2014 Utilization Management Program Description

Independence Care System
1 Introduction

One of the cornerstones to the success of any utilization management program is its ability to ensure high quality care as well as effective, efficient and timely utilization of healthcare services. Independence Care System (ICS) Medicare-Medicaid Plan (MMP) recognizes that physicians are the key managers in the healthcare delivery system. We believe that the delivery of high quality medical care is achieved when physicians:

• Practice timely, cost-effective, preventive, curative, and palliative medicine.
• Effectively employ inpatient and outpatient diagnostic and therapeutic procedures utilizing evidence based medical criteria, to help ensure members receive quality healthcare in an appropriate setting and timely manner.
• Manage the member's total health needs.

ICS contracts with a full range of practitioners and providers (physicians, primary care practitioners, ancillary services providers and facilities) to deliver comprehensive medical services to members.

The Utilization Management (UM) Program description summarizes procedures, processes, and standards that govern the Utilization Management (UM) Program.

The Utilization Management (UM) Program is designed to promote the delivery of high quality, medically necessary, and cost efficient healthcare for our members. The program is under the clinical direction of the Medical Director.

ICS defines medically necessary services as those items and services necessary to prevent, diagnose, correct, or cure conditions in the Participant that cause acute suffering, endanger life, result in illness or infirmity, interfere with such Participant's capacity for normal activity, or threaten some significant handicap. Notwithstanding this definition, ICS will provide coverage in accordance with the more favorable of the current Medicare and NYSDOH coverage rules, as outlined in NYSDOH and Federal rules, and coverage guidelines. ICS will cover all items and services as outlined in the Three-way Contract and in the State and Federal guidance and will not impose more stringent coverage rules unless explicitly authorized by the Three-way Contract.
Additionally, all care must be provided in accordance and compliance with the ADA, as specified in the Olmstead decision.
2 Mission Statement

Independence Care System is dedicated to supporting adults with physical disabilities and chronic conditions to live at home and participate fully in community life.

3 Target Population

The target population for Independence Care System’s Medicare-Medicaid Plan (MMP) is beneficiaries who are dually eligible for Medicare and Medicaid, ages 21 or older; require community-based long-term care services for more than 120 days; and reside within the defined service area. They are not eligible if they are receiving services through the New York State Office of People with Developmental Disabilities system or in a New York State Office of Mental Health facility. There are 123,800 people who are dually eligible who meet the criteria and live in the eight defined counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester. The ICS MMP will operate in 4 of these counties – Bronx, Kings, New York, and Queens – with an eligible population of 106,010 people.

Independence Care System (ICS) is a nonprofit Medicaid Managed Long-Term Care plan. ICS began operation in April, 2000 and currently serves over 5,000 MLTC beneficiaries as of October 2013. It operates in the four largest counties of New York City – Bronx, Kings, New York and Queens. For most of the last 12 years, ICS has generally served a population of adults with physical disabilities, due to neurologic and muscular disease or injury. In 2012, ICS began to serve a chronically ill senior adult population as well. Both groups need 120 days of community based long-term social supports in order to be eligible to enroll in an MLTC plan and ICS.

4 Scope

The Utilization Management (UM) program incorporates the review and evaluation of all aspects of preventive; diagnostic, and treatment services in both inpatient and outpatient care settings.
Independence Care System (ICS) Program embraces a collaborative approach to our member’s care. ICS recognizes UM and Care Management (CM) programs are interrelated and integrate all components to assure that members receive equitable access to care and services across the service network, as well as quality, cost effective care delivered in a timely fashion.

The Program’s policies and procedures are developed by the Utilization Management Department Clinical Staff and are reviewed and updated on an as needed basis, minimally annually.

The Utilization Management policies and procedures are submitted to the Quality Improvement Committee (QIC) annually for formal adoption.

The Medical Director is responsible for the oversight and direction of the Utilization Management program.

The Utilization Management program is assessed for effectiveness, processes and procedures on an annual basis.

**Components of the UM program include, but are not limited to, the following:**

- Prior Authorization and/or notification
- Concurrent review
- Retrospective review
- Outpatient Services review
- Durable medical equipment review
- Evaluation of Utilization Patterns
- Identification of Potential Quality of Care Issues

5 **Purpose**

The ICS Utilization Management Program is developed to incorporate quality of clinical care and quality of services provided to members. The Program is designed to objectively and systematically measure, monitor, evaluate and improve the quality and appropriateness of care and service provided to members. Monitoring is designed to identify and pursue opportunities for improvement. Quality Improvement activities are based upon those findings.
Utilization Management Objectives:

Support the provision of effective, efficient and appropriate utilization of facilities and services through an ongoing monitoring and educational program.

Promote fair and consistent utilization management decision making.

Promote consistency in authorization processing through application of nationally recognized criteria and adherence of UM policies and procedures.

Provide a system to monitor the medical care and ancillary services delivered to our health plan members to ensure services are provided in a timely, effective, and efficient manner consistent with quality, value enhanced care.

Continually monitor, evaluate, and optimize healthcare resource utilization delivered to our health plan members.

Monitor utilization practice patterns of the physicians, contracted hospitals, and contracted ancillary services and specialty providers.

Provide appropriate and timely feedback to members, practitioners, and hospitals to communicate reasons for treatment denial, the minimum clinical criteria required for authorization, and methods for appeal as defined in the UM policies and procedures.

Safeguard medical record, treatment authorization, and all other confidential information through appropriate operational protocols and use of physical mechanisms to protect member-specific information used in UM; all HIPAA and appropriate state regulations regarding confidentiality are observed.

Coordinate UM with quality improvement activities to support the ongoing monitoring of compliance with quality standards for the delivery of health services to members.

Additional objectives may be assigned as identified or needed.

6 Program Structure

The Medical Director has ultimate responsibility for the clinical aspects of the UM program.

Oversight of all Utilization Management performed by ICS is under the direction of the Quality Improvement Committee.
Promoting Appropriate Utilization

The health plan’s UM decision making is based only on appropriateness of care and service and existence of coverage.

The Utilization Review Nurse refers all requests to the Interdisciplinary Team (IDT) to perform a review of their recommendations within the same business day. All determinations are made by the IDT.

The health plan identifies any significant variance from the standard of care, either as a sentinel event if an unjustifiable adverse outcome that warrants immediate action or based on a pattern of practice that falls significantly outside the standards of practice.

Analysis is performed at the plan and local level to identify over or underutilization. More detailed analyses are conducted as warranted to investigate and resolve identified problems.

Performance comparisons are made against benchmarks or goals, and historical norms. Established methodologies are used for measurement purposes to every action plan as established by ICS Quality improvement Committee. Such action plans may include provider education, member education, staff development, administrative changes, provider contract changes and/or alteration of provider privileges. The scope of each action plan is determined based on the circumstances and identified causes that relate to each unique adverse outcome or variance from standard. The scope of each action plan is approved by Medical Director which assures that interventions are timely and meaningful. Re-measurement is performed at appropriate intervals to determine the effectiveness of interventions.

Reporting and Analysis

During the performance of utilization functions, any QI concerns are promptly reported to the Medical Director and for QI review as needed. ICS will also be notified of any potential quality issues as specified by contract.

Prior Authorization trends, denial statistics, bed days, and ambulatory treatment patterns are all recorded and analyzed by QIC at least quarterly.
## Program Staffing

The Utilization Management Program is staffed by members listed below. All staff members are experienced and trained in Utilization Management. All UM program employees who obtain information regarding a patient’s specific medical condition, diagnosis and treatment options or protocols directly from the physicians or dentists are nurses, physician’s assistants, or healthcare providers qualified to provide the service.

<table>
<thead>
<tr>
<th>Position</th>
<th>Responsibility</th>
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<tbody>
<tr>
<td>The Medical Director</td>
<td>The Medical Director is responsible for direct oversight of UM activities. The Medical Director is consulted by participating physicians and the Utilization Management Department’s staff on decisions requiring physician input. The Medical Director is ultimately responsible for all initial adverse medical necessity decisions made by the IDT. The Medical Director is accessible to the staff and willing to interface directly with the providers as needed. Only the Medical Director has the authority to deny authorization for medical services and reverse denials on appeal. The Medical Director is directly involved in all denials related to medical necessity and is available to speak with providers upon request during normal business hours. This collaborative approach facilitates presentation, via discussion, of relevant medical information that may have a bearing on the determination of medical appropriateness before a final decision of denial or approval is made.</td>
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<tr>
<td>Clinical Directors</td>
<td>Clinical Directors, in conjunction with Medical Director, are responsible for supporting and developing the UM program. The Clinical Directors are accessible to the UM staff to supervise the day-to-day implementation and oversight of the UM program. They capture and report data to the Medical Director and QIC. The Clinical Directors work directly with the local affiliated physician networks and delegates to make sure all requested data is being captured.</td>
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Utilization Management Staff

This staff is comprised of licensed nurses and other licensed healthcare practitioners along with non-licensed support staff.

Liaison with Claims and Finance:

Claims and Finance departments are actively engaged in daily communication. Prior Authorizations and facility utilization concurrent review are actively entered into the electronic Care Management system to facilitate claims payment and financial accountability. Meetings with claims and finance are held to define issues related to the authorization process.

7 Utilization Management Processes

All utilization review criteria are consistent with nationally accepted clinical practice guidelines. Medical reviews decisions are made by licensed UM staff members. A licensed medical director or other licensed delegated physician makes all medical denial decisions. The process of utilization management does not include any bonus or other incentive for denials of medically necessary services.

UM Criteria

The UM department staff utilizes recognized medical criteria (see below) to determine appropriate place of service and length of stay (LOS) for inpatient stays as well as specific outpatient services and procedures. When conducting routine prospective, concurrent, and retrospective utilization review all reasonable efforts are made to gather only information necessary to certify the admission, procedure, treatment length of stay and/or frequency and duration of services.

Criteria used to support UM decisions include the following:

- National and local Medicare Coverage Guidelines from the CMS and local Medicare contracted affiliates
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- McKesson’s InterQual® Clinical Decision Support Criteria (licensed for On-line use with multiple users; copies of criteria can be printed on request).

- Local specific coverage criteria developed and approved by the Medical Director.

- Hayes Health Technology

- Other nationally recognized criterion which has been approved by the QIC.

Copies of specific criteria utilized in the determination of the authorization are available on request from the UM department to any requesting practitioner or provider.

Although UM information will be available to all members of the IDT, through the ICS care manager, UM staff will not sit directly on the IDT.

Utilization management standards are reviewed, by the Quality Improvement Committee, at least bi-annually (i.e. every two years), to determine whether the standards utilized meet industry best practices, as well as the health care needs of ICS members.

Utilization management staff will update utilization management standards that require a more immediate change (e.g. a new national Medicare Coverage Determination). These changes will be implemented per state or federal guidance and will be reported to the Quality Improvement Committee, during quarterly meetings.

Utilization Management (UM) Processes for Pharmacy Benefit

UM Criteria for Pharmacy Benefit

The Pharmacy & Therapeutics (P & T) Committee is a committee of MedImpact and is responsible for the review, guidance and clinical approval for the therapeutic use of drugs as contained within the ICS formulary. The Committee decisions on therapeutic designation and appropriate prescribing guidelines are to place products on formulary for use in the ambulatory care setting and will provide for constant updating and revision as appropriate. Placement is based on the objective evaluation of products relative therapeutic efficacy safety, patient outcome and cost effectiveness. Selection of products is based on monographs of drugs and therapeutic classes or disease states based
upon references from government agencies, medical associations, nation’s commissions, peer-reviewed journals and authoritative compendia.

During the drug selection process utilization management (UM) criteria is included for drugs requiring prior authorization, step therapy and quantity limits. UM criteria are added to some drugs for safety, cost-effectiveness and appropriate use of therapeutic alternatives.

Annual formulary files are provided to ICS for review prior to submission to CMS. Upon CMS approval ICS is provided a full formulary file. Monthly updates to the formulary are submitted by MedImpact to CMS; upon approval monthly files are forwarded to ICS, indicating all formulary changes. Separate files for each type of CMS approved UM criteria are also provided to ICS by MedImpact on a monthly basis.

On a monthly basis ICS is provided a report of all members impacted by a formulary change for that month. Report will include member information, claims history and the formulary change impacting member. Members are notified of change via their Explanation of Benefits.

In the case of notification of drug recalls and/or withdrawals, MI will provide ICS a report of all patients who have received drugs withdrawn from the market, and prescribers who have prescribed withdrawn drugs. ICS will be notified of actions taken by MI regarding the drug that has been recalled/withdrawn within 48 hours for Class I and within 30 days for Class I recalls/withdrawals.

UM Approvals/Denials for Pharmacy Benefit

ICS has the ability, to check real time the status of any member requesting a coverage determination/redetermination for drugs with UM criteria. ICS will monitor denials for appropriateness of decision and to ensure that notification to both member and prescriber was timely and appropriate. Additionally, quarterly reports are provided to ICS on all coverage determination/redetermination activity including the type of request and if the request was denied or approved.

ICS receives a daily Transition Notification Report this file contains any members with a transition claim and in the case of non-formulary prescriptions, provided with formulary alternate therapy options. ICS will facilitate contacting the member &/or provider with these options &/or information on pursuing a medical exception request.

Concurrent Review of Pharmacy Benefit
MedImpact, on behalf of ICS, administers concurrent drug utilization review (cDUR) edits to identify and rectify member safety issues at point of sale. The program provides pharmacist advisory online messages and warnings before a prescription is dispensed. There are eight different cDUR edits; Drug Interaction, Drug Dosage, Ingredient Duplication, Age Precaution, Pregnancy Precaution, Gender Conflict, and Therapeutic Duplication.

cDUR reports will be provided to ICS, on a monthly basis with inappropriate utilization pattern identified, including under and over utilization. ICS will engage providers as necessary regarding potential inappropriate drug utilization. Follow up reports will be utilized to monitor and measure provider behavior as a result of interventions.

Retrospective Review of Pharmacy Benefit

On a quarterly basis, MedImpact will conduct Retrospective Drug Utilization Evaluations on various sample program topics and criteria used to determine treatment and utilization patterns. Topics will be determined by ICS, and will be based upon targeted populations within membership to improve the prescribing, administration and use of medications. MedImpact will provide ICS quarterly reports focused on topics identified. Program will target primarily prescribers through educational materials which encourage and promote clinically appropriated and fiscally responsible medication therapy.

Medication Therapy Management Program (MTMP)

MedImpact will administer ICS’s CMS approved MTMP, including identification of members eligible, Comprehensive Medication Review (CMR’s), and Targeted Medication Reviews (TMR’s). ICS’s IDT will engage in scheduled CMR’s and will receive copies of CMR’s upon completion as well as monthly Case Management Reports. Additional monthly reports will summarize all MTMP services provided. Quarterly service summary reports will be provided to ICS providing detail on beneficiary interventions, education summaries. Outcome reports detailing cost savings and therapeutic changes based upon recommendations will be also be provided quarterly.

Authorizations by the IDT
The IDT makes coverage determinations and authorizes virtually all of the FIDA Demonstration Covered Items and Services. Some of these items and services will be authorized through the Person-Centered Service Plan and others will be authorized as the need arises, as described below.

Most service planning and authorization decisions are made collaboratively by all IDT members, including the member and/or his/her designee. While all
decision-making should involve all IDT members, not all IDT members must agree with the decision in order for it to stand. The IDT members are expected to strive for compromise where agreements cannot be reached.

ICS will assemble a Participant’s IDT as soon as possible but no later than 30 days from the effective date of enrollment of the Participant. Notwithstanding the requirements of this section, in the interim period between the effective date of enrollment and the date upon which the IDT has been assembled, service authorizations related to new needs for service that arise during this time may be made by and only by the FIDA Plan Medical Director.

The IDT is responsible authorizing all items and services that can be anticipated through the PCSP which is to be updated at least every 6 months. IDT members must operate within their professional scope of practice, appropriate for responding to and meeting the participant’s needs, and complying with the State’s licensure/credentialing requirements. Each member of the IDT must meet the applicable state, federal, or other requirements for his/her profession. While the IDT is highly encouraged to work collaboratively, where consensus and compromise are not possible, and where a care decision is required to be made by a provider with a certain licensure and or certification under the applicable laws and regulations of New York State, the ultimate decision always rests with the appropriately licensed/certified treating member(s) of the IDT.

The IDT is able to authorize items and services through the PCSP development process. Any items or services indicated in the most recent version of the PCSP are authorized by virtue of the IDT’s agreement to the PCSP. The services will remain authorized until the IDT changes the PCSP so that those services are no longer indicated. There shall be no further internal or external review of the PCSP within the FIDA plan. However, between IDT meetings, ICS is responsible for authorizing items and services not indicated in the PCSP. All service authorizations shall be made with consideration given to clinical guidelines, evidence-based best practices, and medical necessity.

In the event that the need for services is a change of condition that would prompt a Reassessment, the Comprehensive Reassessment and PCSP update/revision process will begin immediately as outlined in the IDT policy.

When Participants are in a hospital awaiting discharge because of a need for community-based services or nursing facility placement authorization, IDTs shall provide any prior authorizations within 48 hours of readiness for discharge to ensure that delays do not adversely affect discharge planning at the hospital or service delivery.
Timing of Authorization Decisions

For standard authorization decisions ICS must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 3 calendar days after the date the organization receives the request for service, with a possible extension of up to 14 additional calendar days, if the enrollee, or the provider, requests an extension; if ICS justifies a need for additional information and how the extension is in the enrollee's interest or; if there is a need for additional information where there is reasonable likelihood that receipt of such information would lead to approval of the request, and provided that the outstanding information is reasonably expected to be received within 14 calendar days.

For cases in which a provider indicates, or ICS determines, that following the standard timeframe could seriously jeopardize the enrollee’s life or health or ability to attain, maintain, or regain maximum function, ICS must make an expedited authorization decision and provide notice as expeditiously as the enrollee’s health condition requires and no later than 24 hours after receipt of the request for service. ICS may extend the 24 hour time period by up to 14 calendar days if the enrollee or provider requests an extension, or if ICS justifies to NYSDOH and CMS upon request) that the extension is in the enrollee's interest and that there is additional information needed because the receipt of such information is reasonably expected to result in an approval of the request, and that the outstanding information is reasonably expected to be received within 14 days.

Services Exempt from IDT Prior-Authorization Requirements

ICS and the IDT ensure that the member can self-refer for the following services:
1) Emergency or Urgently Needed Care;
2) Out-Of-Network Dialysis when the Participant is out of the service area;
3) Primary Care Doctor visits;
4) Family planning and Women’s Health specialists services;
5) For any Participant that is an Indian eligible to receive services from a participating Indian health care provider; Indian Health Service (IHS); and Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider; covered services provided by that I/T/U provider, as long as that provider has capacity to provide the services;
6) Public health agency facilities for Tuberculosis Screening, Diagnosis and Treatment; including Tuberculosis Screening, Diagnosis and Treatment; Directly Observed Therapy (TB/DOT);
7) Immunizations;
8) Palliative care;
9) Other preventative services;
10) Vision Services through Article 28 clinics that provide optometry services and are affiliated with the College of Optometry of the State University of New York to obtain covered optometry services;
11) Dental Services through Article 28 Clinics Operated by Academic Dental Centers;
12) Cardiac Rehabilitation, first course of treatment (a physician or RN authorization for subsequent courses of treatment);
13) Supplemental Education, Wellness, and Health Management Services.
14) Prescription drugs:
   a. Which are on the formulary, or
   b. Which are not on the formulary, but where a refill request is made for an existing prescription within the 90-day transitional period.

Services that must be authorized by a specialist (not ICS or the IDT):
   1) Preventative Dental x-rays – these require Dentist authorization
   2) Comprehensive Dental – These services require Dentist authorization
   3) Eye Wear – These require Optometrist or ophthalmologist authorization
   4) Hearing aids – these require Audiologist authorization.

Prior Authorization

Request for authorization of services may be initiated by a member, licensed hospital, physician, specialist or other ordering practitioner or provider either by telephone, mail, or fax. Providers and IDTs are informed of which services require prior authorizations and made aware of the procedures and required time-frames for prior authorization through provider handbooks, newsletters, and periodic training. Requested services are compared to the Evidence of Coverage (EOC) and InterQual® guidelines for medical necessity.

For a service that must be pre-authorized, the IDT must decide and provide notice of a determination to the Participant or Participant's designee and the Participant's health care provider by telephone and in writing within three business days of receipt of the necessary information.

- Pre- Authorization of selected medical service is required prior to services being rendered. ICS has appropriate personnel reasonably available at toll free number to accept verbal and written requests for services and to provide authorization determinations between the hours 8:00 am to 6:00
pm local time on work days Monday through Friday. After hours, weekends, and holidays, the on-call UM nurse is available via telephone.

- The health plan has staffing available, during regular business hours (local time) for verification of eligibility, benefits and other services not delegated.

- Members have direct access to Women’s Health Specialists within the health plans’ networks. No referral from the primary care physician is necessary. Women’s Health Specialists may directly request preauthorization for all procedures relating to women’s health issues.

- For emergency situations, a physician and behavioral health provider are available 24 hours a day, seven days a week to authorize necessary services and to coordinate the transfer of stabilized members in an emergency.
  
  o After the authorization is made the IDT and Care Management Interdisciplinary Team (CMIT) will follow the policies and procedures outlined in the Transitions of Care Policy and Procedure (CM.4).

**Denials**

Any decision to deny an item or service authorization request or to authorize an item or service in an amount, duration, or scope that is less than requested must be made in accordance with IDT policy (dated June 5, 2014) and process requirements and in compliance with 42 CFR 438.210.

**Denial of a Prior Authorization Request**

The Medical Director is responsible for making all denial recommendations, including out-of network denial decisions. The Medical Director reviews requests on a case-by-case basis taking into consideration special circumstances that may deviate from established protocols. The ultimate denial of an authorization, however, is made by the IDT. Authorizations follow the policies and procedures outlined in the Coverage Determination Policy and Procedure (i.e. CO.20).

**Determination of Extended Health Care Services**

1) For a determination involving continued or extended health care services, additional services for a member undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, ICS will provide notice of such determination
to the member or the member’s designee, which may be satisfied by notice to the member’s health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, in which case ICS shall provide notice of the determination within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. For a determination involving health care services which have been already delivered, the FIDA Plan shall provide notice of the determination within fourteen days of receipt of the request for service.

Extensions and Failure to Meet Timeframes

1) Failure by the IDT to make a determination within the time periods prescribed in this section shall be deemed to be an adverse determination subject to appeal pursuant to the FIDA Demonstration appeals process.

2) For standard authorization decisions, ICS shall provide notice as expeditiously as the member’s health condition requires and no later than 3 calendar days after receipt of the request for service, with a possible extension not to exceed 14 additional calendar days. Such extension shall only be allowed if:

- The member or the Provider requests an extension, or
- ICS can justify (to the satisfaction of NYSDOH and CMS upon request) that:
  - The extension is in the member’s interest; and
  - There is a need for additional information where:
    - There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
    - Such outstanding information is reasonably expected to be received within 14 calendar days.

Members in an Inpatient Setting

1) FIDA Plan will ensure that when Participants are in a hospital awaiting discharge because of a need for community-based services or nursing facility placement authorization, IDTs shall provide any prior authorizations within 48 hours of readiness for discharge to ensure that delays do not adversely affect discharge planning at the hospital or service delivery.

Expeditied Service Authorization Decisions

1) For expedited service authorization decisions, where the Provider indicates or the FIDA Plan determines that following the standard timeframe could seriously jeopardize the Participant’s life or health or ability to attain, maintain,
or regain maximum function, the FIDA Plan must make a decision and provide notice as expeditiously as the Participant’s health condition requires and no later than 24 hours after receipt of the request for service, with a possible extension not to exceed 14 additional calendar days. Such extension shall only be allowed if:

- The Participant or the Provider requests an extension; or
- The FIDA Plan can justify (to NYSDOH and CMS upon request) that:
  - The extension is in the Participant’s interest; and
  - There is a need for additional information where:
    - There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

Such outstanding information is reasonably expected to be received within 14 calendar days.

**Concurrent Review of Inpatient Care**

Concurrent review is conducted in accordance with the provider contract. Concurrent review includes a review of medical necessity, the determination of the next review date, discharge planning, and researching and coordinating alternatives to inpatient care with the IDT (e.g., Home Healthcare).

**Retrospective Review**

Unauthorized care for services that have been completed prior to notifying ICS may be retrospectively reviewed. Services are compared to the Evidence of Coverage (EOC) and InterQual® guidelines for medical necessity, appropriateness of setting, and length of stay. This may result in disallowing inappropriate services. Certain facility contracts require notification of urgent admissions within a certain number of business days. Late notification secondary to contractual issues may result in an administrative denial. When that occurs, retrospective review for medical necessity is not performed. The facility is responsible for completion of the claims review/appeals process. The member is not financially liable for any administrative denial related to facility contract issues. Concurrent review includes a review of medical necessity, the determination of the next review date, discharge planning, and researching and coordinating alternatives to inpatient care with the IDT (e.g., Home Healthcare).

Retrospective review may occur for authorized services in order to match the preauthorized information with the clinical findings and the services performed. A discrepancy may result in the recommendation for non-authorization of payment for services not authorized.
Processing of Denials

Authorization consists of concurrence with medical necessity and agreement to pay for services to the extent of the benefit level; denial of services is the suspension or withholding of authorization.

The Medical Director reviews all medical necessity and out-of-network requests, which are potential denials. Consultation with the requesting provider may occur when appropriate. This includes retrospective reviews of medical services and requests for continuity of care.

Denial Notices

The Health Plan clearly documents and communicates the reasons for each medical necessity denial. Members and practitioners or providers receive sufficient information via mail or fax to understand and decide whether to appeal a decision to deny care or coverage.

8 Satisfaction with the UM Process

ICS continually assesses provider and member satisfaction with the UM process to identify areas for improvement. Feedback from members shall be conducted annually with data analyzed through the quality improvement process with applicable interventions and actions taken. Member feedback may be obtained through a member survey.

9 Transplant Coordination

All transplant evaluations or requests are forwarded to the UM Team, who has a registered nurse trained in the management of transplant coordination. ICS requires all transplants to be coordinated prior to receiving any services.

All evaluations and requests are reviewed by the ICS Medical Director on an expedited basis. The Utilization review Nurse along with the IDT assumes coordination of transplant-related services from the time of the referral until a year post-transplant, including assisting member with any applicable travel expenses covered under the Travel Expense Policy.

10 Quality Improvement and Performance
The UM program is audited internally to ensure consistent optimum performance. All staff performing utilization management activities are required to maintain 95% compliance on a monthly basis. If the score falls below 95%, an action plan is developed to improve reviewer performance to required standards. If consistent opportunities for improvement are identified, a corrective action plan is developed and changes are made to the program. The effectiveness of those changes is evaluated via the continuous quality improvement cycle.

**11 Reporting and Analysis**

During the performance of utilization functions, any QI concerns are promptly reported to the Medical Director and for QI review as needed.

Prior Authorization trends, denial statistics, bed days, and ambulatory treatment patterns are all recorded and analyzed by the QIC at least quarterly.

These reports are evaluated by the plan’s Medical Director for over- and inappropriate utilization.

**12 Appeals and Grievances**

ICS maintains written policies and procedures for thorough, appropriate, and timely resolution of member appeals to make certain that there is a full and fair process for resolving member disputes and responding to member requests to reconsider a decision the member may find unacceptable regarding their care and service.

All appeals and grievances are forwarded to the Appeals and Grievances (A&G) department for logging and further evaluation. Quality of Service (QOS) grievances are investigated by the A&G department with the assistance of the plan, while Quality of Care (QOC) Grievances are sent to the QOC Coordinator in the Quality Improvement department for further investigation. Appeals are sent to Utilization Management and presented to the Medical Director for reconsideration. All appeal denials are sent to a Center for Medicare and Medicaid Services (CMS) Qualified Independent Contractor per CMS policies. All QOC complaints are also reviewed by a Medical Director and reported to the QIC Committee for further action if appropriate.
13 Evaluation of the Program

Performance Measurement Activities

Utilization Management has developed a core set of performance measures called Key Performance Indicators (KPI).

The Key Performance Indicators that are produced and analyzed by the plan and reported to Quality Improvement Committee and may include but not be limited to the following:

- Inpatient utilization patterns: admits; admits per 1,000 enrollees; days; days per 1,000 enrollees; and average length of stay (ALOS).

- Outpatient utilization patterns: visits, visits per 1,000 enrollees, and average number of visits.

- Accessibility of services via direct care practitioner or providers in network.

- Acute inpatient readmissions.

- Ambulatory follow-up after discharge from acute inpatient stay.

- Timeliness of clinical review processes.

- Consistency of application of medical necessity criteria (i.e., tests of inter-rater reliability) for Utilization Review Nurses, Medical Directors, and other professionals involved in the UM decision making process, including appeals.

- Adherence to clinical practice guidelines.

- Coordination between behavioral healthcare and medical care.

- Timeliness and outcomes of appeal process.

- Adverse incident and Quality of Care occurrence reporting.

Program Effectiveness
The Utilization Management Program, work plan, and clinical criteria are reviewed and approved through the quality improvement structure on an annual basis.

The evaluation of the Utilization Management Program includes, but is not limited to, the following:

- Creating and reviewing policies and procedures related to utilization management.
- Monitoring trends and patterns of key utilization management indicators for over-and under-utilization of items, services, and prescription drugs, and appropriateness of care.
- Requesting studies or focused reviews, if applicable, on areas identified from data review suggest the potential for affecting the outcomes of care and related quality concerns.
- Annually, after the completion of the year, the QIC evaluates the impact of the UM program. The evaluation identifies problems and/or concerns and provides UM recommendations for removing barriers to improvement. A Utilization work plan is developed each year under the auspices of the Quality Improvement Program and collects data for program evaluation.
- UM Staff decisions are audited on a routine basis to determine compliance with UM Policy and Procedures.
- All criteria used for Utilization Management decisions are reviewed, modified as appropriate, and approved through the quality improvement structure on an annual basis.
- Policies and procedures are evaluated on an annual basis. Policies and procedures are updated as necessary.

Tracking and utilization trend data will be shared routinely with participating physicians for purposes of continued education and improvement. At any time when an outlier pattern identified, the local UM Committee Chairman or his/her designee will thoroughly review the pattern with the physician involved. This collaborative discussion will be for educational purposes and in all cases will be a physician-to-physician personal contact. This may be related to utilization patterns, such as long length of stays or continuing failure to submit clinical information with inappropriate requests.
14 Confidentiality, HIPAA, and Privacy

ICS is committed in all its endeavors to comply with the federal Standards for Privacy of Individual Identifiable Health Information known as “HIPAA” or the “Privacy Rules” (45 CFR parts 160 and 164). In connection with the UM protocols and services described in the UM Program, a Business Associate working with Covered Entities will comply with all applicable federal and state confidentiality and security laws, adhering to the provisions of the Privacy Rule and Security standards applicable to a Business Associate to include, but not be limited to, the following privacy and security practices:

- Use and disclosure of protected health information (“PHI”)
- Disclosure to agents and subcontractors
- Proper use and disclosure of designated records sets
- Data aggregation
- Use of authorizations, where applicable
- Minimum necessary disclosures.

Protected Health Information (“PHI”) as defined by HIPAA or its states equivalents are kept confidential in accordance with applicable federal and state laws and will not be used in violation of such applicable laws.

15 Affirmative Statement Regarding Incentives

ICS provides no incentive, financial or otherwise, to discourage appropriate utilization or to encourage underutilization of care or services, nor does the health plan use incentives to encourage barriers to care and service. ICS distributes the following statement to all members and to all practitioners, practitioner or providers and employees who make UM decisions. Distribution may be made through the practitioner or provider and member web portals, via newsletters or other forms of written notification.

- UM decision making shall be based only on appropriateness of care and service and the existence of coverage.
- ICS does not reward practitioners or other individuals for issuing denials of coverage or care.
• There are no financial incentives for UM decision-makers to encourage decisions that result in underutilization of care or services.

16 Inter-Rater Reliability

ICS will evaluate the consistency with which healthcare professionals involved in UM apply criteria in decision making. When opportunities for improvement are identified through the review process, appropriate interventions will be taken.

Inter-rater reliability shall apply only to recommendations made as part of the UM process, i.e., any referral that requires prior approval is considered a UM recommendation where a primary care practitioner referring a member to a specialist is not considered a UM recommendation when the referral does not require preauthorization.

17 Delegation

Should any function of Utilization Management be delegated to another entity, delegation standards shall be adhered to and based on requirements set forth by the Centers for Medicare and Medicaid Services (CMS) including the following:

• Pre-delegation audit

• Annual audit

• Corrective action plans, as necessary

• Delegation agreement with delineated responsibilities, handling of protected health information and terms for revocation

• Regular reporting due to ICS.

18 Evaluation of New Technology, Experimental, and Investigative Review

ICS evaluates the inclusion of new technology and the new application of existing technology in its benefits plan, including medical and behavioral health
procedures, pharmaceuticals and devices. Evaluation of new technology, experimental, and investigative is described in a separate policy.

When a request for services is considered being experimental or new technology for which CMS has not yet issued a national coverage determination, the request is forwarded to the Medical Director. Hayes Technology assessment services are consulted before a determination is made. Additional consultation with the health plan's Medical Director is recommended for case approval or utilization of the Benefits Exception Policy. Please refer to Benefits Exception Policies and Procedures.

19 Advance Directives

An Advance Directive is a written document completed in advance of an incapacitating illness or injury in which the member specifically makes choices about healthcare treatments or names someone to make those treatment decisions should the member become incapacitated. It is the function of ICS to inform members of the right to institute advance directives in compliance with the Federal Law 1990 “Patient Self-Determination Act.”

The Utilization Management Program description for 2014 above was reviewed and adopted by the Quality Improvement Committee on

_________________________________  _______________________
Medical Director                        Date

_________________________________  _______________________
Director of Quality Assurance           Date