GROUP HEALTH COOPERATIVE OF SOUTH CENTRAL WISCONSIN

Utilization Management

2016 Program Description

Group Health Cooperative of South Central Wisconsin has a structured UM Program that allows for fair, impartial and consistent utilization decisions affecting the health care of our members.

To keep the UM program current and appropriate, GHC-SCW annually evaluates:

- The program structure, scope, processes, and information sources used to determine benefit coverage and medical necessity.
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioners in the program.
- Member and practitioner experience data

The UM program description is reviewed and approved by the Clinical and Service Quality Committee (CSQC) annually. The CSQC may provide recommendations for QI activities to improve the comprehensive UM program. GHC-SCW's Medical Directors for Medical and Behavioral Health provide direction and oversight for revising the UM program structure or processes based on the above assessments and evaluations.

Program Structure UM 1 A factor 1 p 2-

GHC-SCW's UM Staff consists of the following individuals:

1. Behavioral Health Team
    a. Medical Director of Behavioral Health
    b. Director for Medical Specialty Services
    c. Case Managers – Social Workers
    d. Behavioral Health Utilization Management Social Workers
    e. Care Management Manager
2. Medical Health Team
    a. Medical Director of Care Management
    b. Physician Reviewers
    c. Care Management Manager
    d. Utilization Coordinator – LPN
    e. Utilization Management RNs
    f. Care Management Associates
    g. Case Managers – RNs and Social Workers

UM Staff apply evidence-based criteria to requested services and approve when criteria has been met. In the event criteria is not met, UM Staff prepare case review for presentation at scheduled rounds which are conducted three times weekly. UM staff presents cases to the Medical Director or Medical Director for Behavioral Health and/or Physician Reviewer for determination of medical necessity. These scheduled rounds are an opportunity to develop inter-rater reliability amongst UM reviewers. Per department policy, all UM reviewers attend all scheduled rounds.

GHC-SCW's Medical Director is a Board Certified Family Practice physician who is responsible for the implementation of clinical utilization management (including behavioral health care aspects) and quality improvement. Medical effectiveness and utilization trends are shared with the medical staff on

an ongoing basis to monitor under and over utilization. The Medical Director is available by cell phone and/or in the administrative office and will provide for appropriate coverage if unavailable by designating a qualified, licensed senior physician to act in their absence, as necessary.

The Medical Director for Behavioral Health is a psychiatrist who is actively seeing patients part-time for GHC-SCW. GHC-SCW's Medical Director is available for Behavioral Health reviews as back up as needed.

Medical and Behavioral Health reviews for determining medical necessity are performed utilizing the following criteria:

1. Milliman (MCG) 19th Edition
2. ASAM
3. GHC-SCW CM.MED and TAC internal Policies
4. Hayes, Inc.

Purpose:
To conduct a series of coordinated and integrated activities that assist in:

1. Maintaining and improving high quality medical and behavioral health care and services to our members across the full continuum of care.
2. Meeting fiduciary responsibilities.
3. Complying with accreditation and regulatory requirements.

Goals:
To be objective, consistent, impartial, and fair while at the same time achieving the following standards:

1. Promoting, monitoring, and evaluating the delivery of high quality, cost effective medical and behavioral health or Substance Use Disorder (SUD) care services for all members
2. Making UM decisions based on medical necessity, appropriateness, and availability of resources and benefits
3. Ensuring confidentiality of personal health information
4. Monitoring and improving practitioner and member satisfaction
5. Connecting members to case management services when appropriate

Objectives:

1. To provide consistency during the UM review and decision making process
2. To ensure that medical and behavioral health care and SUD services are medically necessary, appropriate, and provided in the most cost-effective setting.
3. To facilitate communication and collaboration among members, practitioners/providers and the organization in an effort to support cooperation and appropriate utilization of health care benefits.
4. To provide information to practitioners regarding utilization management updates and activities.
5. To identify high utilization of resources and implement appropriate case management activities.
6. To render timely determinations and issue timely notifications.

7. To identify and initiate process improvement activities to enhance overall quality improvement.
8. To assist with discharge planning and transition of care issues.

Utilization Management Structure and Accountability
(UM 1 Element A; UM 1 Element B & C)

The GHC-SCW Board of Directors grants UM authority to the Chief Medical Officer and the Medical Director of Care Management with the Medical Director having direct responsibility for UM activities. The Medical Director delegates the responsibilities of the daily UM operations to the Care Management Manager. The Medical Director of Care Management also delegates behavior health and SUD UM activities to the Medical Director of Behavioral Health and Director of Medical Specialty Services, Pharmacy UM activities to the Manager of Pharmacy Services, and Chiropractic UM activities to the Chiropractic Chief of Staff.

The Medical Director of Care Management and the Care Management Manager conduct an annual evaluation of the program structure, processes, and sources used to determine benefit coverage and medical necessity including UM Policies. The outcome of an effective UM Program demonstrates appropriate utilization of medical resources to maximize the effectiveness of care and services provided to the members. Updates to the written UM Program Description are presented at least annually to the Clinical and Services Quality Committee for review and approval.

UM Responsibilities
The following persons are actively involved in implementing specific aspects of the UM Program.

1. *Medical Director* – responsibilities include, but are not limited to:
    a. General Care Management (CM) Department oversight.
    b. Serves as the liaison between the organization's primary care practitioners and external specialists and the Care Management Department.
    c. Assists in the analysis of utilization data for problem identification and prioritization
    d. Develops and implements action plans along with evaluation of corrective actions.
    e. Acts as the primary physician reviewer and makes determinations regarding:
        i. All Medical Necessity denial determinations.
        ii. All potentially cosmetic/experimental procedures.
        iii. Out-of-network practitioners.
    f. Assists in the selection of UM criteria, reviews and updates medical policies.
    g. Chairs the Technology Assessment Committee and participates in reviews.
    h. Collaborates with vendors, employer groups, and providers regarding UM issues, and serves as a clinical resource for the Care Management Department.
    i. Participates in CSQC meetings as appropriate.
    j. Actively involved in implementing GHC-SCW's UM program.
    k. Delegates UM decisions to other physician reviewers as needed. Other physician reviewers include:
        i. *GHC-SCW's Chief Medical Officer*
        ii. *Primary Care Physician Reviewers*
        iii. *Medical Director of Behavioral Health*

iv. *Chiropractic Chief of Staff*

2. The Behavioral Health Medical Directors responsibilities include, but are not limited to:
    a. Assists with the development, revisions, and/or implementation of Mental Health UM activities, policies, and procedures.
    b. Reviews and makes determinations regarding:
        i. All Medical Necessity Behavioral Health denial determinations including SUD, transitional & inpatient admissions and continued stay.
        ii. Requests for services with Out-of-network practitioners
    c. Actively involved in implementing the behavioral healthcare aspects of the UM Program.
    d. Attends Continuity & Coordination of Medical and Behavioral Health Care Committee and Technology Assessment Committee (TAC), meetings as appropriate.
3. The Director of Medical Specialty Services responsibilities include, but are not limited to:
    a. Making decisions regarding the appropriateness of behavioral health services including the level of care and proper setting based on evidence-based criteria including Milliman Care Guidelines, Technology Assessment Policies, American Society of Addiction Medicine (ASAM), or Care Management Medical Policies.
    b. Delegating clinical decision making to a Master's level clinician, who has a minimum of five years of experience who can then provide and supervise initial assessments, prioritization of patients for behavioral health treatment via telephone and/or face to face intake (triage).
    c. Ensuring all departmental therapists are duly licensed by the State of Wisconsin for their appropriate level licensure in order that they are able to participate in prioritization of members for behavioral health treatment and referral decision making.
    d. Supports the use of a licensed board certified psychiatrist for oversight of inpatient utilization services and formal denials of other behavioral health services.
    e. Participates in the Technology Assessment Committee (TAC) as needed.
4. Chiropractor Chief of Staff
    a. Reviews and makes determinations regarding retrospective Chiropractic Care.
5. The Care Management Manager's responsibilities include, but are not limited to:
    a. Directs and manages the UM/CM Processes and the Care Management Department,
    b. Collaborates with the Medical Director, on the annual review of the effectiveness of the UM Program.
    c. Ensures that the department is in compliance with NCQA Standards and regulatory requirements.
    d. Develops, revises, and implements CM policies.
    e. Coordinates Inter-rater reliability activities and UM Rounds, both medical and mental health (behavioral health and SUD).
    f. Collaborates with internal practitioners, external vendors, employer groups, and providers regarding UM issues.
    g. Supervises staff responsible for making administrative denials.
    h. Participates in multi-departmental committees related to appeals, benefits, finance, operations, and technologies.
    i. Assists the Medical Director with technology assessment.
    j. Updates and presents UM and CM program descriptions annually to CSQC for approval.

6. Case Managers (RN/SW), Utilization Management RNs, and Utilization Coordinators (LPNs) responsibilities for medical and behavioral health include, but are not limited to:
    a. Perform pre-service, concurrent, and post-service reviews.
    b. Utilization Management RNs can approve UM benefit and medical coverage if medical and or benefit criteria is met. If medical criteria are not met, case must be taken to medical rounds for the Medical Director/Physician Reviewer approval or denial.
    c. Case Managers can approve Transition of Care for periods of up to 90 days for new members who meet for continuity of care.
    d. Utilization Coordinators may approve services per criteria and deny administrative benefit coverage only.
    e. Assuring referral authorizations and administrative denials are made within recommended time frames.
    f. Collaboration with internal practitioners, external vendors, employer groups, and providers on UM issues.
    g. Participating with inter-disciplinary committees.
    h. Collaborating with patient, providers and employer groups to assess, plan, implement, coordinate, monitor and evaluate options and services.
    i. Assist in the management of patient care to ensure optimum outcomes.
    j. Provide education and assistance with available resources to promote quality, and cost effective outcomes.
7. Care Management Associates (CMA) responsibilities include, but are not limited to:
    a. Perform timely data entry of referrals.
    b. Care Management Associates can make benefit approvals on procedures and tests that are listed on the CMA approval list. This list is reviewed as needed and at least annually.
    c. Provide assistance to the UM staff to ensure timeliness of referral activities, i.e. obtaining On Base scans for UM staff to begin their reviews.
    d. Direct practitioners to appropriate referral resources.
    e. Authorize routine referral services that do not require a Prior Authorization.
    f. Refer all services requiring prior authorization to UM Staff.
    g. Conduct 2nd claims review.
    h. Ensure timely printing of pre-certification, authorization and denial letters.
8. Manager of Pharmacy Services responsibilities include, but are not limited to:
    a. Making pharmaceutical determinations based on medical necessity and the implementation of a recommended step-therapy protocol.
    b. Manages administrative pharmacists who make UM approvals and denials.
9. Manager of Member Services responsibilities include, but are not limited to:
    a. Processing appeals of UM denials.
    b. Manages the day to day activities of Member Services staff that provide members with benefit information and explanation.

Scope (UM 1 Element A)

Care Management develops criteria for UM Staff through the Technology Assessment Committee and/or with input from an appropriate specialist. As new procedures, medications and treatments become available, the Technology Assessment Committee reviews related research information from reputable resources such as Hayes Technology. The committee meets and discusses the research

including the input from specialists to determine whether the technology is appropriate, evidence-based and/or standard of practice. Medical or Behavioral Health criteria may be revised periodically as changes occur and/or annually by Medical Director or Technology Committee.

UM staff has policies and workflow processes to assist them in determining referral management, outpatient and inpatient medical necessity along with the appropriate medical and/or behavioral health criteria sets. Each UM staff is trained in applying the evidence based criteria and in preparing UM reviews for the Medical Director and/or Physician Reviewer. UM staff audits are also performed biannually to ensure consistency with what is being provided to the Medical Director, that proper selection and application of evidence-based criteria is taking place, and that any administrative denials are made within the UM's scope.

UM staff has written procedures delineating how to document and select the appropriate policy, TAC, or Milliman Guideline to support the clinical decisions they are making. These procedures are contained in policy CM.MED.002 Care Management Review Criteria.

The scope of UM activities for Medical and Behavioral Health include but are not limited to the following functions:

1. Benefit clarification.
2. Referral Management.
3. Pre-service, concurrent, and post-service review and timely determinations.
4. Out-of-area services.
5. Complex Care Management, including discharge planning and transition of care.
6. Second review of claims.
7. Technology assessment.
8. Inter-rater reliability.
9. Monitoring adverse effects and sentinel events.
10. Integration with QM Department, Pharmacy, Mental Health Department, Marketing, Finance, and Insurance Operations.
11. Interdisciplinary communications.
12. Over and underutilization.
13. Review, discussion, and adaptation of UM criteria to NCQA language.
14. Develop policies to clarify benefits.
15. Denial and appeal notifications.

Processes for the UM activities/functions:

1. Benefit clarification to determine whether member has coverage
    a. UM staff is responsible to know the benefits related to a member's Certificate language when requests are received for a UM review
    b. UM staff checks eligibility on each UM requests received as part of the review process
2. Prior Authorization Management
    a. GHC-SCW provides Primary Care services and select specialty services within GHC-SCW owned clinics. Specialty services/care outside of a GHC-SCW owned clinic is subject to requiring prior authorization. The prior authorization list is determined by senior

leaders and based upon standards of practice and financial impact of select services. PCP's initiate outside services with a written order.

b. PCP submits an order to Care Management Associates who are responsible for either approving the request or routing it to UM Staff for review. Policy CM.MED.028 Referral Requests and the Special Review outline steps for approval.

Type of Review	Decision Timeline	Written Notification	Verbal	Extension
Routine (non-urgent)	15 calendar days from receipt	15-45 days		Written extension before 15 days
Urgent	48-72 hours of receipt	3 calendar days after verbal	72 hours of receipt -Notified member within 24 hours regarding lack of info	If insufficient info/lack of info and requested by GHC, can allow 1 day up to 48 hours to obtain info
Concurrent (Active Treatment)	24 hours of receipt	24 hours	72 hours of receipt	24 hours – additional info needed extend up to 72 hours
Retro	30 calendar days	30 calendar days		

3. Pre-service, concurrent, and post-service review and timely determinations; Over and underutilization of services; Denial and appeal notifications
    a. UM staff follows NCQA guidelines for timely decision making in each respective category:
        i. CM.MED.007 Pre-Service and Timely Determinations
    b. UM staff utilize evidence based medicine guidelines which consists of the following:
        i. Member's Certificate language-benefit information
        ii. Care Management Medical Policies, TAC policies, Milliman 19th Edition, ASAM, Hayes
    c. UM staff utilize the policy/guidelines in the UM process and documents the appropriate clinical information within Epic to show if the services received meet/not meet the guidelines
        i. policy CM.MED.013 Documentation of Clinical Information
    d. UM staff prepares cases for review by MD which do not meet guideline/criteria in a timely manner as defined in the NCQA Standards and Guidelines, table above and CM.MED .003
    e. ER services are not reviewed for medical necessity
    f. Out of area services follows #3 above and are reviewed by the Medical Director/Physician Reviewers to determine medical necessity and adherence to policies and benefit coverage

4. Complex Case Management, including discharge planning and transition of care (TOC)
    a. Complex Case Management follows the Complex Case Management Program
    b. Case Managers assist with discharge planning and TOC following policy CM.MED.012; Discharge Planning and Transition of Care.
5. Second review of claims
    a. "Pended" claims are reviewed by UM staff for claims which have no prior authorization on file or do not match a current authorization; (retrospective)
    b. PPO members who do not obtain prior authorization according to their benefit summary may be penalized by UM Reviewers as stated in the Member's Schedule of Benefits
6. Technology Assessment
    a. Policy CM.ADM.010 Technology Assessment Committee documents the existence of the Technology Assessment Committee and its role at GHC-SCW
    b. Peer reviewers/specialists provide clinical information on new technologies/procedures/trends within medical, pharmacy and behavioral health fields
7. Inter-rater reliability
    a. Policy CM.MED. 011 Inter-rater Reliability documents the process that GHC-SCW uses to review and assess the consistency of personnel involved in making utilization review determinations.
8. Monitoring for adverse effects and sentinel events
    a. Policy CM.MED.018 Quality of Care Issues establishes procedures for dealing with "adverse events" associated with the care of members within GHC-SCW clinics/services or contracted medical staff and facilities.

UM Clinical Criteria Review (UM 1 Element A ; UM 2 Elements A & B)

UM staff makes determinations based on medical necessity and appropriateness for inpatient and outpatient care including behavioral health and SUD. Staff uses clearly written, published criteria which is evidence-based to evaluate the necessity of medical services. These criteria sets are intended to be used as guidelines, and in combination with professional clinical judgment, applied when determining necessity of requested services. Adaptation of these guidelines may be necessary based on individual needs and standard of care within the local delivery system.

The Care Management Manager annually reviews the criteria and the procedures for applying them and updates the criteria when appropriate. The criteria used are the most current edition of:

- Milliman Care Guidelines (released in February of each calendar year)
- ASAM
- GHC-SCW Care Management policies and/or Technology Assessment policies as delineated in CM.MED.002
- Hayes, Inc.

The UM decisions are determined with the use of nationally developed guidelines/criteria, as well as, GHC-SCW considers the following additional information regarding our members:

- Age
- Comorbidities
- Complications
- Progress of treatment

- Psychosocial situation
- Home environment, when applicable

GHC-SCW also considers the characteristics of the local delivery system such as:

- Availability of skilled nursing facilities (SNF), sub-acute care facilities, or home care to support the member upon discharge
- Awareness of individual coverage of benefits for SNF, home care and sub-acute facilities to support medical/behavioral health services when appropriate
- The availability of services within local hospitals to provide member with needed care.

Active practitioners and specialists are members of the Technology Assessment Committee which meets 4-5 times a year in order to review new technology and services available to GHC-SCW members. This committee is involved in the development, adoption and review of Milliman Criteria revisions and nationally developed standards. Criteria used to make UM determinations are available to practitioners on the GHC-SCW Intranet and upon request. Practitioners and members are informed about how to request the UM criteria upon receipt of the denial letter. Practitioners can obtain information within the Provider Resource Manual Section 6, PA Guidelines: 6.1, located on ghcscw.com. Practitioners receive additional information regarding availability of criteria via the Practitioner Update newsletter. At least annually, the criteria utilized are reviewed and presented to the Clinical and Service Quality Committee to include:

1. *The American Society for Addiction Medicine (ASAM) Criteria for AODA Treatment.*
2. *Care Management Medical and/or TAC policies*
3. *Hayes, Inc.*
4. *The current Edition of Milliman Care Guidelines for :*
    a. *Inpatient and Surgical Care*
    b. *Ambulatory Care*
    c. *General Recover Guidelines*
    d. *Behavior Health Guidelines*
    e. *Recovery Facility Care Guidelines*
    f. *Home Care Guidelines*
    g. *Inter-rater Reliability*

Inter-rater Reliability (UM 2 Element C)

At least annually, GHC-SCW evaluates the consistency with which health care professionals involved in UM apply criteria in decision making. This process includes physicians, UM clinical staff consisting of Social Workers, RNs, LPNs, and pharmacists making medical and behavioral health and or SUD determinations. Cases are reviewed at identified intervals as part of a group educational process. These include, but are not limited to, at least weekly UM Medical and Mental Health Rounds to evaluate determinations and problem cases. When areas of improvement are identified, processes and/or interventions are developed or policies are revised. The changes are implemented after staff education is provided. Monitoring of these improvements occurs during the weekly Rounds.

The goals of inter-rater reliability include, but are not limited to:

1. Consistency in the application of clinical guidelines.
2. Evaluation of reviewers' ability to identify potentially avoidable utilization thus reducing costs.
3. Evaluation of reviewers' ability to identify quality-of-care issues.
4. Identifying specific areas in need of improvement.
5. Identifying areas where additional training is needed.

In addition, the CM department has available an inter-rater reliability tool through Milliman Care Guidelines which provides on-line case scenarios where in the UR staff apply the guidelines and are scored according to correct application of the guidelines. GHC has set a 95 % passing score as a standard for UR personnel. Additional learning modules are available through Milliman and assigned for staff that need additional education.

The Care Management Manager conducts randomized audits. When issues or concerns are identified, a process improvement plan will be implemented to rectify the concern. The department conducts monthly staff meetings where areas of concern and issues regarding UR are discussed as a group and additional education is provided as needed. Appropriate changes are made within the department's processes per CM.MED.011; Inter-Rater Reliability.

Communication Services (UM 3 Element A)

Care Management staff are accessible to members and practitioners/providers to discuss UM issues. (Communication Services CM.MED.021)

- Care Management staff is available electronically or by phone between the hours of 8:00 am and 5:00 pm, Central Standard Time, Monday through Friday, excluding holidays. There are both local and toll-free phone numbers for the Care Management Dept.
- During weekends, holidays, and non-working hours, the Care Management Department has confidential electronic and voice mail boxes which are responded to within 24 business hours from receipt of the message. Staff has the availability to access their voicemail remotely in case of unexpected absences; callers can be referred to alternate staff for assistance if needed.
- Care Management staff identifies themselves by name, title, department, and organization when initiating or returning phone calls.
- The Care Management Department has a dedicated fax machine located within the department which is available 24 hours per day, 7 days per week.
- GHC-SCW Member Services screen incoming phone calls and transfer calls to the appropriate Care Management personnel when appropriate.
- GHC-SCW offers TDD/TTY services for deaf, hard of hearing or speech-impaired members.
- GHC-SCW offers free of charge language assistance for non-English speaking members to discuss UM issues.

Appropriate Professional (UM 4 Element A, E, and F)

Utilization Management determinations are made by qualified, licensed healthcare professionals. These professionals include physicians, chiropractors, dentists, appropriate behavioral health practitioners, physical/occupational therapists or pharmacists. The appropriate professional reviews medical and/or behavioral health denials based on medical necessity. Board-certified physician specialists are utilized to assist in making medical necessity determinations per CM.MED.017 Appropriate Professionals .

- Four (4) Physician Reviewers are available for making medical necessity determinations: the Chief Medical Officer; the Medical Director of Care Management, the Medical Director of Quality and Informatics, Interim Chief Executive Officer, along with the Chiropractor Chief of Staff and the Medical Director for Behavioral Health Services. In addition, Physician Reviewers make determinations related to potentially cosmetic/experimental procedures, benefit exceptions, for out-of-network care and services, and when individual needs and assessment of the local delivery system indicate that the UM utilized criteria are not appropriate for the member. UM decisions are not made based on pre-existing conditions.
- The Care Management Department is supervised by a Bachelors level Registered Nurse, who is a certified Complex Case Manager. Professional clinical staff includes: the manager, registered/licensed practical nurses, and licensed social workers who can approve services for medical necessity based on criteria and make administrative denials based on the members' benefit certificate of coverage. Administrative staff makes approvals of select services per the direction of the Manager of the Care Management Department.
- Care Management Associates are responsible for answering and routing department phone calls, starting and routing prior authorization requests to the correct reviewer, and placing referrals for services that do not require medical necessity review.
- The Pharmacy Department is supervised by a Registered Pharmacist. The Manager and other administrative registered pharmacists make appropriate medical necessity approvals and denials based on the member's use of a recommended prerequisite drug or a step-therapy protocol.
- The Mental Health Department is supervised by a Master's level Licensed Social Worker. The Manager and the other master's level mental health clinicians assist the UM RN/SW's in making appropriate medical necessity approvals based on criteria while making administrative denials based on the members' benefits.
- A licensed doctoral level clinical psychologist oversees out-patient prior authorization of patients for behavioral health treatment and referrals while the Mental Health Associate Medical Director oversees inpatient utilization.
- A licensed Chiropractor oversees the appropriate use of Chiropractic services for acute and/or chiropractic interventions.
- Board-Certified Physician Consultants from the University of Wisconsin (UW) Hospital and Clinics and UW Medical Foundation may be used as consultants, when necessary, to assist in making determinations of medical necessity when clinical situations occur where the clinical judgment is sufficiently specialized such that primary care physicians are unable to adequately address the issues in question. The GHC-SCW Medical Staff Administrator (Credentialing Coordinator) maintains the list of such specialists and makes it available to the physician reviewers and above mentioned department managers on an as needed basis.
- UM decision making is based only on appropriateness of care and service and existence of coverage. GHC-SCW does not use incentives to encourage barriers to care and service nor does it make decisions about hiring or terminating practitioners or other staff based on the likelihood, or on the perceived likelihood, that the practitioner or staff supports, or tends to support denial of benefits.
- GHC-SCW has a written job description identifying the qualifications required for a practitioner to review denials of care as related to their specific professional experience.
- Practitioners must have a current license to practice without restrictions.

- New employees and practitioners are presented the Affirmative Statement Regarding Incentives (policy (CM.MED.020) during their employee orientation. The Affirmative Statement is signed annually thereafter.
- The Affirmative Statement is also annually distributed to members and practitioners via the member and practitioner newsletters.
- GHC-SCW does not offer any type of incentive to encourage denials or placement of barriers for members to receive care.
- GHC-SCW ensures that a physician, appropriate behavioral healthcare practitioner or pharmacist, as appropriate, reviews any behavioral healthcare denial of care based on medical necessity.
- A benefit denial is a requested service which is specifically excluded from a member's benefit plan, which GHC-SCW is not required to cover under any circumstances. These may be limited by numbers, duration or frequency in the benefit; limited to no extensions beyond specific date, time or number and/or specified if an exclusion in the benefit plan.

Timeliness and Notification of UM Decisions (UM 5)

CM staff and physician reviewers make timely and consistent determinations for all UM activities requiring review to assess the medical necessity and/or appropriateness of care or services. These determinations apply to both urgent and non-urgent requests, and extensions of time may be requested if a determination cannot be made in a timely manner due to the lack of necessary information. In whole or in part decisions and notifications are communicated to appropriate members, practitioners, and providers in a timely manner to accommodate the clinical urgency of the situation to minimize any disruption in the provision of health care. (Policies CM.MED.003, CM.MED.004, CM.MED.007).

1. Timeliness of Decision Making for Medical and Behavioral Health UM Decision:
    a. For non-urgent pre-service decisions, GHC-SCW makes decisions within 15 calendar days of receipt of the request. For requests which come in after hours, GHC-SCW counts the time of receipt as the next business day.
    b. For urgent pre-service decisions, GHC-SCW makes decisions within 72 hours of receipt of the request.
    c. For urgent concurrent review, GHC-SCW makes decisions within 24 hours of receipt of the request.
    d. For post-service decision, GHC-SCW makes decisions within 30 calendar days of receipt of the request.
2. Notification of Medical and Behavioral Health Decisions:
    a. For all determinations, GHC-SCW gives electronic or written notification of the decision to practitioners and members within the above designated time frames as per NCQA guidelines.
    b. Notification of urgent care request decisions, GHC-SCW may notify the practitioner only of the decision since NCQA considers the treating or attending practitioner is acting as the member's representative.
    c. If the denial decision is either concurrent or post-service (retrospective) and the member is not at financial risk, GHC-SCW is not required to notify the member. GHC-SCW must notify the member in all other cases.

d. If the decision for urgent care requests is either concurrent or post-service (retrospective) and the member is not at financial risk, GHC-SCW is not required to notify the member. GHC-SCW must notify the member in all other cases.
e. If requests for health care services come from a practitioner, GHC-SCW may send the request for additional information to the practitioner; but must notify the member if it denies the services.

Care Management accepts non-urgent prior authorization requests via fax or electronic entry. Fax requests are accepted and processed the next business day. On weekends and holidays, fax requests are entered the next business day.

GHC-SCW reviews requesting services for our members the following ways:

1. Referrals: Referrals results from written orders from Primary Care Providers to see in-plan specialty care provider. The terminology of "referrals" is used similar to prior authorization. Not all referrals require review and many serve only as proof of GHC-SCW's intent to pay for the requested service.
2. Prior Authorization: The basic elements of prior authorization review include: eligibility verification, benefit interpretation and administration, medical necessity review of both in and outpatient services. The Prior Authorization list is available on GHC-SCW's website for providers and members convenience. Disclaimer indicates that the Member's Certificate supersedes the Prior Authorization list as the list is not all inclusive for all products or benefit certificates that GHC-SCW offers. Requests for services requiring prior authorization is reviewed and determinations are made by using appropriate clinical criteria applied by UM personnel. Any additional services or extension of services beyond initial authorization will require submission of clinical documentation for medical necessity review.

Medical Necessity/Medically Necessary means a service or supply which is determined by the Medical Director to be required for the treatment or evaluation of a medical condition, is consistent with the Diagnosis documented, and could not have been omitted under generally accepted medical standards or provided in a less intensive setting.

Pre-Service Review Determinations

1. Pre-service urgent determinations are defined as any request for medical care or services whereby application of non-urgent time periods could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, **or** in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.
2. Pre-service non-urgent determinations are defined as those required for a request presented prior to the member receiving medical care or services.

Concurrent Review Determinations

1. Concurrent review determinations are any review for the extension of a previously approved ongoing course of treatment over a period of time or number of treatments. These reviews are typically associated with inpatient admissions or ongoing ambulatory care.
2. Concurrent urgent determinations are defined as any request for medical care or services whereby application of non-urgent time periods could seriously jeopardize the life or health of

the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or in the opinion of a practitioner with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

3. Concurrent non-urgent determinations are defined as those requests that do not meet the above definition for urgent care and may be handled as a new request and decided within the time frame appropriate to the type of decision.

Post-Service Review Determinations (Retrospective Reviews)

1. Utilization Staff and physician reviewers make timely and consistent determinations for all UM activities requiring review to assess the medical necessity and/or appropriateness of care or services requested that have already been provided to the member. Extensions of time may be requested if a determination cannot be made due to lack of necessary information. Decisions and notifications are communicated to appropriate members, practitioners, and providers in a timely manner.

Extension of timeframes

1. Non-urgent pre and post services decisions or Urgent pre-service/concurrent decisions are acceptable if the organization is unable to make a decision due to the lack of necessary information. Members may also voluntarily agree to extend a decision timeframe if they need to obtain information or be evaluated by specialists.

Clinical Information (UM 6)

Relevant clinical information that is pertinent to an identified episode of care is collected from the treating physician and other appropriate practitioners and documented to support accurate and appropriate UM determinations of coverage based on medical necessity for medical and behavioral health services i.e. MH and SUD; CM.MED.013.

Clinical information may include, but is not limited to:

- Office and hospital records.
- A history of the presenting problem.
- Physical exam results.
- Diagnostic testing results.
- Treatment plans and progress notes.
- Patient psychosocial history.
- Information on consultations with the treating practitioner.
- Evaluations from other health care practitioners and providers.
- Operative and pathological reports.
- Rehabilitation evaluations.
- A printed copy of criteria related to the request.
- Information regarding benefits for services or procedures.
- Information regarding the local delivery system.
- Patient characteristics and information.
- Information from family members.

Behavioral Health

GHC-SCW *does not* have a centralized triage and referral process. GHC-SCW has numerous ways for our members to obtain Behavioral Health services as it is based on who the member selected as their PCP/Clinic.

- GHC-SCW members have direct access to behavioral health care without prior authorization or referral at four different GHC-SCW clinics and at UW Behavioral Health and Recovery.
- GHC-SCW members can directly call or walk in to a clinic to obtain behavioral healthcare. After hours, GHC-SCW members calling the 24-hour crisis line with behavioral healthcare inquiries are routed to an on-call behavioral healthcare practitioner.
- GHC-SCW Member Service staff provides members with information about in-network behavioral healthcare practitioners and how to access care, but do not make judgments about the needed level of care or type of practitioner that the member should see.
- GHC-SCW members who selected a PCP outside of Dane County have access to contracted Behavioral Health providers who follow an authorization process for medical necessity review.
- GHC-SCW members who selected a PCP outside of Dane County can contact the 24-hour crisis line with behavioral healthcare inquiries and have access to GHC-SCW NurseConnect, a 24-hour health information line.

Denial Notices (UM 7)

The Utilization Review staff clearly documents and communicates the reasons for each denial and provides members and their treating practitioners with the opportunity to discuss a denial with an appropriate reviewer. A copy of the benefit language or criteria on which the denial determination was made is sent to the provider, member, and practitioner upon request. This applies to all UM denials: medical, pharmaceutical, and behavioral health and SUD. Members and providers are directed to the GHC-SCW Member Services Department for appeal submission and resolution.

1. Utilization Review staff provide written denial notifications for all medical necessity denials that include the following:
    a. The specific reasons for the denial, in easily understandable language.
    b. A reference to the benefit provision, guideline, protocol or other similar criterion on which the denial decision is based.
    c. A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
    d. For lack of information denials, reference to the clinical criteria that has not been met must be included. If we are unable to provide a specific policy, we describe the information needed to render a decision.
2. Staff members attach written appeal information in all denial notifications which includes:
    a. Description of appeal rights, including the right to submit written comments, documents, or other information relevant to the appeal
    b. Explanation of the appeal process, including the right to member representation, and time frames for deciding appeals
    c. If a denial is an urgent pre-service or urgent concurrent denial, a description of the expedited appeal process is included. (policy SM.MS.001)

    d. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care
3. For medical necessity denials, UR staff notifies practitioners of the availability of an appropriate reviewer for discussion of the denial and how to contact that reviewer either via written directions in the denial letter, staff messages in the Epic system, or a phone call to the practitioner's office. Staff documents the time and date of both the denial notification, the offer of reviewer availability, as well as conversations with the practitioner regarding the specific case while the denial decision was pending.
    a. The Medical Director and UR staff is available for discussion of medical denials.
    b. The Chief of Chiropractic Services is available for discussion of chiropractic care denials.
    c. The Behavioral Health Medical Director, Director of Medical Specialty Services, UR staff and appropriately qualified clinical mental health staff are available for discussion of behavioral health/SUD denials.
    d. The Manager of Pharmacy Services and administrative pharmacists are available for discussion of pharmaceutical denials.
    e. GHC-SCW Practitioners are informed of the denial and appeal process during their initial orientation and periodically in the "Practitioner Update" newsletter.
    f. Member appeals/grievances will be accepted by Member Services without time limitation.
4. The External IRO appeal process is administered by the Federal Government Office of Personnel Management (OPM). The member or representative has the right to request an independent review. An insured member may authorize another individual to request an independent review in any written form that is signed by the insured member. (CM.MED. 003 Denial and Timely Appeal Notification)
    a. A written request must be submitted within 4 months of notice of the adverse benefit determination or final internal adverse benefit determination.
    b. The request for an external review must be submitted in writing or electronically to: DisputedClaim@opm.gov; by fax to 202-606-0036; or by mail to PO Box 791, Washington, DC 20044.
    c. If there are any questions during the external review process, the member or representative may call toll-free 877-549-8152.
    d. If additional written comments are submitted to the external reviewer at the mailing address above, it will be shared with GHC-SCW in order to give GHC-SCW the opportunity to reconsider the denial.
    e. The IRO's decision is legally binding on both the complainant and the insurer.

Appropriate Handling of Appeals (UM 9)

GHC-SCW has a full and fair process for resolving member disputes and responding to member's requests to reconsider a decision they find unacceptable regarding care and service. The documentation, investigation and appropriate response to an appeal are coordinated through the Member Services Department.

Evaluation of New Technology (UM 10)

GHC-SCW has a formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in its benefits plan to keep pace with changes and to

ensure that members have equitable access to safe and effective care. The Technology Assessment Committee (TAC) is scheduled to meet at least 4- 5 times annually or as needed, to conduct technology assessments. This is described in the Technology Assessment Committee Policy CM.MED.010.

GHC-SCW's written process for evaluating new technology and the new application of existing technology for inclusion in its benefits plan includes an evaluation of the following:

1. Medical procedures.
2. Behavioral healthcare procedures.
3. Pharmaceuticals.
4. Devices.

The Formulary Committee (FC) is the first level committee to evaluate new pharmaceuticals or new uses of existing pharmaceuticals. Recommendations from the FC are forwarded to the TAC for final review and approval.

1. Technology Categories: technologies encompass medical procedures, behavioral health procedures, pharmaceuticals, and devices.
2. Review Categories:
    a. Proactive reviews are usually initiated when a new technology is identified from published scientific evidence or an appropriate government regulatory body.
    b. Reactive or urgent reviews are triggered by a provider's request for the use of a new technology, a new application of an existing technology, or a special review case.
    c. Retrospective reviews are conducted when the request was received after the service was provided.
    d. Scheduled review of established GHC-SCW technology assessments.
3. Technology Evaluation Sources may include but are not limited to:
    a. Hayes Incorporated, which is a major vendor of technology assessments.
    b. The Food and Drug Administration (FDA) information as contained in the Hayes & TEC reports
    c. Technology Evaluation Center (TEC) sponsored by the Blue Cross/Blue Shield Association and Kaiser Permanente.
    d. Reports from governmental agencies and medical associations, i.e. Center for Disease Control (CDC), American College of Obstetricians & Gynecologists or recognized sites like Medline may be utilized.
    e. Medical literature published in peer reviewed journals or by other health plans i.e. Aetna, Cigna, United Healthcare, CMS, Medline, etc.
    f. Local medical expert opinion or specialty physician consultants.
    g. Up-to-date - evidence-based clinical decision support resource authored by physicians to help healthcare practitioners make the best decisions at the point of care by combining the latest clinical knowledge with cutting-edge technology.
    h. CMS-Medicare regulatory rules
    i. Milliman Care Guidelines
4. Review Criteria for Determinations: technology assessment decisions are based upon the following criteria:
    a. The technology must have received final approval from the appropriate government regulatory bodies, if applicable, e.g. FDA, AMA, CMS (formerly known as HCFA).

b. The scientific evidence must permit conclusion concerning the effect of the technology on health concerns.
c. The technology must be as beneficial as any established alternative.
d. The technology must improve the net health outcome of the patient.
e. The technology must be attainable outside the investigational setting.

Emergency Services
GHC-SCW does not review any ER services for medical necessity.

Pharmaceutical Management
The complete description of the Pharmaceutical Management Program is outlined in policy CL.PH.BEN.008 and can be found on ghcscw.com as part of the Provider Resource Manual.

Triage and Referral for Behavioral Health
This standard and the two elements are not applicable to Group Health Cooperative of South Central Wisconsin because the health plan does not have a centralized triage and referral process as described on page 15 under Behavioral Health.

Delegation of UM
GHC-SCW does not delegate UM activities.

Assessing Experience with the UM Process
GHC-SCW annually assesses both member and practitioner experience/satisfaction with the UM Process by evaluating data from surveys and/or complaints and appeals. Identifiable sources of dissatisfaction are addressed through process improvement activities to meet UM goals and objectives, and to meet member and practitioner expectations.

Procedure for Monitoring Member Experience
1. GHC-SCW conducts the annual CAHPS member experience survey; questions related to UM processes are included in that survey. Results are shared with the Clinical and Service Quality Committee, practitioners, and Care Management staff.
2. CM staff participates in the analysis of data for the identification of improvement opportunities.
3. GHC-SCW member complaint and appeal process is monitored
4. Evaluation provides opportunities for member education and/or benefit changes.

Procedure for Monitoring Practitioner Experience
- The CM Department conducts an annual practitioner survey of all primary care practitioners and/or the office managers and referral coordinators of their respective primary care clinics.
- CM staff participates with the Care Management Manager in the evaluation of the survey responses. Results are presented to the Medical Director, the Clinical & Service Quality Committee, the Board of Directors, and practitioners.
- Trends and issues are identified for process improvements; action plans are developed by the Medical Director, Care Management Manager, CM staff, and other appropriate practitioner committees and then presented to the Clinical & Service Quality Committee

- The results of improvement activities are continuously monitored through practitioner feedback and evaluation of the GHC-SCW complaint and appeal processes; annual resurveys also provide feedback.
- Evaluation provides opportunities for practitioners' education and/or benefit changes.

Quality of Care Issues

Care Management (CM) staff monitor, identify, document, and report potential quality of care issues to the Medical Director, Medical Staff Administrator and the Quality Management department. These issues are referred to as Adverse Events and include issues related to medical and behavioral health care and services provided to members.

1. An Adverse Event is an untoward event with a less-than-optimal outcome.
2. CM staff report the following adverse events for potential evaluation by the Medical Director policy CM.018)
    a. Unplanned return to the operating room within 48 hours during the same hospital admission;
    b. Unanticipated in-hospital deaths;
    c. Severe post-surgical infections;
    d. Unplanned admission to the hospital after outpatient test or procedure;
    e. Trauma or injury suffered while in a health care facility/practitioner office/HMO site i.e. surgery on wrong body part, loss of function not related to illness or condition, rape or suicide in a 24-hour care facility.

Complex Case Management

Case Management is a collaborative process in which a care manager assesses plans, facilitates and advocates for options and services to meet an individual member's health needs throughout the continuum of care. UM ~~staff work~~staff works collaboratively with ~~CM staff~~CM staff to identify potential cases ~~who~~that may benefit from complex case management services such as~~:~~:
:

- Complex medical cases e.g. severe multiple trauma
- Members with a chronic disease diagnosis and multiple co-morbidities
- Frequent ER visits and/or
- Frequent hospitalizations (re-admissions)