Arizona Priority Care™

One Goal. One Priority. Your Healthcare.

BEHAVIORAL HEALTH

UTILIZATION MANAGEMENT PROGRAM

2022

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PHILOSOPHY

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

UM 1: UTILIZATION MANAGEMENT PROGRAM STRUCTURE

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

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

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

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

All BH UM decision-making will be based on medically necessary care and service. Annually, AZPC will fax blast a notification of online availability of the approved BH UM Program within 30 calendar days, and as needed for changes, of UMC approval to all AZPC contracted providers to ensure that all are advised of the AZPC BH UM requirements.

PROGRAM OVERSIGHT

Governing Body

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

Utilization Management Committee

The Utilization Management Committee (UMC) and any ad-hoc committees or subcommittees of

the UMC will report to the AZPC Executive Committee. The UMC will meet at least quarterly to review, evaluate, and provide Executive Committee with recommendations for revisions to the UM Program.

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

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

1. Senior-level AZPC Medical Director
2. AZPC Medical Director(s)
3. Vice President of Clinical Services
4. Director of Prior Auth & Credentialing
5. Senior Director of Clinical Services
6. Director of Quality, Credentialing, and Compliance
7. Behavioral Health Practitioner
8. Other clinical staff as appropriate,
9. Additional personnel and technical experts as requested by the UM Committee or Executive Committee

The UM Committee responsibilities shall include:

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

Designated Behavioral Health Care 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.

Designated Senior-Level Physician

AZPC shall employ, contract or designate a Senior-level Medical Director who holds an unrestricted license to practice

The Medical Director is fully credentialed and serves as the designated physician who is involved in BH UM Program development, evaluation, and provides clinical oversight of all UM activities, supports the various committees, staff, resources, and makes recommendations based on clinical care and administrative data. The Medical Director shall be available for assistance with member behavioral health UM procedures and processes, complaints, development of behavioral health guidelines, recommendations on service and safety, follow-up on identified issues, and attend UM and QI committee meetings, at least once every 12 months.

Effective April 10, 2019, the State of Arizona recognizes equivalent occupational or professional licenses for 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

PROGRAM SCOPE AND PURPOSE

Behavioral Health Utilization Review Program Responsibilities

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

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

1. A senior-level licensed physician or doctoral-level clinical psychologist will provide clinical oversight to all UM staff responsible for making UM determinations.
2. Licensed physician reviewers may recommend to approve, modify, delay, and/or deny any services based on medical necessity and benefit coverage.
3. Administrative reviewers (i.e., foreign medical graduates) may approve services, deny benefit driven services, and provide input to licensed physician reviewers for medical necessity denials.
4. Licensed nurse reviewers may recommend to approve services, deny benefit driven services, and provide input to licensed physician reviewers for medical necessity denials.
5. Non-clinical UM 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 AZPC Medical Director will be responsible for all final decisions to deny any service 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.

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

Program Goals and Objectives

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

1. To evaluate the utilization of services, member benefits and resources related to the provision of care by reviewing requests for services, conducting concurrent review and discharge planning as needed retrospective review, and care management.
2. To ensure that all members receiving inpatient, partial hospitalization program (PHP), intensive outpatient program (IOP), and outpatient (OP) care will have a completed continuity-of-care plan developed prior to safe discharge to a lower level of care.
3. To encourage effective, efficient use of services and resources through communication and education of employees, providers, members, and their families.
4. To ensure all practitioners and UM reviewers have access to and are utilizing the most current criteria, guidelines, and policies as approved by the 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 aligned with the member's diagnosis and level of care required.
6. To monitor and improve the coordination of medical and behavioral healthcare.
7. To identify and care coordinate members with complex healthcare needs across the continuum of community and facility-based services with the goal to facilitate health promotion, risk reduction, and prevention of illness complications.
8. To communicate and interact effectively with the primary care physicians, specialists, and other contracted ancillary providers by various methods to include, but not limited to electronic, written and verbal correspondence, and education forums.
9. To work in conjunction with the QIC to refer those issues which require a quality review.
10. To recommend and develop Corrective Action Plans (CAPs) or Quality Improvement Plans (QIPs), if found necessary, to improve practice or system issues.
11. To identify utilization issues within the UM process and use a continuous quality improvement process to develop interventions to address issues identified.
12. To ensure a process by which members and practitioners are informed of their rights and the process to appeal a determination.

AZPC BH UM Program achievements will be measured through the evaluation of UM work plans, annual program evaluation and other utilization activity reports. The AZPC UMC will routinely review and monitor the services provided by the BH UM staff 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 approved according to AZPC policies and procedures.
6. Prospective review 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 daily by BH UM/Care Managers while the member is hospitalized in the acute hospital setting.
2. Concurrent review of psychiatric and substance abuse admissions are conducted by Care Managers and discussed with the Behavioral Health designated Physician for determination of medical necessity, for continued stay, severity of illness, level of care, intensity of service, diagnostic studies, treatment plans, identifying barriers to discharge, and the quality of care being rendered.
3. Referral to outpatient Complex Care Management or other AZPC Clinical Services Programs as appropriate.
4. Documentation of review will be maintained in the member's electronic utilization management record.
5. Care shall not be discontinued until the member's treating provider has been notified of the decision and a care plan has been agreed upon by the treating provider that is appropriate for the needs of that patient.

Retrospective Review – Hospitalizations

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

Emergency Room

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

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

Post Stabilization Transfer

No person needing emergency services and care may be transferred for any non-medical reason unless certain conditions are met including, but not limited to, a provision that the person is examined and evaluated by a physician and/or surgeon prior to transfer. A patient is considered stabilized when, in the

opinion of the treating provider, the patient's medical condition is such that within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient.

Prospective and Retrospective Review - Outpatient Services

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

1. Medical indication for referral.
2. Specific number of visits or services specified on the form.
3. Sufficient clinical information is documented so that the consulting provider has all known significant information relating to the requested services.
4. Correct coding - level of care
5. Contractual arrangements

Out of Network / Non-Contracted Provider Referrals

Contracted providers will be utilized whenever possible. If a contracted provider is not available, then a referral for an out of network or non-contracted provider will be reviewed for medical necessity by the Medical Director or designee. For services determined to be medically necessary and not available in network, a Letter of Agreement (upon request) will be generated prior to the patient's visit or as soon as reasonably possible as not to delay care. All out of network or non-contracted provider referrals will be reviewed by the Medical Director or designee.

Behavioral Health Care Review

AZPC BH UM requires that:

1. Only licensed practitioners make decisions that require clinical judgment.
2. Staff that make clinical decisions are supervised by a minimum of a licensed master's level 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 referral decisions.
4. Protocols for behavioral healthcare triage and referral address all relevant mental health and substance abuse situations. Protocols also address the level of urgency and appropriate setting. The protocols should be reviewed at least annually and as necessary.
5. The designated behavioral healthcare practitioner will;
    a. Be involved in the implementation of the behavioral healthcare aspects of the UM program and policy development;
    b. Participate in UMC meetings; and
    c. Review behavioral health UM cases as needed.

Second Opinions

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

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.

4. If a member's request for a second and/or third opinion is denied or modified, the member shall be notified in writing of the reasons for the denial and of their right to file a grievance or appeal, as applicable. If not authorized by AZPC, the cost will be the responsibility of the member.
5. Second and/or third opinions are covered even though the surgery or other procedure, if performed, is determined not covered. Payment may be made for the history and examination of the patient, and for other covered diagnostic services required to properly evaluate the patient's need for a procedure and to render a professional opinion.

Reporting Requirements

1. Annual Initial Work Plans - AZPC will complete and submit an annual BH UM initial work plan to the AZPC UMC by February of each new calendar year. The annual work plan is to include:
    a. UM goals and objectives, program scope, areas of program focus, and the specific utilization related activities and studies that are to occur.
    b. Planned monitoring of Utilization data, including tracking statistics over time.
    c. Planned annual evaluation of the UM program.
    d. Action steps and recommendations including a target date for completion and responsible party.
2. Work Plan Evaluations – AZPC will update and submit a work plan to the AZPC 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 trends
    c. An analysis of whether there have been any demonstrated improvements in the utilization management program
    d. A description of how these improvements were meaningful to the organization's population should be included.
3. Monthly/Quarterly/Semiannual/Annual UM Reports - Based on regulatory and plan contracting requirements for all UM reports will be submitted timely per the UM Submissions Calendar provided by the contracted health plan.
4. Final Work Plan Evaluation/2nd Semiannual report - AZPC will complete and submit a final work plan evaluation to the AZPC 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 AZPC BH UM's attainment of written goals and any additional strategies and clarifications

UM 2: CLINICAL CRITERIA FOR BH UM DECISIONS

The UM review process uses a wide range of criteria, guidelines, and reference tools to assist in determinations of benefit coverage, behavioral health needs, and medical appropriateness.

Supporting clinical and benefit information relevant to each particular case will be reviewed when making medical necessity coverage determinations.

AZPC maintains written policies addressing the application of objective and evidence-based guidelines, criteria, and publications in making UM determinations while taking into account the following that may include but is not limited to local delivery system, individual circumstances, member's age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment.

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 specialty resources.

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

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

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

Annual Review of Criterion

1. Materials are reviewed, approved, and/or updated/modified as needed. This review shall occur a minimum of one time annually through the UMC process.
2. Only appropriate clinical and behavioral health practitioners with relevant experience are involved in the development, adoption, and reviewing of the criteria.
3. Criterion complies with Medicare local and national coverage determinations and relevant Medicare requirements as well as established guidelines that may include but are not limited to MCG.
4. Upon final approval, all materials are made available to UM staff and practitioners in writing either by mail, fax, email, or on the AZPC website according to AZPC standard communication/dissemination process. If materials are posted online, a fax blast will be sent to network provides notifying of online availability.

Availability of Criteria, Guidelines, Policies

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

INTER-RATER RELIABILITY

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 referral delay was clearly documented, if applicable.
3. There was sufficient clinical documentation to support the decision.
4. The files were correctly categorized.
5. The appropriate UM criteria or benefit provision was applied.
6. There was appropriate referral to the Medical Director.

Inpatient Services

1. Documentation supports the medical necessity for admission and continued stay.
2. There was sufficient clinical documentation to support the decision.

3. The appropriate UM criteria or benefit provision was applied.
4. Disposition of patient is documented
5. There was appropriate referral to the Medical Director.
6. Continuity of care and discharge planning initiated and family involved, when applicable

Physician Reviews

At least five (5) randomly selected cases shall be reviewed by a Medical Director not responsible for the initial decision, and all selected records shall be reviewed by an independent physician to ensure determinations are made based on adopted clinical guidelines against the following criteria:

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

Results of Reviews

These results must be presented to the AZPC UMC for review and discussion. The AZPC UM Committee 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 ensure that staff, members and practitioners, seeking information about the UM process will be provided access to the appropriate information. Inbound and outbound communications may include communication with practitioners and members in person, in writing by mail or fax, by telephone, or by electronic communications (e.g. sending e-mail messages or leaving voicemail messages.) Communication requirements shall include:

1. Staff available at least eight (8) hours a day during normal business days for inbound calls regarding UM issues.
2. Ability of staff to receive inbound member and provider communication after normal business hours regarding UM issues.
3. Staff members identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
4. A toll-free number or a staff who accepts collect calls regarding UM issues.

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

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

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

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

UM 4: APPROPRIATE PROFESSIONALS

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

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

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

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

The UM staff or behavioral health care professional responsible for making a UM 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. There are no financial incentives for UM decision makers to encourage decisions that result in underutilization.

To encourage appropriate utilization, discourage underutilization and clearly indicate that AZPC does not use incentives to encourage barriers to care and service, affirmative statements that incentives are not utilized is available online for all members, staff, providers, and practitioners involved with UM determinations. Distribution may include but not limited to:

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

UM 5: TIMELINESS OF UM DECISIONS

In accordance with AZPC 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):

This includes inpatient, outpatient, skilled nursing facility, 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 is based on the date and time it arrives at AZPC, not the date and time it arrives in the correct department.

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

For the purpose of determining timeliness standards, “Urgent/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 provider, member, or member representative for behavioral health care services, AZPC will obtain relevant clinical information and consult with the member's treating practitioner, as needed, in order to make a determination of medical necessity.

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

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

UM 7: DENIAL NOTICES

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

1. Only the UMC, a Medical Director with an unrestricted license, or a board certified and current licensed physician reviewer with 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 behavioral healthcare services must specify the services that were approved or denied.
6. Communications regarding decisions to deny, delay, or modify a provider's treatment request must be communicated to the member and requesting provider in writing by issuing a, Notice of Denial of Medical Coverage, (NDMC), 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 AZPC, 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.

In the event AZPC decides to terminate approved service coverage (such as Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehab Facility (CORF), the member will be issued a Notice of Medicare Non-Coverage (NOMNC) no later than two 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
5. Alternative appeal mechanisms if the member fails to meet the deadline for an immediate appeal.

Should the member appeal AZPC's decision to terminate services, AZPC must provide the Detailed Explanation of Non-Coverage (DENC), an explanation as to why the provider services are no longer reasonable or necessary or are no longer covered. The DENC shall include:

1. Applicable CMS rules, instruction, or policy including citations
2. How the member may obtain copies of such documents
3. Other member specific facts or information relevant to the non-coverage decision in easy to understand language.

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

Upon notification that a member has been advised that inpatient care is no longer necessary and the member has requested an immediate review of the determination, AZPC or the facility shall provide the member with a Detailed Notice of Discharge (DND) as soon as possible but no later than noon of the day after the notification. During the review process, AZPC shall ensure that all information the QIO needs to make its determination is provided, either directly (with hospital cooperation) or by delegation, no later than noon of the day after the QIO notifies the delegate that a request for an immediate review has been received from the member. The DND shall include:

1. Detailed explanation of why services are either no longer reasonable and necessary or are no longer covered in an inpatient hospital setting
2. Description of any applicable CMS coverage rule, instruction, or other CMS policy used in this determination, including information about how the member may obtain a copy of the CMS policy, any applicable organization policy, contract provision or rationale upon which the

discharge determination was based
3. Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case

UM 8: POLICIES FOR APPEALS

AZPC 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 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 AZPC UM Committee or Committee member designee will review all recommendations for new technologies or changes to existing technologies. Review will include at least a review of government standards, medical literature, or other sources, and be reviewed by the appropriate specialty physicians, and health plan. All necessary parties will be notified at least 24 hours prior to implementation of new technologies. New technologies may include, but are not limited to:

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

UM 11: PROCEDURES FOR PHARMACEUTICAL MANAGEMENT

AZPC is not delegated for pharmaceutical management.

UM12: 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 responsibilities 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
4. Urgent concurrent review and decisions
5. Post-service review and decisions
6. Approvals and denials
7. Assessing member and provider 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.

TRIAGE AND REFERRAL FOR BEHAVIORAL HEALTHCARE

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

EXPERIENCE WITH THE UM PROCESS

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

The surveys will include indicators to measure satisfaction with BH UM processes. Opportunities for improvement will be identified and correction action(s) will be taken if necessary.

Results of member and provider experience surveys performed will be analyzed at least annually by the AZPC UMC and QIC.