6. There was appropriate prior authorization to the Medical Director/physician advisor.
7. Medical necessity denials included physician signatures.

Inpatient Services

1. Documentation supports the medical necessity for admission and continued stay.
2. There was sufficient clinical documentation to support the decision.
3. The appropriate utilization management criteria or benefit provision was applied.
4. Disposition of patient is documented on worksheet.
5. There was appropriate prior authorization to the Medical Director/physician advisor.
6. Continuity of care and discharge planning initiated and family involved, when applicable.

Physician Reviews

At least five (5) randomly selected denials shall be reviewed by a Medical Director not responsible for the initial decision and all selected denials shall be reviewed by an independent

physician to ensure determinations are made based on adopted clinical guidelines against the following criteria:

a) The case was approved with appropriate utilization management criteria applied.
b) The case was pended, if applicable, and determination was made within required timeliness.
c) The case was denied using appropriate utilization management criteria and process.
d) There was sufficient clinical documentation to support the decision.
e) Physician review was clearly documented.

Results of Reviews

These results must be presented to AZPC UM Committee for review and discussion. AZPC will act on opportunities to improve consistency in applying criteria, as applicable.

Corrective action shall be implemented for any reviewer not meeting the established benchmark of 80% in either category.

Results of such surveys shall be documented by AZPC on the work plan and will subsequently be reviewed by the AZPC UM and QI Committees. The findings and any corrective action or performance improvement recommendations will also be reported to the AZPC Executive Committee.

Opportunities for improvement will be monitored by the AZPC UM and QI Committees, as applicable.

UM 3: COMMUNICATION SERVICES

AZPC will provide access to staff for any member or practitioner seeking information about the utilization management process and the authorization of care. Inbound and outbound communications may include communication with practitioners and members in person, in writing by mail or fax, by telephone or by electronic communications (e.g. sending e-mail messages or leaving voicemail messages). Communication requirements shall include:

A. Staff available at least 8 hours a day during normal business days for inbound calls regarding utilization management issues.

B. Ability of staff to receive inbound communication after normal business hours regarding utilization management issues.

C. Out bound calls regarding inquiries about utilization management during normal business hours, unless otherwise agreed upon.

D. Staff identifies themselves by name, title and organization name when initiating or returning calls regarding utilization management issues.

E. A toll-free number or a staff who accepts collect calls regarding utilization management issues.

F. Access to staff for callers with questions about utilization management process.

G. TDD/TTY services for deaf, hard of hearing or speech-impaired members.

H. Language assistance for members to discuss utilization management issues as described in AZPC communication services and availability will also be posted on AZPC's website.

AZPC will maintain written policies and procedures regarding the above communication requirements and standards including, at minimum:

- The business hours during which staff are available.
- Instructions for obtaining specific information about a request.
- Instructions for faxing or leaving a voicemail message outside of business hours that prompt members and practitioners to provide contact information for responses by the Utilization Management staff on the next business day.
- Instructions on how out-of-area callers can obtain information.

In accordance with AZPC's privacy and information security policies, as well as all state and federal regulations regarding use and disclosure of PHI, all providers, practitioners, and AZPC staff with access to patient information must maintain the confidentiality of member information and records in the course of any written, verbal or electronic communications.

UM 4: APPROPRIATE PROFESSIONALS

AZPC requires that only qualified licensed health professionals:

1. Assess the clinical information used to support utilization management decisions;
2. Supervise all medical necessity decisions; and
3. Review denials of care based on medical necessity.

The healthcare professionals who provide medical necessity review will have the education, training or professional experience in medical or clinical practice and shall be required to have a current, unrestricted license to practice in the state of Arizona.

1. A licensed physician with a current, unrestricted license to practice in the state of Arizona will review any clinical, non-behavioral health denial based on medical necessity for covered services such as:

- Decisions about covered medical benefits, including hospitalization and emergency services listed in the Certificate of Coverage or Summary of Benefits.

- Decisions about pre-existing conditions when the member has creditable coverage and the health plan has a policy to deny pre-existing care or services.

- Decisions about care or services that could be considered either covered or non-covered, depending on the circumstances, including decisions on requests for care that the health plan may consider experimental.

- Decisions about dental procedures that are covered under the member's medical benefit. If dental and medical benefits are not differentiated in the health plan's benefits plan, the organization must identify the services or care as if there is a differentiation. This means identifying only care or services associated with medically necessary medical or surgical procedures that occur within or adjacent to the oral cavity or sinuses.

- Decisions about medical necessity for "experimental" or "investigational" services.

- Decisions about pharmacy-related requests regarding step therapy or prior authorization cases.

2. When delegated, a behavioral health practitioner will review any behavioral healthcare denial of care based on medical necessity.

3. Board certified physician consultants may be used, as needed, to assist in making medical necessity determinations, such as:
    - Pharmacists: Pharmaceutical denials
    - Dentists: Dental denials
    - Chiropractors: Chiropractic denials
    - Physical therapists: Physical therapy denials

4. Staff members who are not qualified healthcare professionals may collect data for pre-authorization and concurrent review under the supervision of appropriately licensed health professionals. They may also have the authority to approve (but not to deny) services for which there are explicit criteria. Staff members who are not qualified healthcare professionals may approve or deny coverage determinations such as benefit determination, which is a denial of a requested service that is specifically excluded from a member's benefit plan and the plan is not required to cover under any circumstances (e.g., in vitro fertilization). Benefit determinations include the following:

    - Decisions about services that are limited by number, duration or frequency in the member's benefit plan.
    - Denials for extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan.
    - Decisions about care that do not depend on any circumstances, such as the member's medical need or a practitioner's order.
    - Request for personal care services.

Decisions on personal care services, such as transportation, cleaning and assistance with other Activities of Daily Living (ADL), are considered benefit determinations and are not subject to utilization management file review. However, these benefit decisions may be appealed and are

included in the scope of appeal file review.

UM staff at AZPC will be supervised by a licensed practitioner with appropriate clinical experience (e.g., physician, RN, NP or other appropriately licensed Utilization Management staff). Licensed doctoral-level clinical psychologists may oversee behavioral healthcare utilization management decisions.

All staff that provides utilization management determinations will have a current job description on file at AZPC. The job description will include the qualifications that are required, including but not limited to:

1. Education level (Masters, Doctoral, etc.)
2. Training or professional experience in medical or clinical practice
3. A current, unrestricted professional license

The Utilization Management staff or behavioral healthcare professional responsible for making a determination for approval, benefit or administrative denial or medical necessity denial must be clearly documented by use of initials, unique electronic identifier, signature or notation in the electronic record.

Compensation for individuals who review services will not contain incentives, direct or indirect. Practitioners are ensured independence and impartiality in making prior authorization decisions that will not influence hiring, compensation, termination, promotion or any other similar matters.

Practitioners, providers and staff who make utilization related decisions and those who supervise them must annually affirm the following:

- Utilization management decision-making is based only on appropriateness of care and service and existence of coverage.
- The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
- Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization.

To encourage appropriate utilization, discourage underutilization and clearly indicate that AZPC does not use incentives to encourage barriers to care and service, these affirmative statements will be distributed by AZPC annually to all members, staff, providers and practitioners involved with Utilization Management determinations.

Distribution may be accomplished by any of the following methods:

- Mailings
- Newsletters
- Email
- Published on the internet
- Included in provider/member handbooks

UM 5: TIMELINESS OF UTILIZATION MANAGEMENT DECISIONS

In accordance with AZPC's policy, AZPC will provide medical and behavioral health determinations, when delegated, and notifications for approvals and denials according to the following timeliness standards:

MEDICARE TIMELINESS (CMS):

This includes inpatient, outpatient, skilled nursing facility, residential and ambulatory care

- *Emergent: Physician available 24 hours a day, 2 hour maximum*
- *Expedited Initial Determinations: Within 72 hours of receipt of the request (includes weekends and holidays)*
- *Standard Pre-Service: As soon as medically indicated, within a maximum of 14 calendar days after receipt of the request*
- *Post-Service (retrospective) - Within 14 calendar days of receipt of the request only in instances where the claim has not been received.*

All Utilization Management determinations for Medicare Advantage members will be compliant with the timeliness standards outlined in the Utilization Management Timeliness Standard policy.

For the purpose of determining timeliness standards, "Urgent" shall mean a condition or situation that:

- Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or
- In the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Members and member representatives may request an expedited review verbally or in writing. For urgent care decisions, AZPC will allow a healthcare practitioner with knowledge of the member's medical condition (e.g. a treating practitioner) to act as the member's authorized representative. Physicians who request or support a member's request for expedited review will not encounter punitive or other disciplinary actions.

UM 6: CLINICAL INFORMATION

When AZPC receives a request from a practitioner, member or member representative for health or behavioral healthcare services, AZPC will obtain relevant clinical information and consult with the member's treating practitioner in order to make a determination of medical necessity.

In the event the reviewer believes additional information may be needed to support medical necessity, the reviewer or the reviewer designee may delay or defer the request in order to obtain the necessary information.

An authorization request may only be deferred one time. If sufficient information is not available to render a decision following one deferral, the Medical Director or designee is to contact the requesting provider directly. Documentation of this communication will be added to the prior authorization package and a decision will be rendered.

UM 7: DENIAL NOTICES

Denial of medical or behavioral health services will be managed by AZPC as follows:

- Only the Utilization Management Committee, a board certified Medical Director or a board certified and current Arizona licensed physician reviewer from the appropriate education, training, professional expertise or specialty may initiate a denial for medical necessity.

- In the event the denial is for behavioral healthcare, a psychiatrist, doctoral level clinical psychologist or certified addiction medicine specialist will review any denial based on medical necessity; however, the final denial determination may only be made by the Utilization Review Committee or a Medical Director.

- Written notification is sent to both patient and requesting provider.

- Regulatory (federal, state), plan specific or best practice (Industry Collaboration Effort) approved pre-service denial, delay, modification notification forms/letters and all pertinent inserts and attachments will be utilized to communicate determinations to members and requesting providers.

- Communications regarding decisions to approve or deny a provider's request to provide health or behavioral healthcare services must specify the services that were approved or denied.

- Communications regarding decisions to deny, delay or modify a provider's treatment request must be communicated to the affected member and requesting provider in writing, although initial communications can be made by telephone, facsimile or online notification.

- These communications must include:
  i) A clear and concise explanation of the reasons for the denial decision that is specific to the member's diagnosis, condition or situation in easy to understand language, so that the member can understand the reason for denying the service.
  ii) A description of the benefit provision, criteria or guidelines used as a basis for the decision.
  iii) Other clinical information used as a basis for a decision regarding medical necessity.

iv) Notification that the member can obtain a copy upon request of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based.
v) Information as to how the member may file a grievance with the plan and for Medicaid members, an explanation of how to request an administrative hearing.
vi) A description of the member's appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
vii) An explanation of the appeal process, including the right to member representation and appeal timeframes.
viii) A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
ix) Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.
x) Information will be included, where applicable, of the member's right to file a complaint.

- Provider notification will include the contact telephone number to reach the physician if the provider wishes to discuss the case.

- Alternative plan of care will be identified in the case of medical necessity issues.

- Only reasonable, necessary, adequate and appropriate information will be gathered and considered to make initial denial determinations.

- A tracking system for status of authorizations, denials and appeals will be maintained electronically by appropriate department.

- If AZPC delays a determination because it cannot make a decision regarding a treatment request within the required timeframe because AZPC has not received all of the information reasonably necessary and requested, or AZPC requires consultation by an expert reviewer, or AZPC has asked that an additional examination or test be performed upon the member, AZPC will immediately upon the expiration of the specified timeframe, or as soon as AZPC becomes aware that it will not meet the time frame, whichever occurs first, notify the provider and the member in writing that a determination cannot be made within the required timeframe. The notification will indicate the information needed, the expert consultation to be obtained, or the test or examination required, as well as the anticipated date on which a determination will be made.

AZPC has a written policy to allow the reopening of a denial decision if an appeal has not been filed with the health plan. Possible reasons for a reopen are as follows: Reliable evidence that the original decision was made with was procured by fraud, or a similar fault, a clerical error, new material evidence, information requested initially has been submitted. Clerical errors include human and mechanical errors on the part of the part of the Medicare health plan, such as:

- Mathematical or computational mistakes

- Inaccurate data entry
- Denials of claims as duplicates

- In the event AZPC decides to terminate approved service coverage (such as Skilled Nursing Facility (SNF), Home Health Agency (HHA), Hospice Or Comprehensive Outpatient Rehab Facility (CORF), AZPC shall provide the member with a Notice of Medicare Non-Coverage (NOMNC) no later than two days before the proposed end of the services. The NOMNC shall include:
  - the date of the member's financial liability for continued services begins;
  - a description of the member's right to an immediate appeal via the Quality Improvement Organization (QIO);
  - information about how to contact the QIO;
  - the member's right to submit evidence to the QIO; and
  - alternative appeal mechanisms if the member fails to meet the deadline for an immediate appeal.

- Should the member appeal AZPC's decision to terminate services, AZPC must provide the Detailed Explanation of Non-Coverage (DENC) , an explanation as to why the provider services are no longer reasonable or necessary or are no longer covered. The DENC shall include:
  - applicable CMS rules, instruction, or policy including citations;
  - how the member may obtain copies of such documents; and
  - other member specific facts or information relevant to the non-coverage decision in easy to understand language.

- If the QIO reverses AZPC's decision to terminate services, AZPC shall notify the Member with a new notice consistent with the QIO determination.

- Upon notification that a member has been advised that inpatient care is no longer necessary and the member has requested an immediate review of the determination, AZPC or the facility shall provide the member with a Detailed Notice of Discharge (DND) as soon as possible but no later than noon of the day after the notification. During the review process, AZPC shall ensure that all information the QIO needs to make its determination is provided, either directly (with hospital cooperation) or by delegation, no later than noon of the day after the QIO notifies the delegate that a request for an immediate review has been received from the member. The DND shall include:
  - a detailed explanation of why services are either no longer reasonable and necessary or are no longer covered in an inpatient hospital setting;
  - a description of any applicable CMS coverage rule, instruction, or other CMS policy used in this determination, including information about how the member may obtain a copy of the CMS policy, any applicable organization policy, contract provision or rationale upon which the discharge determination was based; and
  - facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case.

UM 8: POLICIES FOR APPEALS
UM 9: APPROPRIATE HANDLING OF APPEALS

AZPC is not delegated for handling member appeals. However, AZPC maintains an established, impartial process for responding timely to health plan information requests related to member appeals.

UM 10: EVALUATION OF NEW TECHNOLOGY

The Medical Director or designee may initiate a review of new technologies or new uses for existing technologies which may be requested by a health plan, provider or member. The UMC or committee member designee will review all recommendations for new technologies or changes to existing technologies. Review will include at least a review of government standards, medical literature or other sources and be reviewed by the appropriate specialty physicians and health plan. All necessary parties will be notified at least 24 hours prior to implementation of new technologies.

New technologies may include, but are not limited to:

- Medical procedures
- Behavioral healthcare procedures
- Pharmaceuticals
- Devices

UM 11: EXPERIENCE WITH THE UTILIZATION MANAGEMENT PROCESS

AZPC will assess the member and provider satisfaction with the UM process by utilizing surveys designed to document positive and negative experiences of members and providers.

The surveys will include indicators to measure satisfaction with the UM Program. Opportunities for improvement will be identified and corrective action(s), as appropriate, will be taken.

Results of patient satisfaction and physician satisfaction Utilization Management surveys performed by the contracted provider groups will be analyzed at least annually by the UMC.

UM 12: EMERGENCY SERVICES

Emergency services are available to members 24 hours a day, 365 days a year. Emergency services shall consist of:
Emergency service providers, acting as an authorized representative on behalf of AZPC, shall:

- authorize the provision of emergency services

- screen and stabilize the member without prior approval, where a prudent layperson acting reasonably, would have believed that an emergency medical condition existed.

It is AZPC's standard procedure to approve all ED visits unless clearly evident that the member has a history of abusing ED prudent layperson rights by using the ED for routine/non emergent services during hours when their Primary Care Physician is available via office visit or phone call.

AZPC may deny emergency ancillary services based on medical necessity, retrospectively, after medical review by AZPC's physician reviewer. Claims for non-emergent care may be denied retrospectively but the member will not be billed for these services.

AZPC will not deny emergency services based on medical necessity. Claim for non-emergent care may be denied retrospectively.

AZPC will sign annual attestations confirming non-denial of emergency services as appropriate.

UM 13: PROCEDURES FOR PHARMACEUTICAL MANAGEMENT

AZPC is not delegated for pharmaceutical management.

UM 14: TRIAGE AND REFERRAL FOR BEHAVIORAL HEALTHCARE

AZPC is not delegated for triage or referral functions for behavioral healthcare services.

UM 15: DELEGATION OF UTILIZATION MANAGEMENT

AZPC does not delegate UM responsibilities. AZPC develops and/or adopts all operational programs, work plans and policies, including but not limited to:

- Adopting criteria
- Monitoring the quality and timeliness of decisions
- Pre-service decisions by service
- Urgent concurrent review and decisions
- Post-service review and decisions by service
- Approvals and denials
- Assessing member and practitioner satisfaction of Utilization Management
- Evaluating new technology