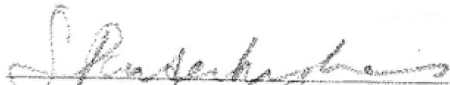




UTILIZATION MANAGEMENT PROGRAM

2026

Approval signature: 
Dr. Stacie Pinderhughes, Sr. Medical Director
Committee Chair

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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 care, items or 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, is 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 3: 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 care, items or 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.

Program Structure

Governing Body

Heritage Provider Network, Inc.'s (HPN) 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 comply with all aspects of the UM Program. The structure and responsibilities of the Executive Committee are outlined in the Executive Committee Charter and made available to its committee members.

Utilization Management Committee

AZPC's Utilization Management Committee (UMC) reports to the Executive Committee at least semi-annually. Any ad-hoc committee 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 via video conference or web conference with audio 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 and may be conducted via email) utilizing appropriate practitioners (three (3) physicians across primary care and/or specialties) and/or sub-committee members. The meeting to review the annual program and rate evaluations and actions/opportunities to improve the performance of the UM program and UM rates will not be conducted via email.

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
- AZPC's Medical Director(s)
- Vice President of Clinical Services
- Senior Director of Clinical Services
- Director of Quality
- Director of Credentialing and Prior Authorization
- Behavioral health care practitioner from HPN and/or affiliate(s)
- 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. Annual evaluation of the UM program structure, scope, process, and information sources used to determine benefit coverage and medical necessity.

2. Overseeing the appropriateness of health care delivery and member and provider satisfaction with the UM Program.
3. Reviewing, revising, and approving of the UM Program and policies and procedures annually, and more frequently as needed
4. Evaluating AZPC's UM activities to ensure they are being conducted in accordance with AZPC's expectations and regulatory, accreditation, and policy standards
5. Annually or more frequently, reviewing regular reports which include but are not limited to:
 - a. Non-behavioral and pharmacy UM rates:
 - i. Overall approval rate
 - ii. Overall denial rates
 - iii. Rate of notification timeliness for denials, including but not limited to:
 1. Overall
 2. Urgent concurrent
 3. Urgent preservice
 4. Non-urgent preservice
 5. Post-service
 - b. Over-utilization
 - c. Under-utilization
 - d. Volumes and dispositions of authorization requests
 - e. Behavioral healthcare
 - f. Hospitalizations and other inpatient admissions
 - g. Case Management
 - h. Emergency room, ambulance, and urgent care usage
6. Identifying opportunities for quality improvement and needed actions based on the annual program and UM rate evaluation.
7. Prioritization of actions based on their significance.

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. These individuals hold responsibility 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 reviews and approves, modify, or deny requests prior to, retrospectively, or concurrent with, the provision of health care, items or 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

AZPC will designate a behavioral healthcare practitioner to implement and evaluate the behavioral health aspects of the UM Program. This individual 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. AZPC may utilize HPN's designated behavioral health care practitioner or may contract with a vendor or provider meeting similar requirements.

The designated Behavioral health care practitioner holds responsibility for implementing and evaluating the behavioral health aspects of the UM programs, 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 will maintain a current UM department organization chart and staffing plan identifying all key UM positions, decision makers, and department/staff oversight roles. 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, items or services to members in accordance with turn-around time requirements as outlined in the policy.

AZPC is responsible for distributing the UM Program to staff and contracted providers at least annually to ensure that all are advised of utilization management requirements and processes. AZPC's designated senior-level physician will ensure AZPC's policies and procedures are reviewed and adopted and that all clinical and non-clinical staff responsible for UM activities are educated on the most current program, policies and procedures.

UM Staff's Assigned Activities

Non-clinical staff are responsible for intake and data entry of UM requests, evaluating members' 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 care, items or services that do not require prior authorization, do not require medical necessity review or where there are explicit criteria. Non-clinical personnel may also issue carve out and health plan responsibility notices and make notifications when the decision is not based in whole or in part on medical necessity, such as eligibility denials.

Clinical staff are responsible for reviewing requests, researching and attaching clinical criteria, and may include relevant facts regarding whether requests meet medical necessity criteria. Clinical staff may have the authority to approve care, items or services do not require prior authorization, do not require medical necessity review or when the service meets medical necessity criteria. Clinical personnel may also issue carve out and health plan responsibility notices and make denial determinations when the decision is not based in whole or in part on medical necessity, such as eligibility denials.

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 care, 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 6: 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.

Services Requiring or Not Requiring Authorization

AZPC will provide training to contracted providers and staff on care, items or 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 distributing and educating staff and contracted providers regarding requests for care, items or services that do not require prior authorization but may be entered into the UM system for tracking purposes and care coordination. Such services may include but are not limited to the following, subject to the applicable line of business and network status of the treating provider:

1. Emergency Services
2. Family Planning
3. Sensitive Services and Confidential Service 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
11. Outpatient Mental Health Counseling and Treatment including Drug and Alcohol Abuse
12. Tobacco Cessation

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. Specifically, AZPC's appeals policies and procedures provide for the following:

1. Issuance of denial, delay, and modification notices to providers and members that give a description of the applicable appeal rights and the instructions to submit a verbal or written appeal, including an expedited appeal if applicable, to the health plan.
2. Coordination with the health plan by immediately forwarding requests for appeals to the health plan.
3. Responding to inquiries from the health plan regarding initial decisions which have been appealed.
4. Continuation of coverage for the member, when applicable, pending the outcome of the appeal.
5. Effectuation of any overturned appeals from the health plan or any relevant higher-level entity such as the Independent Review Organization (IRO).
6. In the event that in the future AZPC accepts delegation of appeals, the appropriate policies and procedures are in place to ensure appropriate handling.

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 inpatient and outpatient care, items or 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 4: Clinical Criteria for UM Decisions.

Medical Necessity Review

Medical necessity review is a process to consider whether care, items or services that are covered only when

medical necessity meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the member's circumstances, relative to appropriate clinical criteria and the organization's policies. Medical necessity requires that denial decisions be made only by an appropriate clinical professional. AZPC's policies and procedures outline the applicable definitions of medical necessity.

Decisions about the following require medical necessity review:

1. Any covered medical benefits defined by the contracted health plan's Certificate of Coverage or Summary of Benefits, including but not limited to.
 - a. Dental and vision services covered under medical benefits, including dental care, items or services associated with procedures that occur within or adjacent to the oral cavity or sinuses.
 - i. If medical and dental benefits are not differentiated in the health plan's benefits, requests for care or services associated with dental procedures

that occur within or adjacent to the oral cavity or sinuses are included in medical necessity review.

- b. Pharmaceuticals covered under medical benefits or, if delegated by the plan, covered under pharmacy benefits.
2. Pre-existing conditions when the contracted health plan has a policy to deny coverage for care, items or services related to pre-existing conditions.
3. Care, items or services whose coverage depends on specific circumstances.
4. Out-of-network services that are only covered in clinically appropriate situations.
5. Prior authorizations for pharmaceuticals and pharmaceutical requests requiring prerequisite drug for a step therapy program, if delegated to make the determination.
6. “Experimental” or “investigational” requests covered by the contracted health plan, if delegated to make the determination.

Decisions about the following do not require medical necessity review:

1. Services in the member’s benefits plan that are limited by number, duration, or frequency;
2. Extension of treatments beyond the specific limitations and restrictions imposed by the member’s benefits plan;
3. Care, items or services whose coverage does not depend on any circumstances; and
4. Requests for personal care items or services, such as cooking, grooming, transportation, cleaning, and assistance with other activities of daily living (ADLs).
5. “Experimental” or “investigational” requests that are always excluded and never covered under any circumstances. If delegated by the contracted health plan to make these determinations, the affiliate will either:
 - a. Identify the specific service or procedure excluded from the benefits plan, **or**
 - b. If benefits plan materials include broad statements about exclusions but do not specify excluded care, items or services or procedures, notify the member that they have the opportunity to request information on excluded care, items or services or procedures based on the contracted health plans’ internal policies or criteria for these services or procedures.

If AZPC makes an exception to authorize a service, grant an extension of benefits, or make an exception to a limitation in the health plan’s benefits plan (e.g., up to approve 20 visits are covered but AZPC allows 21 visits), a subsequent denial of the same service or a request for an extension or exception is considered a medical necessity determination.

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.

Medical Necessity Review of requests for Out of Network Coverage

Requests for coverage of out-of-network care, items or services that are only covered when medically necessary or in clinically appropriate situations require medical necessity review. Such requests indicate the member has a specific clinical need that the requestor believes cannot be met in-network (e.g., a service or procedure not provided in-network; delivery of care, items or

services closer or sooner than provided or allowed by the organization's access or availability standards).

If the contracted health plan's Certificate of Coverage or Summary of Benefits specifies that an out-of-network service is never covered for any reason, the request does not require medical necessity review.

Behavioral Health Care

Where delegated, AZPC will process requests for behavioral health services utilizing processes aligned with those for non-behavioral health services, unless otherwise specified within AZPC's UM Program or policies and procedures. So long as the member has appropriate eligibility/benefits at the time of service, affiliates do not deny requests for in-network, outpatient behavioral health consultations or ongoing in-network outpatient follow-up care. Sites of behavioral healthcare services (e.g., psychology groups) for outpatient services are determined based on the site of service requested by the requesting provider or member. AZPC will ensure coordination across the member's medical and behavioral health care services by sharing information/records across the member's practitioners, where documentation is obtained permitting AZPC to do so.

Requests for specialty outpatient behavioral health care services and inpatient behavioral health care services will undergo medical necessity review by qualified professionals. Behavioral health care denials based in whole or in part on medical necessity will be reviewed by an appropriate reviewer as described under UM 4: Appropriate Professionals.

Triage and Referral

Triage and Referral (T&R) functions for behavioral healthcare services are provided via direct access or direct referral by a primary care physician, or specialist. AZPC staff provide information about the BH practitioners but do not make judgements regarding the level of care needed or type of practitioner the member should see.

Program Evaluation

AZPC's UMC will continually evaluate the UM Program through ongoing reporting as well as UM Work Plans to be developed and submitted by AZPC. AZPC's Work Plans will document goals, objectives, areas of focus, planned monitoring, and action steps to be taken to ensure the appropriateness of UM activities and enable AZPC to oversee such activities.

The Director, Clinical Services Operations will complete the UM Program evaluation report for presentation to the UMC to ensure that it remains current and appropriate, including but not limited to assessment of:

1. Program structure
2. Program scope, processes, and information sources used to determine benefit coverage
3. and medical necessity
4. UM rates
5. UM criteria
6. Prior authorization requirements

7. The level of involvement of designated senior level physician(s) and designated behavioral healthcare practitioner(s) in the UM Program

The Director, Clinical Services Operations will also consider member and practitioner experience data when evaluating its UM Program, utilizing surveys designed to measure satisfaction and document positive and negative experiences of members and providers.

In addition, the timeliness data will be used to evaluate AZPC's UM rates at least annually. Timeline rates will be used to gain insight into authorization patterns and practices that may cause inefficiencies or unnecessary delays. Conclusions about the appropriateness of the rates will be drawn and recommendations for improvements will be included in the annual program evaluation.

The UM committee annually reviews the evaluation of UM rates, evaluates the UM program, and identifies actions to address opportunities from each.

As areas for action or improvement are identified, the Directors of Clinical Services in conjunction with the Designated Senior-Level Physician, will make revisions to its Program, policies, or procedures and will undertake corrective action and follow-up on improvement opportunities. A minimum of one recommended action from the UMC related to program improvement and one for UM rates will be implemented annually as appropriate. Revisions to the program, policies, or procedures and any corrective action plans will be approved by the Designated Senior-Level Physician in conjunction with the UMC.

Role in Quality Improvement Program

AZPC recognizes the importance of collaboration between its UM and Quality functions to ensure that care, items or services delivered to members are high quality, appropriate, cost-effective, efficient, and accessible. To this end, AZPC's QI Program has an infrastructure for ongoing monitoring of UM activities to ensure established metrics are met and to identify any improvement opportunities. AZPC's UMC will collaborate with its Quality Improvement Committee (QIC) to:

1. Identify areas which overlap both UM and quality
2. Collectively monitor and evaluate identified areas on an ongoing basis through reporting from AZPC
3. Take action to resolve areas of concern and address opportunities for improvement

UM information to support QI activities may be collected through materials reported to the UMC, reports generated for other internal or external oversight activities, or direct analysis of UM data. Specific requests for UM information needed for QI Program activities be fulfilled by HPN or AZPC as part the ongoing collaboration between the UM and QI Programs. Staff responsible for QI Program activities will leverage the UM information provided to compare performance to established metrics and benchmarks, perform additional investigations where needed, and identify potential opportunities for improvement.

Activities undertaken by the UMC and QIC will be documented within the respective committees' meeting minutes. Additional reporting of HPN's Executive Committee will be performed as determined to be appropriate.

UM 4: CLINICAL CRITERIA FOR UM DECISIONS

AZPC does not develop its own clinical criteria but rather reviews and adopts the criteria from our contracted health plans. This criteria is based on sound clinical evidence 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 care, items, or services requested. Criteria are applied considering individual circumstances and the member needs (such as age, comorbidities, 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:

- Availability of inpatient, outpatient, and transitional facilities
- Availability of outpatient services in lieu of inpatient services such as surgicenters vs. inpatient surgery
- Availability of highly specialized services, such as transplant facilities or cancer centers
- Availability of skilled nursing facilities, subacute care facilities, or home care in the AZPC service area to support members after discharge
- Local hospitals' ability to provide all recommended services within the estimated length of stay

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 should 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. Criteria to be considered when making UM determinations may include but are not limited to plan eligibility and coverage (benefit plan package), CMS criteria when applicable (National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and Local Coverage Articles (LCAs), Medicare Benefit Policy Manuals), state regulations, health plan criteria (e.g., coverage summaries, medical policies), and evidence-based criteria (e.g., MCG, InterQual).

Annual Review of Criteria

Materials are reviewed, approved and/or updated/modified as needed but not less than annually. Appropriate practitioners with clinical expertise in the applicable areas, including practitioners on staff and participants in the network, are involved in the review, and adoption of criteria, as well as instructions for applying criteria. Criteria comply with the applicable regulatory requirements for the given line of business, are reviewed against current clinical and medical evidence, and reflect new scientific evidence, as appropriate. If new scientific evidence is not available, AZPC may determine if further review of criterion is necessary.

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's website according to AZPC standard

communication/dissemination processes. If materials are posted online, a fax blast will be sent to network providers notifying them of online availability.

Availability of Criteria

AZPC will make criteria available electronically at the point of care. Criteria may be found in the electronic health record, provider portal or via website. Upon request, AZPC will make available all criteria, clinical review guidelines, and medical review policies 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/TTY 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.

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) audits 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.

UM 5: 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, or member web portal.
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.

Customer service staff may triage communications to UM Staff. Communication services and availability will be posted on AZPC's website, as well as included in AZPC's Provider Manual and other materials 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 6: 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. Participating 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. Monitoring staff documentation for adequacy; and
5. Being 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 care, items or 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.

The following practitioner types are considered appropriate for reviewing the specified UM denial decisions based in whole or in part on the medical necessity of the requested service:

1. Physicians, all types: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic, and vision denials.

2. Nurse practitioners (within scope of their license): Medical, behavioral healthcare, pharmaceutical, dental, chiropractic, and vision denials.
3. Doctoral-level clinical psychologists or certified additional medicine specialists: Behavioral healthcare denials.
4. Pharmacists: Pharmaceutical denials.
5. Dentists: Dental denials.
6. Chiropractors: Chiropractic denials
7. Physical therapists: Physical therapy denials
8. Doctoral-level board certified behavioral analysts: Applied behavioral analysis denials.

Documentation of the appropriate professional responsible for the denial will include the name, title and clinical credentials (e.g., MD, DO, PhD) and either:

1. The reviewer's handwritten signature or initials; or
 2. The reviewer's unique electronic signature or identifier on the denial letter or on the notation of denial in the file; or
- A signed or initial 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, either directly 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 7: UM INFORMATION INTEGRITY

AZPC has policies and procedures in place that address the integrity of UM information (both paper and electronic), define audit processes to identify inappropriate documentation, analyze findings to identify integrity issues, and develop corrective action plans to address these issues. UM denial information integrity involves maintaining and safeguarding information used in UM

denial decision process against inappropriate documentation and updates. AZPC's UM information integrity policies and procedures specifically address the integrity of information used in the UM denial process. Policies and procedures specify:

1. The scope of UM information.
2. Staff responsible for completing UM activities
3. Process for documenting updates to UM information
4. Defines inappropriate documentation and updates.
5. Outlines the process for auditing, documenting, and reporting information integrity issues.

AZPC has UM staff complete information integrity training annually.

At least annually, perform information integrity audits that include qualitative analysis on denial of information.

1. Undertake improvement actions by implementing corrective actions to address inappropriate documentation and updates found in the information integrity audit.
 - a. Conducts follow-up audits on the effectiveness of corrective actions.

UM 8: DELEGATION OF UM

AZPC is wholly owned and controlled by HPN. HPN develops all operational programs and policies to support AZPC in executing all services as delegated by contracted health plans to HPN and AZPC.

UM Decisions and Notifications (UMA 1-3)

AZPC will comply with the information outlined below in the handling of non-behavioral, behavioral, and pharmacy requests (when delegated).

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, behavioral healthcare, and pharmacy decisions and notifications. See AZPC policy and procedure for detailed decision & notification TAT requirements.

Timeliness Reporting

AZPC will monitor the timeliness of decision making and notification for all requests to calculate the percentage of decisions that adhere to the required timeframes for each type of request (e.g., urgent vs. non-urgent, pre-service vs. concurrent vs. post-service) in accordance with AZPC reporting standards.

CLINICAL INFORMATION

When making medical necessity determinations, AZPC uses all information relevant to a member's care, obtaining relevant clinical information and consulting with treating practitioners as necessary prior to rendering a decision. AZPC will make and document their attempts to gather the relevant clinical information to support UM decision making and may elect to take a delay/extension as permitted and applicable per AZPC's policies and procedures. The relevance of clinical information is considered in terms of the criteria utilized to make approval or denial decisions. Requests for clinical information are not intended to be burdensome and are intended to obtain the information necessary to evaluate the appropriateness of and the member's need for the requested care.

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

1. Office and hospital records
2. Conversations with appropriate physicians/providers
3. A history of the presenting problem
4. Diagnosis codes
5. Physical exam results
6. Diagnostic testing results
7. Treatment plans and progress notes
8. Patient psychosocial history
9. Information on consultations with the treating practitioner
10. Evaluations from other health care practitioners and providers
11. Operative and pathological reports
12. Rehabilitation evaluations
13. A printed copy of criteria related to the request
14. Information regarding benefits for care, items or services or procedures
15. Information regarding the local delivery system
16. Member characteristics and information
17. Information from family members

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. 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 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 (specific medical necessity criteria not met for the condition or requested service, based on review of relevant clinical information), 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 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 internal 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.

The following information will be included in the denial file:

1. The denial notification, if the treating practitioner was notified of the opportunity to discuss the medical necessity denial in the denial notification.
2. The time and date of the notification and the name of the individual at the organization, if the treating practitioner was notified of the opportunity to discuss a medical necessity denial by telephone.
 - a. If the treating practitioner was notified by voicemail, the name of the individual who left the voicemail, and the date and time.
3. Evidence that the treating practitioner was notified that a physician or other reviewer is available to discuss the denial, if notified in materials sent to the treating practitioner.

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 assist contracted health plans with their efforts to process appeals in an appropriate and timely manner. Specifically, AZPC's process for handling appeals and making appeal determinations are outlined in the appeals policies and procedures and provide for the following:

1. Issuance of denial, delay, and modification notices to providers and members that give a description of the applicable appeal rights and the instructions to submit a verbal or written appeal, including an expedited appeal if applicable, to the health plan.
2. Coordination with the health plan by immediately forwarding requests for appeals to the health plan.
3. Responding to inquiries from the health plan regarding initial decisions which have been appealed.
4. Continuation of coverage for the member, when applicable, pending the outcome of the appeal.
5. Effectuation of any overturned appeals from the health plan or any relevant higher-level entity such as the Independent Review Organization (IRO).
6. If in the future AZPC accepts delegation of appeals, the appropriate policies and procedures are in place to ensure appropriate handling.

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

APPROPRIATE HANDLING OF APPEALS

AZPC is not delegated for appeals but does 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 because 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.

PROCEDURES FOR PHARMACEUTICAL MANAGEMENT

AZPC is not delegated for Procedures for Pharmaceutical Management for the pharmacy or medical benefit. AZPC is not delegated for the management of the pharmacy benefit. Services are performed by contracted health plans or are carved out of the benefit. In addition, for drugs covered under the medical benefit. AZPC is not delegated for the development of pharmaceutical management procedures such as prior authorization, generic substitution, therapeutic interchange, or step therapy. AZPC uses the procedures and criteria provided by the contracted health plan to make decisions on authorization requests for drugs covered under the medical benefit. AZPC is not delegated for communications with members and prescribing practitioners regarding pharmaceutical lists, restrictions and preferences, nor regarding pharmaceutical patient safety issues.