Arizona Priority Care™

One Goal. One Priority. Your Healthcare.

BEHAVIORAL HEALTH

UTILIZATION MANAGEMENT PROGRAM

2019

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PHILOSOPHY

The philosophy of Arizona Priority Care (AZPC), through the Utilization Management program is to facilitate clinically sound and medically necessary behavioral health resources to its members.

UM 1: UTILIZATION MANAGEMENT STRUCTURE

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

The AZPC BH Utilization Management Program is designed to facilitate the following services:

1. Case Management
2. Utilization Management
3. Efficient, effective, and medically necessary healthcare
4. Resource management
5. Member and provider experience
6. Provider orientation and education regarding utilization

AZPC shall participate in a policy setting and interactive educational role. AZPC ensures that systems and resources for behavioral health can meet the medically necessary behavioral healthcare and service demands of the population served in a quality based and cost effective manner. The AZPC BH UM Program will ensure compliance with regulatory and accreditation agency standards. AZPC BH UM Program will provide appropriate data collection and reporting to meet the needs of all constituents.

All BH UM decision-making will be based on medically necessary care and service.

Annually, AZPC will fax blast a notification of online availability of the approved BH UM Program within 30 calendar days, and as needed for changes, of UM committee approval to all AZPC contracted providers to ensure that all are advised of the AZPC BH UM requirements.

PROGRAM OVERSIGHT

Governing Body

The AZPC Executive Committee (Governing Body) shall have authority and responsibility for the AZPC BH UM Program. It shall provide oversight in the establishment and maintenance of an effective and efficient BH UM program. The Executive Committee will ensure that all contracted providers comply with all aspects of the BH UM Program. The UM Committee will review, evaluate, and make any necessary revisions to the UM Program annually at a minimum. The structure and responsibilities of the UM Committee are outlined in the AZPC UM Program 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 AZPC Executive Committee. The UMC will meet at least quarterly to review, evaluate, and provide Executive Committee with recommendations for revisions to the UM Program.

Minutes and records are kept of all UMC activities for which the UMC is responsible. Such materials are considered confidential and kept in a designated secure area at AZPC and are only available to the appropriate staff, auditors or designees for annual review or follow up. Each attendee, including guests, at each Committee meeting will sign confidentiality and a conflict of interest statement.

The composition of the UM Committee shall include but is not limited to:

1. AZPC Chief Medical Officer
2. AZPC Medical Director(s)
3. Director of Clinical Services Operations
4. Director of Care Coordination
5. Director of Quality, Credentialing, and Compliance
6. Behavioral Health Practitioner
7. Other clinical staff as appropriate,
8. Additional personnel and technical experts as requested by the UM Committee or Executive Committee

The UM Committee responsibilities shall include:

1. Review and approval of the UM Program annually and as needed
2. Review of regular UM reports
3. Evaluate UM activities to ensure they are being conducted in accordance with AZPC'S expectations, health plan, and regulatory standards
4. Ensuring all member information remains confidential and protected from unauthorized dissemination

Designated Physician

AZPC shall employ, contract or designate a Medical Director who holds an Arizona unrestricted license to practice medicine issued pursuant to Arizona Revised Statute (ARS);32-1421 – 32-1439.

The Medical Director is fully credentialed and serves as the designated physician who is involved in BH UM Program development, evaluation, and provides clinical oversight of all UM activities, supports the various committees, staff, resources, and makes recommendations based on clinical care and administrative data. The Medical Director shall be available for assistance with member behavioral health UM procedures and processes, complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health UM statistical data, follow-up on identified issues, and attend UM and QI committee meetings.

PROGRAM SCOPE AND PURPOSE

Behavioral Health Utilization Review Program Responsibilities

AZPC will develop policies and procedures that are utilized to support UM decisions. AZPC policies and

procedures meet all state, federal, and regulatory requirements such as CMS and NCQA. Medical decisions are to be made by credentialed, qualified medical providers, unhindered by fiscal and administrative management using objective criteria based on medical evidence.

Medical decisions will be in accordance with AZPC approved UM Program description and will be supported by including evidence of coverage and benefit limitations as well as approved clinical criterion, and in accordance with all state and federal regulations by the following:

1. A senior licensed physician or doctoral-level clinical psychologist will provide clinical oversight to all UM staff responsible for making UM determinations.
2. Licensed physician reviewers may approve, modify, delay, and/or deny any services based on medical necessity and benefit coverage.
3. Licensed nurse reviewers may approve services, deny benefit driven services, and provide input to physician reviewers for medical necessity denials.
4. Non-clinical UM 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 AZPC 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.

All BH UM information must be kept on file for at least 36 months.

Program Goals and Objectives

The BH UM Program will be implemented as directed by the UMC. The goal of the BH UM Program is to ensure that BH network practitioners provide medically necessary care in the most cost-effective manner.

1. To evaluate the utilization of services, member benefits and resources related to the provision of care by reviewing requests for services, conducting concurrent review and discharge planning as needed retrospective review, and care management.
2. To ensure that all members receiving inpatient, partial hospitalization program (PHP), intensive outpatient program (IOP), and outpatient (OP) care will have a completed continuity-of-care plan developed prior to safe discharge to a lower level of care.
3. To encourage effective, efficient use of services and resources through communication and education of employees, providers, members, and their families.
4. To ensure all practitioners and UM reviewers have access to and are utilizing the most current criteria, guidelines, and policies as approved by the UM Committee.
5. To develop systems to ensure that criteria and physician/non-physician reviewer decisions are applied consistently and that services delivered are medically necessary and aligned with the member's diagnosis and level of care required.
6. To monitor and improve the coordination of medical and behavioral healthcare.
7. To identify and care coordinate members with complex healthcare needs across the continuum of community and facility-based services with the goal to facilitate health promotion, risk reduction, and prevention of illness complications.
8. To communicate and interact effectively with the primary care physicians, specialists, and other contracted ancillary providers by various methods to include, but not limited to electronic, written and verbal correspondence, and education forums.
9. To work in conjunction with the Quality Improvement Committee to refer those issues which require a quality review.

10. To recommend and develop Corrective Action Plans (CAP), if found necessary, to improve practice or system issues.
11. To identify utilization issues within the UM process and use a continuous quality improvement process to develop interventions to address issues identified.
12. To ensure a process by which members and practitioners are informed of their rights and the process to appeal a determination.

AZPC BH UM Program achievements will be measured by the following;

1. Evaluation of UM work plans, annual program evaluation and other utilization activity reports
2. AZPC UM Committee will routinely review and monitor the services that are provided by the BH UM staff

Concurrent Hospital Review

1. Performed daily by BH UM/Care Managers while the member is hospitalized in the acute hospital setting.
2. Care Managers, social services designee, discharge planner, inpatient physicians, and Medical Director will review as necessary to determine medical necessity of continued stay, level of care, intensity of service, diagnostic studies, treatment plans, identifying barriers to discharge, and the quality of care being rendered.
3. Referral to outpatient care management, as appropriate.
4. Documentation of review will be maintained in the member's electronic record.
5. Care shall not be discontinued until the member's treating provider has been notified of the decision and a care plan has been agreed upon by the treating provider that is appropriate for the needs of that patient.

Retrospective Review – Hospitalizations

1. Appropriateness of admission and disposition
2. Severity of illness and intensity of service
3. Patient outcome
4. Proper documentation
5. Complications of patient care
6. Appropriateness of the length of stay
7. Delays of service

Emergency Room

Services necessary to screen, stabilize, and transport members do not require preauthorization of emergency services in cases where a prudent layperson, acting reasonably would have believed that an emergency medical condition exists.

Retrospective claims, primarily consisting of emergency room services, are reviewed only in an effort to track utilization criteria for improved patient care and/or PCP availability to patient population. The designated personnel consisting of claims reviewer/auditor with involvement of clinical staff as needed will do review on this level.

Post Stabilization Transfer

No person needing emergency services and care may be transferred for any non-medical reason unless certain conditions are met including, but not limited to, 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.

Prospective and Retrospective Review - Outpatient Services

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

1. Medical indication for referral.
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

Out of Network / Non-Contracted Provider Referrals

Contracted providers will be utilized whenever possible. If a contracted provider is not available, then a referral 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 (upon request) will be generated prior to the patient's visit or as soon as reasonably possible as not to delay care. All out of network or non-contracted provider referrals will be reviewed by the Medical Director or designee.

Behavioral Health Care Review

AZPC BH UM requires that:

1. Only licensed practitioners make decisions that require clinical judgment.
2. Staff that make clinical decisions are supervised by a minimum of a licensed master's level clinician with five years of post-master's clinical experience.
3. A licensed psychiatrist or a licensed doctoral-level clinical psychologist will oversee triage and referral decisions.
4. Protocols for behavioral healthcare triage and referral 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 necessary.
5. The designated behavioral healthcare practitioner will;
    a. Be involved in the implementation of the behavioral healthcare aspects of the UM program and policy development;
    b. Participate in UM Committee meetings; and
    c. Review behavioral health UM cases as needed.

Second Opinions

Member's request for a second opinion from a qualified health care professional in the health plan or AZPC network will be covered at no cost (with the exception of standard copays and deductibles, and as delegated at risk) to the member.

A member's request for a second opinion with a contracted, qualified health professional will not be denied. Requests for second opinions by a non-contracted provider will be reviewed for availability of a contracted qualified health professional prior to referral to the contracted heath plan for consideration.

Reporting Requirements

1. Annual Initial Work Plans - AZPC will complete and submit an annual BH UM initial work plan to the AZPC UM Committee by February of each new calendar year. The annual work

plan is to include:

a. UM 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 and recommendations including a target date for completion and responsible party.

2. Quarterly Work Plan Evaluations – AZPC will update and submit a quarterly work plan to the AZPC UM Committee based on regulatory and plan contracting requirements. Quarterly work plan updates include;
   a. UM activities completed
   b. The organization's performance in UM trends
   c. An analysis of whether there have been any demonstrated improvements in the utilization management 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 - Based on regulatory and plan contracting requirements for all UM reports will be submitted timely per the UM Submissions Calendar provided by the contracted health plan.
4. Final Work Plan Evaluation: - AZPC will complete and submit a final work plan evaluation to the AZPC UMC by February of each new calendar 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 AZPC BH UM's attainment of written goals and any additional strategies and clarifications

UM 2: CLINICAL CRITERIA FOR BH UM 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 will maintain a list of national evidence based guidelines adopted by the organization from the health plan(s), evidence based literature searches, and other evidence based sources (all sites will be cited). 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, complications, progress of treatment, psychosocial situation, and home environment, when applicable.

Review materials may include, but are not limited to:

1. McKesson®InterQual
2. Milliman® Care Guidelines
3. United States Preventative Services Task Force (USPSTF)
4. American Psychiatric Association Guidelines
5. Policy and Procedure Manual(s) from each contracted Health Plan
6. Availability of SNF, sub-acute or Home Care in service area;
7. Coverage of benefits
8. Availability of local hospitals to provide recommended services within the appropriate length of stay (LOS).

9. Additional sources of data and information (i.e. Literature searches, conversations and/or consultations with appropriate physicians/specialists, review of patient medical records. etc.)
10. Quality Screens and outpatient Care Management activities triggered by utilization review.

The approved and adopted clinical guidelines, criteria or medical policies will be applied as indicated for Medicare Advantage members:

1. Plan Eligibility and Coverage (benefit plan package_
2. CMS Criteria
    a. National Coverage Determination (NCD)
    b. Local Coverage Determination (LCD)**
    c. Local Coverage Medical Policy Article**
    d. Medicare Benefit Policy Manual
    e. CMS General Coverage Guidelines
3. The Social Security Act
4. Health Plan criteria (e.g. Coverage Summary, Medical Policy)
5. Evidence-based criteria (e.g. McKesson InterQual, USPSTF, AHA/ACC, American Imaging Management, Milliman, NIA, etc.)
6. Other evidence-based resources such as Hayes or evidence based literature

***Per CMS Chapter 13; 13.5, LCD **MUST** be within the local jurisdiction.*

AZPC will utilize reports and Care Management services to ensure that practitioners assist with a member's transition to the appropriate levels of care.

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

Annual Review of Criterion

1. Materials are reviewed, approved, and/or updated/modified as needed. This review shall occur a minimum of one time annually.
2. Only appropriate clinical and behavioral health practitioners with relevant experience are involved in the development, adoption, and reviewing of the criteria.
3. Criterion complies with Medicare local and national coverage determinations and relevant requirements.
4. Upon final approval, all materials are made available to UM staff.

Availability of Criteria, Guidelines, Policies

Upon request, AZPC will make available all criteria, clinical review guidelines, and medical review policies utilized for decision making to members and practitioners.

Additionally, all criteria, guidelines, and policies utilized will be maintained and made available to the AZPC staff and health plan upon request.

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 (IRR) audits will be conducted at least annually by AZPC.

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

At a minimum, the IRR 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 referral 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 UM criteria or benefit provision was applied.
6. There was appropriate referral to the Medical Director.

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 UM criteria or benefit provision was applied.
4. Disposition of patient is documented
5. There was appropriate referral to the Medical Director.
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 records shall be reviewed by an independent physician to ensure determinations are made based on adopted clinical guidelines against the following criteria:

1. The case was approved or denied with appropriate UM criteria applied.
2. The case was pended, if applicable, and determination was made within required timelines.
3. There was sufficient clinical documentation to support the decision.
4. Physician review was clearly documented.

These results must be presented to the AZPC UM Committee for review and discussion. As applicable, the AZPC UM Committee will act on opportunities to improve consistency in applying criteria. Corrective action shall be implemented for any reviewer not meeting the established benchmark of 80% in any category. Results of such surveys shall be documented by AZPC on the work plan and will subsequently be reviewed by the AZPC on 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 UM and QI Committees, as needed.

UM 3: COMMUNICATION SERVICES

AZPC will ensure that staff, members and practitioners, seeking information about the UM process will be provided access to the appropriate information. 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:

1. Staff available at least 8 hours a day during normal business days for inbound calls regarding UM issues.
2. Ability of staff to receive inbound member and provider communication after normal business hours regarding UM issues.
3. Out bound calls regarding inquiries about UM during normal business hours, unless otherwise agreed upon.
4. Staff members identify themselves by name, title and organization name when initiating

or returning calls regarding UM issues.
5. A toll-free number or a staff who accepts collect calls regarding UM issues.
6. Access to staff for callers with questions about UM process.
7. TDD/TTY services for deaf, hard of hearing or speech-impaired members.
8. Language assistance for members to discuss UM issues as described in the Clinical Services Communication policy. Availability of UM staff will also be posted on the AZPC website.

AZPC will maintain written policies and procedures regarding the above communication requirements and standards. Additionally, provider information will include, at minimum:

1. The business hours during which staff are available.
2. Instructions for obtaining specific information about a request.
3. Instructions for faxing or leaving a voicemail message outside of business hours that prompt members and providers to leave contact information for responses by the UM staff on the next business day.
4. Instructions on how out-of-area callers can obtain information.

Providers, practitioners, and all 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. This is in accordance with AZPC privacy and information security policies as well as all state and federal regulations regarding use and disclosure of PHI.

UM 4: APPROPRIATE PROFESSIONALS

AZPC requires that only qualified licensed health professionals:

1. Assess the clinical information used to support BH UM decisions
2. Supervise all medical necessity decisions
3. 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.
4. Staff members who are not qualified healthcare professionals may collect concurrent review data for medical necessity determinations under the supervision of appropriately licensed health professionals. Staff members who are not qualified healthcare professionals may approve or deny coverage determinations such as:
    a. A benefit determination that is a denial of a requested service that is specifically excluded from a member's benefit plan, which the plan is not required to cover under any circumstances (e.g., in vitro fertilization). Benefit determinations include the following.
        i. Decisions about services that are limited by number, duration, or frequency in the member's benefit plan.
        ii. Denials for extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan
        iii. Request for personal care services

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

All staff members who provide UM determinations will have a current job description on file with AZPC. The job description will include the qualifications that are required, including but not limited to:

1. Education level (Masters, Doctoral)
2. Training or professional experience in medical or clinical practice.
3. A current license to practice without restriction.

The identity of UM staff or behavioral health care professional responsible for making UM determinations must be clearly documented by use of initials, unique electronic identifier, signature or notation in the electronic record.

Affirmative Statement

Compensation for individuals who review service requests will not contain direct or indirect incentives, Practitioners, providers and staff who make utilization related decisions and those who supervise them must annually affirm the following:

UM decision making is based only on appropriateness of care and service and existence of coverage.

1. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
2. There are no financial incentives for UM decision makers to 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, affirmative statements that incentives are not utilized is available online for all members, staff, providers, and practitioners involved with UM determinations. Distribution may include but not limited to:

1. Mailings
2. Newsletters
3. Email
4. Published on the internet
5. Included in provider/member handbooks

UM 5: TIMELINESS OF UM DECISIONS

In accordance with AZPC policy, AZPC will provide behavioral health determinations according to the following timeliness standards

MEDICARE TIMELINESS (CMS):

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

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

All UM determinations for Medicare Advantage members will be compliant with the timeliness standards outlined in the UM Timeliness Standards policy.

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

1. 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
2. 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 provider, member, or member representative for behavioral health care services, AZPC will obtain relevant clinical information and consult with the member's treating practitioner in order to make a determination of medical necessity.

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

1. Office and hospital records
2. History of the presenting problem
3. Clinical exam
4. Diagnostic testing results
5. Treatment plans and progress notes
6. Patient psychosocial history
7. Information on consultations with the treating practitioner
8. Evaluations from other health care practitioners and providers
9. Rehabilitation evaluations
10. Criteria related to the request
11. Information regarding benefits for services or procedures
12. Information regarding the local delivery system
13. Patient characteristics and information
14. Information from designated responsible family members

UM 7 DENIAL NOTICES

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

1. Only the UM Committee, a Medical Director with an unrestricted license in Arizona, or a board certified and current Arizona licensed physician reviewer with the appropriate education, training, professional expertise or specialty may initiate a denial for medical necessity.
2. 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 UM Committee or a Medical Director.
3. Written notification is sent to both member and requesting provider.
4. Regulatory, health 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.

5. Communications regarding decisions to approve or deny a provider's request to provide behavioral healthcare services must specify the services that were approved or denied.
6. Communications regarding decisions to deny, delay, or modify a provider's treatment request must be communicated to the member and requesting provider in writing, although initial communications can be made by telephone, facsimile, or online notification.
7. These communications must include:
    a. 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.
    b. A description of the benefit provision, criteria, or guidelines used as a basis for the decision.
    c. Other clinical information used as a basis for a decision regarding medical necessity.
    d. 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.
    e. 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.
    f. A description of the member's appeal rights, including the right to submit written comments, documents or other information relevant to the appeal.
    g. An explanation of the appeal process, including the right to member representation and appeal timeframes.
    h. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials.
    i. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.
    j. Information will be included, where applicable, of the member's right to file a complaint.
8. Provider notification will include the contact telephone number to reach the physician if the provider wishes to discuss the case.
9. Alternative plan of care will be identified in the case of medical necessity issues.
10. Only reasonable, necessary, adequate, and appropriate information will be gathered and considered to make initial denial determinations.
11. A tracking system for status of authorizations, denials, and appeals will be maintained electronically by appropriate department.
12. 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, or information requested initially has been submitted. Clerical errors include human and mechanical errors on the part of the part of AZPC, such as:

1. Mathematical or computational mistakes

2. Inaccurate data entry
3. 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), or Comprehensive Outpatient Rehab Facility (CORF), the member will be issued a Notice of Medicare Non-Coverage (NOMNC) no later than two days before the proposed end of the services. The NOMNC shall include:

1. The date of the member's financial liability for continued services begins
2. A description of the member's right to an immediate appeal via the Quality Improvement Organization (QIO)
3. Information about how to contact the QIO
4. The member's right to submit evidence to the QIO
5. 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:

1. Applicable CMS rules, instruction, or policy including citations
2. How the member may obtain copies of such documents
3. 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:

1. Detailed explanation of why services are either no longer reasonable and necessary or are no longer covered in an inpatient hospital setting
2. 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
3. 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

AZPC maintains an established, impartial process for resolving members' disputes and responding to member requests to reconsider a medical and/or behavioral health decision they find unacceptable regarding their care and service as outlined in AZPC UM Appeal policies. When applicable, the member will be provided information regarding their right to continued coverage under their medical and/or behavioral health benefit pending the outcome of an internal appeal.

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

When delegated, 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 AZPC UM Committee 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:

1. Medical procedures
2. Behavioral healthcare procedures
3. Pharmaceuticals
4. Devices
5. Therapies
6. On line interventions

UM 11: PROCEDURES FOR PHARMACEUTICAL MANAGEMENT

AZPC is not delegated for pharmaceutical management.

UM12: TRIAGE AND REFERRAL FOR BEHAVIORAL HEALTHCARE

Triage and referral (T&R) functions for behavioral healthcare services are provided via direct access to the behavioral health provider. Protocols maintained by AZPC address relevant mental health and substance abuse situations, the level of urgency, and the appropriate care setting and treatment. AZPC'S protocols are reviewed and updated a minimum of every two years. A licensed psychiatrist or a licensed doctoral-level clinical psychologist will oversee triage and referral decisions. AZPC maintains a 24-hour crisis hotline for staff to assess the level of care, urgency of response, and type of practitioner needed prior to arranging an appointment.

UM 13: EXPERIENCE WITH THE UM PROCESS

AZPC will assess member and provider experience 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 BH UM processes. Opportunities for improvement will be identified and correction action(s) will be taken if necessary. Results of member and provider experience surveys performed will be analyzed at least annually by the AZPC UMC.

UM 14: 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:

1. Adopting criteria
2. Monitoring the quality and timeliness of decisions
3. Pre-service decisions
4. Urgent concurrent review and decisions
5. Post-service review and decisions
6. Approvals and denials
7. Assessing member and provider satisfaction of Utilization Management
8. Evaluating new technology