group health Cooperative of eau claire **KMTSJ, Inc.**	DEPARTMENT:	Utilization Management
	SUBJECT:	UM Information Integrity
	PRODUCT LINE:	All
	POLICY NUMBER:	UM125
	ORIGINAL POLICY EFFECTIVE DATE:	1/1/2025
	LAST REVISED DATE:	N/A
	LAST REVIEWED DATE:	N/A

PURPOSE:
To ensure integrity of the Utilization Management (UM) information used in the processing of UM denials.

SCOPE:
UM denial information integrity refers to maintaining and safeguarding information used in UM denial decision process against inappropriate documentation and updates. GHC is committed to protecting the integrity of UM information used in the processing of UM denials and UM appeals.

POLICY:
GHC has UM information integrity policies and procedures, audits UM information for inappropriate documentation and updates and implements corrective actions that address identified information integrity issues. GHC protects and ensures the integrity of the following UM denial information:

1. The scope of UM information
2. The staff responsible for completing UM activities
3. The process for documenting updates to UM information
4. Inappropriate documentation and updates
5. Audits of UM staff and the process for documenting and reporting identified information integrity issues

PROCEDURE:

Scope of UM Information

The UM information and how the integrity of it is protected is outlined below:

1. UM Requests from members or their authorized representatives

   Authorization requests are considered protected information. All UM requests are entered and stored in the electronic care management system in the UM module. Only UM staff have access to enter requests, complete clinical reviews, make determinations, enter UM notes, attach documentation to UM case files, and send written notifications. Only UM staff can enter data into this module and GHC staff in other departments do not have permissions to complete any UM processes within this module. Only GHC staff who need access to authorization information to complete health plan processes (i.e., claims processing) are allowed to view UM information to ensure privacy of information.

2. UM request receipt date

   Receipt date of the authorization for purposes of accurately tracking timeliness related to completion of the authorization is protected. Authorization requests received via fax have an autogenerated date and time stamp to reflect the receipt date. Outpatient UM Specialists are responsible for entering this information in the electronic care management system and are expected to maintain the integrity/consistency of this information (i.e., date and time stamp on the auth request received is expected to match what is entered in the electronic care management system). Authorization requests received by other departments are entered and sent to the UM department the same day they are received. The request is forwarded to UM via an internal email group (Health Management Referrals) which has an autogenerated date and time stamp. UM Specialists are expected to

maintain the integrity of the receipt date and time on the email and enter this into the electronic care management system. Finally, authorizations that are physically received, such as via the mail, are electronically scanned in and emailed on the same day they are received. The emailed document has an autogenerated date and time stamp. Again, these are forwarded to the Health Management Referrals email group where date and time stamp integrity is expected to be maintained by the Outpatient UM Specialists. The receipt date entered by the UM staff into the UM case file in the electronic case management system is audited to ensure that UM staff are not modifying the dates that are located on the prior authorization faxes or prior authorization emails.

3. Appropriate practitioner review

   Practitioner review is considered protected information. Only Advisor Reviewers (GHC Clinical Pharmacist, Assistant Medical Directors, or the Chief Medical Officer) are allowed to make medical necessity denial determinations. UM specialists can approve medical necessity determinations when clinical criteria are met and can deny requests that are not related to medical necessity. (Clinical reviews performed by the Advisor reviewers (GHC Clinical Pharmacist, Assistant Medical Directors, or the Chief Medical Officer) are performed directly within the electronic care management system. The electronic care management system captures the date and time of completion of these reviews. Once submitted, these reviews cannot be altered as the electronic care management system does not allow it. The electronic care management system used in the UM process has an advisor queue that only the Advisor reviewers have access to. Also, the pharmacist advisor reviewer can only access the pharmacy advisor reviewer queue and the physicians can only access the physician advisor queue. This prevents access by inappropriate UM staff. An audit report is used to review medical necessity decisions to ensure cases are reviewed by an appropriate advisor reviewer.

4. Use of board-certified consultants

   Board Certified Consultant (BCC) reviews are also considered protected. The decision to refer a request for BCC review is made by the Chief Medical Officer (CMO) or the advisor reviewer and sent out by the UM Manager. Requested completion time of this external review is set to maintain timeliness expectations. The UM Manager receives email notification of a completed BCC review, retrieves the review from the BCC portal, and attaches the BCC review to the related authorization request, maintaining date and time stamp from the BCC portal. Only the CMO or an advisor reviewer can review the BCC review and make a final determination. The CMO or advisor reviewer enters a BCC note in the UM file in the electronic care management system and this date and time of the note entry are autogenerated. Once entered, this note is not modifiable. the date and time of the note are autogenerated.

5. Clinical information collected and reviewed

   Clinical information collected and reviewed is also considered protected information. All clinical information collected and reviewed is attached to the member's UM case file in the electronic care management system. Attached files cannot be removed from the case file. Only UM staff can attach information to the UM case file. Authorization requests are expected to be received with supporting clinical information. There are times additional information may be needed to make a clinical determination and these are tracked as Requests for Information (RFIs) in the electronic care management system. These are manually added as tasks within the electronic care management system for tracking purposes at the time the request is made back to the requesting provider for the additional information. UM Specialists are expected to indicate the date and time the request is made, which is required within the RFI task itself. Any subsequent information sent is received via

fax and is automatically date and time stamped. UM Specialists, as previously outlined, are expected to maintain the integrity of the receipt date of this information when entering it into the electronic care management system for review.

6. UM decision

   UM decisions are considered protected information. All UM decision outcomes, decision dates, and name of the staff making the determination are documented in the UM file in the electronic care management system. The decision dates and name of the staff are autogenerated by the electronic care management system. Due to the enhanced system controls in our electronic care management system, once this information is entered, it cannot be changed. The UM staff name is autogenerated based on title/role and staff can only enter UM information in the UM module if their title/role is assigned to the UM module. Once the UM decision outcome is made and entered, it is unable to be modified.

7. UM decision notification date

   UM decision notification date is considered protected information. The notification date is the date that the letter is sent to the member and provider. This date is autogenerated in the electronic care management system and appears of the letter. Due to the enhanced system controls of the electronic care management system and the date cannot be modified by the UM staff.

8. UM denial notice

   UM denial notices are considered protected information. The denial notice or denial letter is created within the electronic care management system. The notification reflects the determination made by the advisor reviewer or the UM staff (when appropriate). Once the denial letter is completed, it cannot be modified. Only UM specialists have access to the letter generation module and the denial letter templates.

Staff Responsible for Performing UM Activities

Staff responsible for documenting completion of UM activities include the Inpatient and Outpatient UM Specialists, UM Manager, Advisor Reviewers (GHC Clinical Pharmacist, Assistant Medical Directors and the Chief Medical Officer). Activities completed are tracked as tasks within the electronic care management system and date and time stamps are autogenerated at the time they are completed due to the enhanced systems controls of the electronic care management system. Any activities completed that are not automatically captured as a task within the system are manually added as notes in the related authorization file by UM Specialists. These summarize interactions on authorizations and are also date and time stamped when entered. Date and time stamps should not be manually altered. To ensure integrity of the UM information, the UM module has different functional areas and only UM staff whose job description is relevant to entering data in that functional area can enter data in that functional area. Integrity is preserved by outlining the titles/roles of staff and their responsibilities related to UM functions and permitting access to certain UM functions by job role as outlined below:

Staff responsible for documenting completion of UM activities

1. Entering PA request receipt date:
   The receipt date of the requested service is the date the authorization request was received by the Cooperative from the member or the member's representative. The date is entered by the

Outpatient Utilization Management Specialist and documented in the electronic care management system (UM file). The staff are not authorized to modify the receipt date under any circumstances. To ensure accurate entry and that dates are not being modified, this process is audited. The audit process is described below the section entitled, "Auditing Information Integrity."

2. Entering PA requests: The Outpatient Utilization Management Specialists are responsible for entering PA requests.

3. Initial Clinical Review: The Outpatient Utilization Management Specialist and the Inpatient Utilization Management Specialists are responsible for performing the initial clinical review. The Outpatient Utilization Management Specialists perform the clinical review for all outpatient services except those specially listed as being performed by the Inpatient Utilization Management Specialists. The Inpatient Utilization Management Specialists perform clinical reviews on all inpatient, psych and neuropsych testing, home health, and pharmaceutical services.

4. Secondary Review/Medical Necessity Review: These reviews are done by an advisor reviewer. Physician reviewers can review all cases while the pharmacist reviewer can only review pharmaceutical requests. Only the CMO and pharmacist can access the pharmacist queue which includes the pharmaceutical reviews and only the CMO and physician reviewers can access the physician review queue. Limiting access helps ensure integrity of the UM information and processes.

5. Written Notifications: Only the UM specialists are allowed access to generate the written notifications.

Staff Authorized to Modify (edit, update, delete) UM Information

Only UM staff are allowed to modify authorizations to ensure the integrity of the UM information. The Outpatient and Inpatient UM Specialists and UM Manager are the only staff authorized to modify UM information in the clinical review sections of the UM file. The advisor reviewers are the only staff authorized to modify UM information in the advisor review section of the UM file. Due to advanced system controls in the electronic care management system, only UM staff have access to modify UM information. Other GHC staff do not have access to modify UM information. Decision notification dates and all determination dates are auto generated by and recorded in the electronic care management system. Our electronic care management system has advanced system controls capabilities whereby it automatically records dates and prevents changes to these dates once the review is submitted.

Staff Responsible for Oversight of UM Information Integrity Functions, Including Auditing

The UM Manager and CMO are responsible for the oversight and auditing of the UM information integrity. The audit team audits the authorization receipt dates entered into the electronic care management system with oversight of the UM Manager. The UM Manager is responsible for auditing the items as outlined below entitled, "Inappropriate Documentation and Updates."

Process for Documenting Updates to UM Information

Updates to UM information are only allowed in certain circumstances and only allowed by certain UM staff to ensure integrity of the UM information. Modifications, such as editing, updating, or deleting, to existing UM information is appropriate and allowed only in the following circumstances when the practitioner requests a change in service date, change in procedure codes, typographical errors, change of facility or place of service, additional clinical information is received, or a request needs to be voided due to a withdrawal. For these modifications, the original prior authorization request is placed in a pending determination status so the line item can be updated. A new letter is sent with the updated information. Updates made to the authorization are date and time stamped by the electronic care management system and include the name of the staff who made the updates. The update includes what information was updated and why the information was updated. These modifications do not change the original date and time stamps on the authorization due to the advanced system controls in the electronic care management system. Only UM staff (the staff who process the authorization requests) are allowed and have access to make modifications to prior authorization requests in the electronic care management system. All updates to UM information are included in the member's UM file in the electronic care management system. Due to the enhanced security features of the electronic care management system, once data is entered in the UM file, it cannot be deleted or edited. Only UM staff (Inpatient and Outpatient UM Specialist, Advisor Reviewers, and UM Manager) have access to enter and complete processes related to prior authorizations in the company which helps ensure data is protected and not being modified inappropriately. Staff are not authorized to adjust any dates related to timeliness of authorizations such as receipt dates or dates related to completion of tasks on an authorizations, such as clinical reviews, determinations or notifications under any circumstances.

Inappropriate Documentation and Updates

The following documentation and updates to UM information are inappropriate:

1. Falsifying UM dates (e.g., receipt date, UM decision date, notification date).
   No staff are authorized to modify dates related to receipt of the prior authorization, determination decisions, or written notifications under any circumstances. All dates related to the prior authorization process are autogenerated and auto recorded due to the advanced system control capabilities of the electronic care management system. The prior authorization receipt date is manually entered into the electronic care management system and this date is audited to ensure accuracy as outlined in section 4b below.
2. Creating documents without performing the required activities.
3. Fraudulently altering existing documents (e.g., clinical information, board certified consultant review, denial notices).
4. Attributing review to someone who did not perform the activity (e.g., appropriate practitioner review).
5. Updates to information by unauthorized individuals.

Auditing Information Integrity

Auditing and monitoring UM staff documentation and updates are in place to ensure that data is not being altered inappropriately. The UM Manager is responsible for oversight of the UM system controls and UM information integrity. UM staff documentation and updates are audited annually by the UM Manager. Details related to the annual audit are outlined below. The following UM information is audited.

1. UM request receipt date

2. Appropriate practitioner review
3. Use of board-certified consultants
4. Clinical information collected and reviewed
5. UM decision
6. UM decision notification date
7. UM denial notice
8. Updates to UM information

Documenting and Reporting Information Integrity Issues

The audit documentation and any issues identified during the audit is stored in the restricted UM Folder and can be accessed by the UM Manager.

When inappropriate documentation and updates are identified during the audit process, the following occurs:

1. The issue is reviewed with the employee and depending on the extent of the issue consequences may include training, performance improvement plan, or termination. Any staff found to have made changes to authorizations with purposeful malicious intent will receive punitive action including at least a Corrective Action Plan (CAP), or up to termination from employment at the discretion of the UM Manager, Chief Medical Officer and the Executive Director of Human Resources.
2. The issue is recorded in the employee's Health Management file and when necessary their employment file in HR.
3. The issue is reviewed with the CMO and if necessary the CEO, Director of Compliance, and HR Director depending on the circumstances. If UM staff made changes with purposeful malicious intent all listed parties will review the incident.
4. Any purposeful fraudulent changes to UM information found will be reported to NCQA by the UM Manager or Director of Compliance when identified as a reportable event (i.e., self-identification of systemic issues affecting 5% or more of eligible UM files). Toll free phone 844-440-0077 or via the website at https://www.lighthouse-services.com/ncqa or via email at reports@lighthouse-services.com (must include NCQA's name with the report) or via fax at 215-689-3885 (must include NCQA's name with the report). Notification must be made within 30 days of the identified event.
5. Other external entities may be notified when applicable.

Information Integrity Training

To ensure integrity of UM denial information, the UM staff have annual training on inappropriate documentation and updates of UM information as outlined in the section above entitled, Inappropriate Documentation and Updates. The training also informs UM staff of:

1. Audits of staff documentation and updates in UM files.
2. The process for documenting and reporting inappropriate documentation and updates to:
    a. The organization's designated individual(s) when identified.
    b. NCQA, when the organization identifies fraud and misconduct.
3. The consequences for inappropriate documentation and updates

Audit and Analysis of Denial Information

To ensure there is no inappropriate documentation and updates to UM information, GHC annually audits for inappropriate documentation and updates to UM denial receipt and notification dates and conducts qualitative analysis of inappropriate documentation and updates to UM denial receipt and notification dates. GHC's electronic care management system automatically records decision notification dates, and does not permit staff to change UM denial receipt and notification dates under any circumstances. The items listed above in the section entitled, Auditing Information Integrity, are also audited. The electronic care management system has an Auth Decision Modification Report that tracks modifications to authorizations and this is used in the audit process.

The audit universe includes files for UM denial decisions (based on the denial decision notification date) made during the look-back period. GHC randomly samples and audits 5% or 50 files, whichever is less, from the file universe.

The Annual UM Information Integrity Assessment Report includes:

1. Report name: Group Health Cooperative of Eau Claire's Annual UM Information Integrity Assessment Report
2. Report date.
3. Auditor: name and title
4. The 5% or 50 files auditing methodology.
5. Audit date span reviewed
6. File audit universe size (number of UM medical necessity denial decisions)
7. Audit sample size calculation
8. Audit sample size
9. The audit log
    a. The file identifier (case number).
    b. The type of dates audited (i.e., receipt date, notification date).
    c. Findings for each file. A rationale for inappropriate documentation or inappropriate updates.
10. The number or percentage and total number or percentage of inappropriate findings by date type.

Qualitative analysis

GHC annually conducts qualitative analysis of each instance of inappropriate documentation and update identified in the audit (factor 1) to determine the cause. The organization's auditing and analysis report also includes:

- Titles of UM staff involved in the qualitative analysis.
- The cause of each finding.

Improvement Actions for Denial Information

GHC implements corrective actions to address all inappropriate documentation and updates found during the audit. The UM Manager documents all actions taken and planned including timeframe for actions and is responsible for implementing the corrective actions. Six months after completion of the annual audit, another audit is conducted to evaluate the effectiveness of the corrective actions. The audit universe for the audit of the effectiveness of corrective actions includes 3-6 months of UM denial files processed since the date of the annual audit completion.

The Effectiveness of Corrective Actions Report will include the following:

1. Name of the report: Group Health Cooperative of Eau Claire's Annual UM Information Integrity Measure of Effectiveness
2. Report date
3. Auditor: name and title
4. 5% or 50 files Auditing methodology
5. Audit date span reviewed
6. File audit universe size
7. Audit sample size calculation
8. Audit sample size

Reference Sources:
NCQA 2025 HP Standards and Guidelines; UM Factor 12: UM Information Integrity

Michelle Bauer MD.

APPROVED: _____ DATE: 1/1/2025

Formal policies and procedures require department manager review, approval, and signature. Executive and/or administrative policies and procedures require CEO/General Manager review, approval, and signature.

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision