Arizona Priority Care™

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UTILIZATION MANAGEMENT PROGRAM

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Contents

INTRODUCTION

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, are designed to meet or exceed 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 of non-behavioral, behavioral, and pharmacy services as part of the medical benefit (where delegated), address over- and under-utilization, 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 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 Structure

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 receives and complies 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 sub-committee members.

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.

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
- Director of Quality
- Director of Credentialing and Prior Authorization
- 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, only physicians have voting rights and a quorum consisting of three (3) physician members are required. Health plan representatives may participate within areas that apply to individual health plans, upon invitation, at the individual affiliate level.

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

1. Overseeing the appropriateness of health care delivery and member and provider satisfaction with the UM Program.
2. Reviewing, revising, and approving of the UM Program and policies and procedures annually, and more frequently as needed
3. Evaluating AZPC's UM activities to ensure they are being conducted in accordance with AZPC's expectations and regulatory, accreditation, and policy standards
4. Reviewing regular reports which may include but are not limited to:
    a. Over-utilization
    b. Under-utilization
    c. Volumes and dispositions of authorization requests
    d. Behavioral healthcare
    e. Hospitalizations and other inpatient admissions
    f. Case Management
    g. Emergency room, ambulance, and urgent care usage
5. Identifying opportunities for quality improvement

Designated Senior-Level Physician

AZPC shall 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 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 must be a physician or have a clinical PhD or PsyD, and maybe be a medical director, clinical director, or participating practitioner from the organization.

The designated Behavioral Healthcare (BH) Medical Director is the physician who is involved in the behavioral aspects of the UM Program development and evaluation and holds responsibility for setting and adhering to the UM behavioral healthcare policies, reviewing UM behavioral healthcare cases, and participating on the UMC.

Utilization Management Department

AZPC will designate 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) 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 outlined in the policy.

UM Staff's Assigned Activities

Non-clinical staff are responsible for intake and data entry of UM requests, evaluating member's eligibility and benefits, coordinating requests for additional information, routing requests to clinical reviewers, and coordinating delivery of notifications. Non-clinical personnel may have the authority to approve services that do not require medical necessity review or where there are explicit criteria.

Clinical staff are responsible for reviewing requests, researching and attaching clinical criteria, and may include relevant facts regarding whether or not requests meet medical necessity criteria. Clinical staff may have the authority to approve services do not require medical necessity review or when the service meets medical necessity criteria.

UM Staff Who Have the Authority to Deny Coverage

Non-licensed personnel may have the authority to approve but not to deny (or modify) requests based on medical necessity for items or services where there are explicit criteria. Decisions to deny (or modify) requests based in whole or in part on medical necessity will be made by a qualified physician, behavioral health provider, dentist, pharmacist, or other appropriate professional (as described further under UM 4: Appropriate Professionals) with a current unrestricted Arizona license who is competent to evaluate the specific clinical issues involved.

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

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 CCM 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 provide Care Coordination as required. AZPC will monitor the ratio of licensed Care Managers to members on a regular basis.

Services Requiring or Not Requiring Authorization

AZPC will provide education to contracted providers and staff on services which require authorization as part of the UM process, such as:

1. Ambulatory Care
2. Inpatient Services
3. Skilled Nursing Facility Services
4. Home Health Care

5. Rehabilitative Services (such as physical, occupational, speech therapies)
6. Durable Medical Equipment and/or Supplies

This also includes requests for services that do not require prior authorization such as:

1. Emergency Services
2. Family Planning
3. Sensitive Services and confidential treatment (including those related to sexual assault or sexually transmitted disease)
4. Preventive Services (including immunizations)
5. Basic Prenatal Care
6. HIV Testing/Counseling
7. Direct Access to Women's Health
8. Language Assistance Program/Interpretation Services
9. Urgent Care Services
10. Hospice

Appeals

AZPC is not delegated for processing, rendering determinations on, or providing notification regarding appeals; however, policies and procedures are in place to assist contracted health plans with their efforts to process appeals in an appropriate and timely manner.

Oversight of appeal-related activities is the responsibility of AZPC's Quality Improvement (QI) Program.

Processes and Information Sources for Determining Benefit Coverage and Medical Necessity

AZPC will utilize the regulatory requirements, contracted health plans' evidence of coverage (EOC) and benefit limitations as well as approved clinical criteria, medical review guidelines, and policies in determining the appropriateness of services being requested. AZPC may adopt business rules for automatically approving requests or allowing non-licensed staff to approve requests without medical necessity review.

AZPC does not develop their own clinical criteria or medical policies; however, AZPC's policies and procedures define the hierarchy of criteria to be utilized by AZPC in rendering UM determinations based on regulatory and health plan-prescribed requirements. As part of this hierarchy, AZPC reviews and approves the evidence-based criteria and resources to be used. As described further under UM 2: Clinical Criteria for UM Decisions.

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 Evaluation

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 utilizing Milliman Guidelines, (MCG) for medical appropriateness and to determine the 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 utilizing MCG guidelines
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 pre-authorization 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 UM DECISIONS

AZPC 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 in applying objective and evidence-based criteria in evaluating the necessity of medical, behavioral healthcare, and pharmaceutical services requested. 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 in accordance with AZPC's approved policies and procedures on Utilization Management Review Criteria, which also defines the hierarchy under which criteria 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.
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

Upon request, AZPC will make available all criteria, clinical review guidelines, and medical review polices utilized for decision making to members and practitioners, and to the public upon request. Communication methods with practitioners, members, and caregivers may include: in person, in writing by mail or by fax, by telephone, by electronic communication (e.g., email or voicemail message), or by TDD/TYY services for deaf, hard of hearing, or speech-impaired members. 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.

INTER-RATER RELIABILITY

Consistency in Applying Criteria

AZPC will evaluate the consistency with which physician and non-physician reviewers apply UM criteria in decision making and will perform inter-rater reliability (IRR) at least annually by as outlined within AZPC's policies and procedures on UM Inter-Rater Reliability. Results of the IRR reviews will be presented to the UMC for review and discussion within the organization. AZPC will act on opportunities to improve consistency in applying criteria, and will monitor improvement activities undertaken.

AZPC evaluates the consistency with which physician and non-physician reviewers apply UM criteria, and evaluates inter-rater reliability:

- Using hypothetical UM test cases, or
- Using a sample of UM determination files.
    - If using a sample of UM determination files, one of the following audit methods will be used:
        - 5 percent or 50 of its UM determination files, whichever is fewer;
        - NCQA "8/30 methodology;" or
        - Another statistically valid method.

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 provide members and 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 requires that appropriately licensed professionals supervise all medical necessity decisions. Licensed health care professionals will supervise UM activities by:

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; and
5. Are available to UM staff onsite or by telephone

Licensed health care professionals will be used to make UM decisions that require clinical judgement. 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 criteria. Adverse determinations based on benefit exclusions alone do not require a licensed healthcare professional. In addition, auto-approvals based on defined business rules as outlined within AZPC's policies and procedures, the following staff may approve services:

1. Staff who are not qualified health care professionals and are under the supervision of appropriately licensed health professionals, when there are business rules allowing approval without medical necessity review, or explicit UM criteria and no clinical judgement is required.
2. Licensed health care professionals.

Written job descriptions will be maintained by AZPC with qualifications for practitioners who review denials of care based on medical necessity. Practitioners are required to have:

1. Education, training, or professional experience in medical or clinical practice.
2. A current, unrestricted clinical license to practice in the state of Arizona and 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.

Licensed doctoral-level clinical psychologists may oversee behavioral healthcare utilization management decisions.

Documentation of the appropriate professional responsible for the medical necessity denial will be maintained via either:

1. The reviewer's hand written signature or initials;
2. The reviewer's unique electronic signature or identifier on the denial letter or on the notation of denial in the file; or
3. A signed or initialed note from a UM staff person, attributing the denial decision to the professional who reviewed and decided the case.

Board-certified consultants will be used to assist in making medical necessity determinations, as appropriate, in accordance with AZPC's policies and procedures on Board Certified Consultants for UM Determinations.

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

AZPC will make medical and behavioral health determinations and issue notifications, when delegated, in a timely manner to accommodate the urgency of the member situation and in accordance with timeliness standards applicable for each type of request as outlined in AZPC's policies and procedures on UM Turnaround Time (TAT) Standards. These policies and procedures are designed to meet all applicable regulatory and accreditation standards for pre-service, concurrent and post-service non-behavioral, and behavioral healthcare.

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

AZPC will document and communicate reasons for a denial (including notifications and delays/extensions where applicable) in accordance with AZPC's policies and procedures. Members and practitioners are provided enough information to help them understand a decision to deny care or coverage and to decide whether to appeal the decision.

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.

To this aim, denial notices are constructed based on the following criteria:

1. For denials resulting from medical necessity review, practitioners will be given an opportunity to discuss denial decisions with a physician or other appropriate reviewer either:
    a. In denial notification;
    b. By telephone, which includes leaving a voicemail, if the organization documents then name of the individual at the organization who notified the treating practitioner or left the voicemail, and the date and time of the notification or voicemail or;
    c. In materials sent to the treating practitioner, informing the practitioner of the opportunity to discuss a specific denial with a reviewer.
2. Notifications of denial are provided to the member (or authorized representative) and/or the practitioner, orally, electronically, and/or in writing, based on the applicable regulatory and/or accreditation requirements for the given type of request, as outlined within AZPC's policies and procedures on Provider and Member notifications and UM Turnaround Times Standards.
3. All denial communications will include:
    a. A description of the service(s) being denied.
    b. A clear and concise explanation of the reasons for the denial decision that is specific to the member's diagnosis, condition, situation in easy to understand language, so that the member can understand the reason for denying the service. This includes a complete explanation of the grounds for the denial, in language

that a layperson would understand, and does not include abbreviations, acronyms, or health procedure codes that a layperson would not understand.

c. A description of the benefit provision, criteria, or guideline used as a basis for the decision, the criterion referenced must be identifiable by name and must be specific to an organization or source. Reference to benefit documents must include the section title or page number.
d. For denials resulting from medical necessity review of out of network requests, the reason for denial must explicitly address the reason for the request (e.g.; if the request is related to accessibility issues, that may be impacted by the clinical urgency situation, denial must address whether or not the requested service can be obtained within the organization's accessibility standards). The criteria reference may be excerpted from the benefit documents that govern our of network coverage, health plan policies specifying circumstances where out-of-network coverage will be approved, or clinical criteria used to evaluate the member's clinical need relative to available network providers and services. The reference must specifically support the rationale for the decision and must relate to the reason for the request.
e. Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
f. Based on health plan-provided or approved denial notice templates, include:
    i. Information as to how the member may file a grievance/complaint with the health plan or external entity (e.g., applicable regulatory body) or how to request an administrative hearing and aid, pursuant to the applicable regulations;
    ii. A description of appeal rights, including the right to submit written comments, documents or other information relevant to the appeal and how to file an appeal with the health plan;
    iii. An explanation of the appeals process, including the right to member representation and appeal time frames;
    iv. A description of the expedited appeal process for urgent pre-service or urgent concurrent denials, if the same process applies to standard and expedited appeals, there must be a description included in the letter that makes it clear that the process applies to both; and
    v. Notification that expedited external review can occur concurrently with the internals appeals process for urgent care.
g. Additional inserts and attachments, as applicable and required.

4. For denials resulting from medical necessity review provider notification will include name and direct telephone number of the health care professional responsible for the denial determination if the provider wishes to discuss the case.
    a. The practitioner may also be notified by telephone or in other materials of the opportunity to discuss a specific denial with the reviewer.
5. An alternative plan of care will be identified in the case of medical need issues.

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 processing, rendering determinations on, or providing notification regarding appeals; however, there are policies and procedures in place to process grievance and appeals where delegated, please see QI25 Grievance and Appeal Review Process (where delegated).

UM 9: APPROPRIATE HANDLING OF APPEALS

AZPC is not delegated for appeals but do have policies and procedures in place to support contracted health plans in their processing of appeals. In furtherance of those efforts, AZPC maintains documentation of any appeals received and forwarded to the health plan, copies of any appeals received from the health plan, and any activity taken as a result of the appeal (e.g., effectuation of overturned appeals). AZPC will also investigate appeals to evaluate the appropriateness of the initial determination and the care involved.

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 or to make determinations on requests related to pharmacy benefits. Drugs that are prescribed or ordered as part of the medical benefit and are within the delegated responsibility of AZPC will be authorized in accordance with applicable contracted health plan policies, AZPC UM policies and procedures, and applicable federal and state regulations.

UM 12: UM SYSTEM CONTROLS

AZPC has controls in place to protect UM data from being altered outside of specific protocols for UM denial and appeal notification and receipt dates (when delegated). The receipt date 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.