Arizona Priority Care™

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UTILIZATION MANAGEMENT PROGRAM

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Contents

PHILOSOPHY

Arizona Priority Care's (AZPC) Utilization Management (UM) Program provides the structure and standards that govern utilization management functions. In addition, the Program provides a structure to monitor the efficiency and quality of UM services and includes components to ensure the delivery of quality health care and the coordination of resources to manage members across all aspects of the care delivery system. The UM Program, in conjunction with AZPC policies and procedures, meet federal, state, and accreditation requirements including those from the Centers for Medicare and Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA).

UM 1: UTILIZATION MANAGEMENT PROGRAM STRUCTURE

AZPC has the UM infrastructure necessary to provide ongoing monitoring and evaluation of UM activities to address over and underutilization, coordinate medical resources, support continuum-based care management activities, and maintain a systematic process for the education of AZPC and its staff and providers regarding UM. AZPC will make utilization decisions affecting the health care of its members in a fair, impartial and consistent manner that is aligned with individual member needs.

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 fax blast a notification of online availability of 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 UM pre-service determinations such as:

1. Ambulatory
2. Inpatient
3. Skilled Nursing
4. Home Health

5. Rehabilitative Services (such as physical, occupational and speech therapies)
6. Pharmaceuticals (medical based), when delegated
7. Medical Equipment and/or Supplies
8. Behavioral Health

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

1. Emergency
2. Family Planning and Sensitive Services
3. Preventive Services (including immunizations)
4. Basic Prenatal Care (in-network)
5. Sexually Transmitted Disease Services
6. HIV Testing/Counseling
7. Language Assistance Programs/Interpretation services
8. 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.

Behavioral Health

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.

PROGRAM OVERSIGHT

Governing Body

Arizona Priority Care's Executive Committee shall have ultimate authority and responsibility for the UM Program. The Executive Committee will establish and maintain an effective and efficient UM Program, and will ensure that AZPC's providers receive and comply with all aspects of the UM Program.

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

AZPC's Utilization Management Committee (UMC) reports to the Executive Committee at least semi-annually. Any ad-hoc committees or sub-committees of the UMC will report to the Executive Committee via the UMC.

The UMC will meet at least four times per year to review, evaluate and provide the Executive Committee with any recommendations for revisions to the UM Program. For urgent issues that require immediate updating, these will be addressed separately via ad-hoc committee meetings (either virtual or in person) utilizing appropriate practitioners (three (3) physicians across primary care and/or specialties) and/or subcommittee.

Minutes and records are kept of all activities for which the UMC is responsible and materials are considered confidential. Such materials may be made available as required to appropriate staff, or representatives from a contracted health plan, regulators, or accrediting agencies.

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

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 required.

The composition of the UMC shall include, but is not limited to:

- AZPC's designated Senior-Level Physician , or designee
- Medical Directors
- Vice President of Clinical Services
- Senior Director of Clinical Services
- Associate Director of UM Operations
- Director of Quality
- A minimum of one (1) practicing network physician
- Additional personnel from AZPC may participate in the UMC as determined to be appropriate but are not considered voting members of the UMC
- Other AZPC Clinical Services staff as appropriate

The responsibilities of the UMC shall include but are not limited to:

- Overseeing the appropriateness of health care delivery and member and provider satisfaction with the UM Program Reviewing, revising, and approving of the UM Program and policies and procedures annually, and more frequently as needed
- Review of utilization reports
- Evaluating AZPC's activities to ensure they are being conducted in accordance with expectations and regulatory, accreditation, and policy standards
- Ensuring all member information is confidential and protected from unauthorized dissemination
- Reviewing regular reports which may include but are not limited to:
  - Over-utilization
  - Under-utilization
  - Volumes and dispositions of authorization requests
  - Behavioral healthcare
  - Hospitalizations and other inpatient admissions
  - Case Management
  - Emergency room, ambulance, and urgent care usage
- Identifying opportunities for quality improvement

Designated Senior-Level Physician

AZPC shall employ or designate a senior-level physician (medical director, associate medical director, or equivalent) who holds an unrestricted license to practice medicine in the state of Arizona.

This individual is responsible for implementation, supervision, and oversight of the UM Program as well as being involved in UM activities, setting (as applicable) and adhering to the UM Policies, supervising program operations, reviewing UM cases, participating on the UMC, and evaluating the overall effectiveness of the UM Program.

The Senior-Level physician shall ensure that the process by which AZPC review and approves, modify, or deny requests prior to, retrospectively, or concurrent with, the provision of health care services to members, based in whole or in part on medical necessity or on benefit coverage, complies with regulatory, accreditation, and policy requirements.

Designated Behavioral Healthcare Practitioner

When delegated, AZPC may contract with but not delegate UM 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 will employ clinical (including licensed physicians and nurses), administrative reviewers (i.e. foreign medical graduates) and non-clinical staff in the UM Department to execute UM activities. AZPC's designated senior-level physician (described above) who holds an unrestricted license to practice medicine in the state of Arizona shall provide primary oversight of the UM Department.

Effective April 10, 2019, the State of Arizona recognizes equivalent occupational or professional licenses from all other states within the United States, pursuant to requirements listed in Arizona HB 2569 – A.R.S. 32-4302 Out-of-state applicants; residents; military spouses; licensure; certification; exceptions

AZPC's UM Department is responsible for executing functions within the scope of AZPC's UM Program, including but not limited to reviewing requests for authorization prior to, retrospectively, or concurrent with the provision of health care services to members in accordance with turn-around time requirements as outline in the policy.

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

AZPC will have a process for assigning a licensed Care Manager to each CMC enrollee. Assignment will be made to a Care Manager with the appropriate experience and qualifications based on a member's assigned risk level and individual needs. AZPC will ensure an adequate ratio of licensed Care Managers to members to provider Care Coordination as required. AZPC will monitor the ratio of licensed Care Managers to members on a regular basis.

PROGRAM SCOPE AND PURPOSE

Utilization Management Program Responsibilities

An AZPC Senior-level Medical Director 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. A Senior-level licensed physician will supervise all UM staff responsible for making UM determinations.
2. Licensed physician reviewers may approve or deny any services based on benefit coverage and medical necessity.
3. Administrative reviewers (i.e., foreign medical graduates) may approve any services, deny benefit only driven services, and provide guidelines, criteria, and details to physician reviewers for medical necessity review.
4. Licensed nurse reviewers may approve any services, deny benefit only driven services and provide guidelines, criteria, and details to physician reviewers for medical necessity review.
5. Non-clinical staff may verify benefit coverage, retrieve information necessary for clinical review, approve limited services as assigned and deny benefit only driven services as assigned.
6. The Medical Director will be responsible for all final decisions to deny any and all services based on medical necessity.
7. Determinations of coverage and medical necessity for behavioral health services will include involvement of a behavioral health practitioner, when delegated for behavioral health services.

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:

1. Office and hospital records
2. A history of the presenting problem
3. A 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 healthcare practitioners and providers
9. Photographs
10. Operative and pathological reports
11. Rehabilitation evaluations
12. A printed copy of criteria related to the request
13. Information regarding benefits for services or procedures
14. Information regarding the local delivery system
15. Patient characteristics and information
16. 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 UM 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 UM Committee (UMC). The goal of the UM Program is to ensure that AZPC practitioners provide quality 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 prior to authorization, conducting concurrent review, discharge planning, retrospective review, and providing care management.
2. 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.
3. To encourage effective, efficient use of services and resources through communication and education of employees, providers, patients, 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 AZPC UMC.
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 consistent with the patient's diagnosis and level of care required.
6. To monitor and improve the coordination of medical and behavioral healthcare, when delegated.
7. 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.
8. To communicate and interact effectively with the primary care physicians, specialists and other contracted services through committee meetings, newsletters, verbally, written correspondence, and education forums.
9. To work in conjunction with the Quality Improvement Committee (QIC) in referring those issues which require a quality interface/review.
10. To develop Corrective Action Plans (CAPs) or Quality Improvement Plans (QIPs), if necessary, to improve practice or system issues.

11. 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.
12. 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.
13. To ensure a process by which members and practitioners are informed of their rights and the process to appeal a determination.
14. To ensure the QI and UM Departments interface appropriately to maximize opportunities for QI activities.

The Utilization Management (UM) Department frequently identifies potential risk management, quality of care issues, and health education needs through care management, inpatient review, utilization review, referrals, etc. The UM Department can refer these cases to the QI Department in addition to any issues concerning access and availability, member or provider experience issues, and any other concern or activity requiring input, collaboration, and resolution between the UM and QI Departments. These issues are presented and discussed with the QIC to identify findings, barriers, and provide recommendations for resolution and action plans. The QI Department can refer cases to the UM Department for active care management of members with identified chronic conditions. UM Program achievements will be measured by the UMC through the evaluation of the UM work plan, annual program evaluation and other utilization activity reports.

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

Prospective Hospitalization Review

1. Necessity of admission determined according to applicable review criteria.
2. Appropriateness of workup on all elective cases by the Medical Director or designee.
3. Assign a specific number of days, when applicable
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. Prospective review of psychiatric and substance abuse admissions are conducted daily by the Medical Director and/or designee with involvement of behavioral healthcare professional(s), when delegated.
8. Referral to Behavioral Health Assessment Team/disease management, where available, when appropriate.

Concurrent Hospital Review

1. Performed seven days a week by Care Managers
2. Concurrent review of hospital admissions and observation stays are conducted by Care Managers and discussed with the Medical Director or designee for medical necessity and severity of illness to determine level of care, identify barriers to discharge and the quality of care being rendered.
3. Concurrent review of psychiatric and substance abuse admissions are conducted by Care Managers and/or designee with involvement of a behavioral health professional, when delegated.
4. Referral to Complex Case Management, (high risk), Telephonic, (Basic case management, Care coordination, Transitional Care), Palliative Care or other AZPC

Clinical Services Program, when appropriate.
5. Documentation of review will be maintained by the Clinical Services Department.

Retrospective Review - Hospitalizations

Review of inpatient admissions for:

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/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.

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.

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

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.

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

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.

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 are 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:
    i. Be involved in the implementation of the behavioral healthcare aspects of the UM Program and policy development;
    ii. Participate in UMC meetings; and
    iii. Review behavioral health UM cases as needed.

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 healthcare professional.
2. Requests for second opinions by a non-contracted provider will be reviewed for availability of a contracted qualified healthcare professional prior to issuing authorization to the non-contracted provider.
3. AZPC is responsible for coordination of care with a non-contracted provider if an in network provider is not available within the members service area, per the CMS time/distance requirements for the requested specialty and county designation.

Over and Under-Utilization Review of Services

The AZPC UMC 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 UMC will allow sufficient time to elapse prior to evaluating effectiveness of the corrective action(s). Comparisons will be made with the previous findings.

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 year.
    a. The Annual Initial Work Plan is to include:

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

2. Work Plan Evaluations – AZPC will update and submit a work plan to the UMC at least semi-annually. Based on regulatory and plan contracting requirements, work plan evaluations are due to the UMC by February 15th, May 15th, August 15th, and November 15th, unless otherwise noted. Work plan updates must include:
   a. UM activities completed
   b. The organization's performance in UM 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. ODAG, Part C Reporting, ESRD Log, etc.)
4. 1st Semi-Annual report - AZPC will complete and submit to the UMC by August 15th.
5. Final Work Plan Evaluation/2nd Semiannual report - AZPC will complete and submit a final work plan evaluation to the UMC by February 15th of each year.

The final annual 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 written criteria based on sound clinical evidence to make utilization decisions, and specifies procedures for appropriately applying the criteria. AZPC's policies and procedures addressing the application of objective and evidence-based criteria in evaluating the necessity of medical, behavioral healthcare, and pharmaceutical services requiring approval. Criteria are applied taking into account individual circumstances and the member needs (such as age, comorbities, complications, progress of treatment, psychosocial situation, and home environment) as well as an assessment of local delivery systems and the ability of such systems to meet members' specific needs including but not limited to.

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.

The approved and adopted clinical guidelines, criteria or medical policies will be applied as follows:

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, eviCore, MCG, etc.)
6. Other evidence-based resources and literature available per AZPC policy "Medical Necessity in Absence of Policy", a non-exclusive list of specialty resources

** *LCD **MUST** be within the local jurisdiction*.

Annual Review of Criteria

1. Materials are reviewed, approved and/or updated/modified as needed but not less than annually through the UMC process.
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 other relevant requirements.
4. Upon final approval by the UMC, 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. If materials are posted online, a fax blast will be sent to network providers notifying of online availability.

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 providers. 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.

AZPC disseminates to the members and makes available to the public, upon request, criteria or guidelines for specific procedures or conditions used to make UM determinations.

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

INTER-RATER RELIABILITY

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.

AZPC uses the HPN proprietary educational system PRAXIS for IRR examinations. The IRR consists of 30 questions/scenarios. If the first eight (8) questions are answered correctly at 100%, the staff member has passed the IRR exam and no further testing is required. If 100% is not achieved in the first eight (8) questions, the staff member will be required to answer twenty-two (22) additional questions with a minimum score of 80% or 24/30 (electronically calculated), correct answers.

All staff members with less than an overall 80% pass score will be required to remediate until a score of 80% or greater is achieved. Remediation will include the following process:

1. Training will be in person and interactive using test cases or questions relevant to the UM process to ensure understanding of all principles and elements of the UM and/or CM process, as applicable.
2. The trainer will be a supervisor or designated staff member experienced in that particular UM or CM area.
3. Training may also be provided in a webinar, written, or telephonic platform with testing to confirm understanding.
4. Final testing, post-remediation, will be done using PRAXIS and proctored by a clinical services staff member.
5. Ongoing failure of a staff member to pass the IRR will result in possible reassignment of the employee to administrative duties until the staff member is able to remediate and pass the IRR at the required 80%.
6. Testing and completion logs will be made available to health plans and regulatory agencies during audits.

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 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 cases 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:

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

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

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

If AZPC overall does not meet the benchmark score of 80%, a CAP will be initiated by HPN, and must be completed within 30 days of notification of noncompliance. HPN will notify AZPC of acceptance of the CAP. Continued noncompliance, as evidenced by two (2) or more consecutive noncompliant review periods, will be reported to the HPN UMC for recommendation of further action(s).

UM 3: COMMUNICATION SERVICES

AZPC will members or practitioners seeking information about the UM process and the authorization of care with access to staff in accordance with AZPC's policies and procedures on the availability of UM Staff. AZPC will ensure the following:

1. Staff are available at least (eight) 8 hours a day during normal business hours for inbound collect or toll-free calls regarding UM issues.
2. Staff are available to receive inbound communication regarding UM issues after normal business hours using appropriate communication methods including but not limited to telephone, email, or fax.
3. Staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
4. Telecommunications device for the deaf (TDD) or teletypewriter (TTY) services for available for deaf, hard of hearing, or speech-impaired members.
5. Language assistance is available for members to discuss UM issues during normal business hours, free of charge, as described in AZPC communication services and availability will also be posted on AZPC's website as well as included AZPC's Provider manual and other material as applicable.

In accordance with AZPC's privacy and information security policies and procedures, as well as all state and federal regulations regarding use and disclosure of protected health information (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 uses licensed healthcare professionals to supervise UM activities. Licensed healthcare professionals who supervise:

1. Provide day-to-day supervision of assigned UM staff
2. Participate in staff training
3. Monitor for consistent application of UM criteria by each UM staff member, for each level and type of UM decision
4. Monitor documentation for adequacy and accuracy
5. Are available to UM staff onsite or by telephone

Qualified appropriately licensed healthcare professionals will supervise all medical necessity decisions (an LPN is the minimal level of training and licensure allowed to supervise). Non-licensed personnel, including administrative reviewers such as foreign medical graduates, have the authority to approve, but not deny, services for which there are explicit approval criteria. Adverse determinations based on benefit exclusions alone do not require a licensed healthcare professional.

The healthcare professionals who provide medical necessity review resulting in an adverse organization determination 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.

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:
    a. Decisions about covered medical benefits, including hospitalization and emergency services listed in the Evidence of Coverage (EOC) or Summary of Benefits (SOB).
    b. 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.
    c. 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, when delegated.
    d. 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.
    e. Decisions about medical necessity for "experimental" or "investigational" services, as delegated.
    f. 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 for specialty services.
4. Staff members who are not qualified healthcare professionals, including administrative reviewers, may collect data for pre authorization and concurrent review under the supervision of appropriately licensed healthcare 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:
    a. Decisions about services that are limited by number, duration or frequency in the member's benefit plan.
    b. Denials for extension of treatments beyond the specific limitations and restrictions imposed in the member's benefit plan.
    c. Decisions about care that do not depend on any circumstances, such as the member's medical need or a practitioner's order.
    d. 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., pharmacist, physician, RN, NP or other appropriately licensed UM 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 UM 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.

Affirmative Statement

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:

1. UM decision-making is based only on appropriateness of care and service and existence of coverage.
2. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.
3. Financial incentives for UM 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, the affirmative statement is available online for all members, staff, providers and practitioners involved with UM determinations. Distribution may be accomplished by any of the following methods:

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

UM 5: TIMELINESS OF UTILIZATION MANAGEMENT DECISIONS

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

MEDICARE TIMELINESS (CMS):

Items and Services: This includes inpatient, outpatient, skilled nursing facility, behavioral, residential, and ambulatory care

1. Emergent: Physician available 24 hours a day, 2 hour maximum
2. Urgent/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.

The date and time a request is received for an item or service is based on the date and time it arrives at AZPC, not the date and time it arrives in the correct department.

Part B Medications (not covered under Part D benefit)

1. Urgent/Expedited Pre-Service: Within 24 hours of receipt of the request (includes weekends and holidays
2. Standard Pre-Service: Within 72 hours of receipt of the request (includes weekends and holidays)

The date and time a request is received for a Part B drug is based on the date and time it arrives in the correct department for review.

All UM determinations for Medicare Advantage members will be compliant with the timeliness standards outlined in the Utilization Management Timeliness Standard policy. Failure to provide the member with timely notification of an initial organization determination constitutes an adverse determination. When this occurs, the member has the same level 1 appeal rights as a timely adverse organization determination.

For the purpose of determining timeliness standards, "Urgent/Expedited" 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. Could seriously jeopardize the life, health, or safety of the member or others, due to the member's psychological state, or
3. In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences 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, when necessary, in order to make a determination of medical necessity.

In the event the reviewer believes additional information may be needed to support medical necessity, an AZPC Medical Director may give the requesting provider an opportunity to have a peer to peer discussion by notifying of the provider of the intent to deny. If the provider does not request a peer to peer within the designated timeframe, documentation of this will be added to the prior authorization system and an organization determination will be made.

UM 7: DENIAL NOTICES

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

1. Only the UMC, a Medical Director with an unrestricted license in Arizona, 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.
    a. Licensure may be from another state pursuant to HB2569, A.R.S. 32-4302
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 UMC or a Medical Director.
3. Written notification is sent to both member and requesting provider.
4. Regulatory (federal, state), health plan specific or best practice 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 health or 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 affected 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
    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 with the appropriate state or federal agency.
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:

1. Reliable evidence that the original decision was made with was procured by fraud, or a similar fault, or
2. A clerical error, or
    a. 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
3. New material evidence, or
4. Information requested initially has been submitted.

If the above criteria for a reopen is not met, the request will be forwarded to the health plan as a reconsideration.

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 calendar 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; and
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; and
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; and
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 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. All appeals and grievances will be forwarded to the specific health plan as soon as possible after receipt. The health plan retains responsibility of all verbal and/or written communication to member and provider regarding an 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 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:

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

UM 11: PROCEDURES FOR PHARMACEUTICAL MANAGEMENT

AZPC is not delegated for pharmaceutical management.

UM 12: UM SYSTEM CONTROLS

AZPC has UM system controls in place to prevent data from being altered outside of specific protocols for denial and appeal notification and receipt dates and times. The receipt date and time of any UM request or appeal is based on when it is received by AZPC, not by the department responsible for processing the request. Written notification is considered received by the member and/or provider the date the letter is mailed or fax is sent. Written notification dates and times are automatically electronically captured by the authorization or appeals system. Verbal notification dates and times are manually entered in a reportable field within the authorization or appeal system by the individual user.

AZPC employees in a Team Lead or above role can alter a date/time once it has been recorded. This level of access can only be requested by the department head and approved by the authorization or appeal system owner. Alteration of these fields require additional documentation within the system to explain why the field was altered. The designated employee(s) may only alter date/time fields under the following circumstances:

1. Data entry error (verbal notification only)
2. System outage – written notification was mailed or faxed manually

Securing System Data

Authorization and appeals systems will automatically record modifications via the change history or audit trail function of the individual system. Monthly UM audits are conducted by the department head(s). Audits include the validation of automatic and manual recording of dates and times of receipt and notification, as well as appropriate level of access for each user.

Periodic security assessments are conducted by AZPC's corporate parent company, Heritage Provider Network (HPN) to identify appropriate access levels to the various applications containing PHI, and make necessary adjustments as job tiles, roles, and functions change. Upon employee termination, the Human Resources Department provides IS/IT department with the

name of the employee and the termination effective date. Domain access, VPN access, and all application access is removed.

All user-level and system-level passwords must conform to the guidelines established by HPN. This includes: both upper and lowercase letters, numbers, punctuation characters, at least eight (8) characters long, are not a word in any language, and are not based on personal information. Passwords should **never** be written down, emailed, or shared with **anyone**. Different passwords should be used for different systems. All system-level passwords must be changed at least every six (6) months; however the recommended change interval is every three (3) months. If a password is forgotten, only the Information Systems team can set the account to a temporary password so the individual may reset it at the next login. Users are automatically logged off their workstations after a maximum period of 15 minutes of inactivity.

IS/IT departments spot check the audit trails of all accesses and changes to patient/member data on a regular basis. Violations are reported to the Security Officer and appropriate staff as designated. Access to all applications and networks from public networks is protected by control systems such as firewalls, access control lists, and user authentication under the auspices of the HPN Network Security Officer. Virus protection for AZPC and HPN networks or computer systems is maintained by the HPN Network. Security Officer. Access to PHI, including view/read only, who performed the access, what was accessed, and when access occurred is logged and maintained by AZPC and HPN IS/IT departments per record retention policy.

Access to media containing patient/member data is controlled through:

1. Access control lists to network media
2. Physical access control to hardware
3. Purging data on any type of media before it is recycled or discarded
4. Storage of data on media that is backed up

Equipment that has not been purchased, and is owned by, AZPC or HPN shall not be allowed to connect to the AZPC/HPN network without permission and authorization from the HPN Network Security Officer. All company issued desktops and laptops containing PHI will have the hard disks encrypted using Sophos Enterprise Encryption software that will encrypt all fixed and removable disks including hard drives and flash drives. Data containing PHI must be encrypted before transmission to external sources.

Remote/VPN access is granted to employees based on individual job function and role, who are deemed to adhere to HIPAA/HITECH requirements, per AZPC/HPN policy. Approved users are provided VPN access that allows the exact same access security rights whether onsite or offsite. All devices approved for remote access are appropriately secured to protect data and data transfer. Remote access privileges are removed when access is no longer needed or upon security or privacy non-compliance.

Using the risk assessment methodology determined by NIST, HPN conducts a risk analysis is performed periodically, no less than annually, to mitigate potential risk vulnerabilities to the confidentiality, integrity, and availability or electronic protected health information.

UM 13: DELEGATION OF UTILIZATION MANAGEMENT

AZPC does not sub-delegate UM to any entity. 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 by service
4. Urgent concurrent review and decisions
5. Post-service review and decisions by service
6. Approvals and denials
7. Assessing member and practitioner satisfaction of UM
8. Evaluating new technology

EMERGENCY SERVICES

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

1. authorize the provision of emergency services
2. 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 (PCP) 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.

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 member satisfaction and provider satisfaction UM surveys performed by AZPC will be analyzed at least annually by the UMC and QIC.