DEPARTMENT:	Utilization Management
SUBJECT:	Utilization Management Program Description
PRODUCT LINE:	All
POLICY NUMBER:	HM106
ORIGINAL POLICY EFFECTIVE DATE:	01/05/2020
LAST REVISED DATE:	11/17/2024
LAST REVIEWED DATE:	11/17/2024

group health Cooperative of eau claire

KMTSJ, Inc.

SCOPE:

This policy outlines the specific requirements for medical necessity review and the Utilization Management (UM) program to ensure staff members and others understand the UM program structure, scope, processes, and information sources used to make UM determinations. To ensure utilization management decisions affecting the health care of members and benefits are administered in a fair, impartial, and consistent manner with respect to member's rights and is collaborative with our provider network.

POLICY:

1. The UM program is reviewed and updated annually.
2. The UM staff (and all GHC staff) are required to follow HIPPA privacy and confidentiality standards and must acknowledge their understanding of the standards at time of hire and annually.
3. The Utilization Management Manager and CMO provide oversight of the UM program including evaluating, approving, and revising the UM Program.
4. UM staff receive no incentives or monetary compensation in the review process related to denials, limitations, or discontinuation of authorized services.
5. The UM program structure outlines the following components:
    a. UM staff's assigned activities
    b. UM staff who have the authority to deny coverage
    c. Involvement of a designated physician and a designated behavioral healthcare practitioner
    d. The process for evaluating, approving and revising the UM program, and the staff responsible for each step
    e. The UM program's role in the QI program, including how the organization collects UM information and uses it for QI activities
    f. The organization's process for handling appeals and making appeal determinations

PROCEDURE:

UM Program Structure

UM Staff Structure and Assigned Activities:

a. Outpatient UM Specialists: Experience in health plan process and utilization management processes. Review prior authorizations for outpatient services.
b. Inpatient UM Specialists: Credentials include RNs with extensive UR review experience. Review inpatient behavioral and medical services, home health, SNF, and pharmaceutical prior authorizations.
c. Utilization Management Manager is an RN and provides day-to-day supervision of the UM staff, staff training, monitors documentation for adequacy, and monitors for consistency of application of UM criteria by UM staff and is available onsite or by telephone to provide oversight of processes and issues.
d. Chief Medical Officer (CMO): Credentials include MD and MBA. Has license to practice medicine in Wisconsin. Is board certified in Internal Medicine and has 24 years of utilization management review. Serves as the senior-level physician for GHC who oversees the UM program and works with the UM Manager to implement UM processes See "Senior Level Physician Involvement" section below. Is available onsite or by telephone to provide oversight of processes and to answer questions.
e. GHC pharmacist: Credentials include a PharmD. Has a license to practice pharmacy in Wisconsin. Role is to provide expertise on pharmaceutical management, aid in policy development for pharmaceutical coverage, provided oversight of the commercial PBM, and reviews pharmaceutical prior authorization requests that are part of the medical benefit and that require a clinical/medical necessity review. Has 4 years of utilization management experience.
f. Assistant Medical Director (AMD): Credentials include MD or DO. Must have a license to practice medicine in Wisconsin. The role is to review medical and behavioral health prior authorizations. One AMD is a DO and is board certified in Obstetrics and Gynecology and Obesity Medicine and has 3 years of utilization review experience. One AMD is a DO and is board certified in Family Medicine and has 3 years' experience in utilization review. Both are licensed to practice in Wisconsin. Both AMDs are responsible for reviewing prior authorization requests that require clinical judgement and a medical necessity review.
g. Express Scripts: Express Scripts is the PBM that reviews pharmaceutical requests for non-ETF commercial members and makes coverage determinations (Delegated). Medicaid pharmaceuticals are a carve out in Wisconsin and are covered through ForwardHealth. ETF pharmaceutical coverage is a carve out and is covered through the ETF PBM, which is Navitus. GHC does not cover prescription drugs for Medicaid or ETF lines of business.

h. Behavioral Health Provider: Credentials include PhD in Clinical Psychology. Provides feedback on behavioral healthcare aspects of the UM program including setting UM behavioral healthcare policies, reviewing UM behavioral healthcare cases through monthly meetings and participation on the GHC QI Committee.

UM Staff Who Have the Authority to Deny Coverage

A physician (either the AMD or the CMO) reviews all nonbehavioral healthcare, and behavioral healthcare (requests that are not pharmaceutical) prior authorization requests that do not meet medical necessity criteria and makes all medical necessity denial determinations. The CMO is licensed to practice medicine in WI. The CMO is board certified in Internal Medicine. The CMO has 21 years of managed care experience which has included utilization management, disease management, pharmaceutical management, case management, and wellness experience. AMDs are licensed to practice medicine in WI. One's board certified in Obstetrics and Gynecology and Obesity Medicine. One is board certified in Family Practice. Both have 3 years of experience in utilization management review. A pharmacist or physician reviews all pharmaceutical prior authorization requests that do not meet medical necessity criteria and makes all medical necessity denial determinations. The physician or pharmacist making the determination is documented in the UM file under the respective prior authorization event in the dropdown entitled, "Authorized By."

Process for Evaluating, Approving, and Revising the UM Program

UM process issues identified in the day-to-day operations are evaluated thoroughly by the CMO and UM Manager through a root cause analysis. Solutions are vetted and approved, and processes are revised and implemented by the CMO and UM Manager. Process changes are updated in policies and training manuals and outlined in the annual UM Program Evaluation.

UM Program's Role in the QI Program

The UM department reviews the reports outlined below on a regular basis. Data trends, outcomes, and performance goals (when applicable) are reviewed. Based on the analysis of these reports, quality improvement activities may be initiated to improve quality outcomes. The UM department tracks the following data/reports:

- Timeliness of UM Decisions: Timeliness Data Outcomes and improvement initiatives are reviewed in the QI committee.
- ER Utilization by Product Line: Trends are reviewed in the QI committee to identify opportunities for QI initiatives.
- Inpatient Hospital Utilization by Product Line: Trends are reviewed in the QI committee to identify opportunities for QI initiatives.

- Hospital 30 Day Readmission Rates by Product Line: Report is reviewed by the QI department as part of the analysis of the population health programs.
- Hospital Discharge Follow-Up Call Rate: Report is reviewed by the QI department as part of the analysis of the population health programs. A report of hospital discharges is pulled from the utilization management database in the electronic care management system and is shared with the Case Management Department to ensure that follow up calls after hospitalization are being completed according to quality guidelines. All inpatient behavioral health hospitalizations from the UM care management system are sent from the UM Department to the QI department so the telephonic outreach can occur to improve HEDIS metrics for the follow up after hospitalization for mental health and initiation and engagement of substance abuse. All inpatient medical hospital admissions are tracked in a UM queue in the electronic care management system so transitional care planning can occur as part of the population health program to reduce readmissions.
- Prior Authorization Requests (outpatient and inpatient) per 1,000 by product line: Reviewed monthly by leadership and the QI department to identify trends and evaluate opportunities for improvement.
- Prior Authorization Request Denials (outpatient and inpatient) per 1,000 by product line: Reviewed monthly by leadership and the QI department to identify trends and evaluate opportunities for improvement.

Process for Handling Appeals and Making Appeal Determinations

Processes related to appeals are addressed in the Appeals Policy and Procedures.

Behavioral healthcare aspects of the program

GHC does not require a referral for any behavioral health services and does not have a triage process related to behavioral health care. GHC addresses sites of behavioral healthcare services through the utilization management review process. Prior authorization is not required for outpatient counseling services unless the service is intensive outpatient. Neuropsych and Psychological testing, day treatment, residential, and all inpatient psychiatric admissions require prior authorization. The levels of behavioral healthcare services are reviewed using InterQual criteria sets which are evidence based national clinical practice guidelines.

Senior-level physician involvement

The UM program is managed by the Utilization Management Manager and the CMO oversees implementation, supervision, and evaluation of the overall effectiveness of the UM program. The CMO (senior-level physician) has overall responsibility for the plan's clinical decision-making and is involved in various aspects of related plan policies and operations which includes: medical and

utilization review including review of UM policies, benefits and claims management, formulary administration, medical program operations, processing coverage decisions in accordance with adjudication timeframes and notice requirements, provider/prescriber outreach, staff training, and oversight of delegated entities. The CMO participates in the UM inpatient and outpatient meetings, participates in the monthly meetings with the GHC designated behavioral healthcare practitioner, and the QI Committee. The CMO is responsible for ensuring the clinical accuracy of all coverage decisions made by the plan that involve medical necessity. Issues of clinical concern are elevated to the CMO through various avenues including but not limited to participation in meetings (Credentialing, QI Committee, Member Appeals and Grievance, and Provider Appeals), through the adverse events process, or brought directly to the CMO. The Assistant Medical Directors review UM cases and report to the CMO

Designated behavioral healthcare practitioner involvement

A network psychologist (PhD) at Vantage Point Clinic serves as the GHC designated behavioral healthcare practitioner and participates on the QI Committee and participates in monthly meetings with GHC to review UM behavioral health cases and provides feedback on the behavioral healthcare aspects of the program including medical necessity and clinical review criteria and helps set UM behavioral healthcare policies.

UM Program Scope and Description

Prior Authorization

It is the policy of Group Health Cooperative of Eau Claire that specific medical, behavioral health, pharmaceutical services, and out of network requests require prior authorization. This is to ensure providers, as well as members, understand beforehand what the covered benefits are as well as what will not be covered (denied), along with the associated denial reason(s). A list of services requiring prior authorization is reviewed and updated annually and is posted on our website for members and providers. Prior authorization guidelines are provided in the member handbook, the provider handbook, and on the GHC website

A prior authorization (PA) ensures the correct service or referral is being provided based on medical necessity criteria, and plan coverage. A PA verifies clinical appropriateness by using Group Health Cooperative (GHC) policies & procedures, National Coverage Determinations, Local Coverage Determinations, NCCN Clinical Practice Guidelines, InterQual, Up-To-Date, Hayes Technologies, or other nationally recognized practice guidelines/criteria that are evidence-based.

Details related to prior authorization can be found in the Prior Authorization Guideline policy and procedure.

Coverage Determinations

A coverage determination is a decision (either an approval or denial) made by GHC, or its delegated entity, concerning the payment or provision of an item, service, or drug with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services
- Payment for any other health services furnished by a that the member believes are covered or if not covered should have been furnished, arranged for, or reimbursed by the plan
- Refusal to authorize, provide, or pay for services, in whole or in part, including the type or level of services, which the member believes should be furnished or arranged by the plan
- Reduction, or premature discontinuation, of a previously authorized ongoing course of treatment
- Failure of the plan to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide timely notice of an adverse determination, such that a delay would adversely affect the health of the member

Coverage and medical necessity decisions are subject to notification and appeal requirements.

Coverage Determination Process

Benefit coverage for both outpatient and inpatient services that require prior authorization is determined based on the member's respective policy language in the Member Handbook, Certificate of Coverage or Schedule of Benefits, and CMS National and Local Coverage Determinations The first step in the prior authorization review process is to verify that the requested service is a covered benefit under the member's policy using the above resources. If the service is not a covered benefit, it would be denied as a contract exclusion. Member handbooks, Certificate of Coverage documents, and Schedule of Benefit documents are reviewed annually and submitted for approval

to the respective external regulatory agency. UM staff can process denial determinations for contract exclusions.

Medical Necessity Review Process

Medical necessity review is the process to consider whether services (both inpatient and outpatient including medical and behavioral health) that are covered only when medically necessary meet criteria for medical necessity and clinical appropriateness. A medical necessity review requires consideration of the members circumstances, relative to appropriate clinical criteria and the plan's policies.

The following decisions require medical necessity review:

- Covered medical benefits defined by the Certificate of Coverage or Summary of benefits including, but not limited to:
  - Dental and vision services covered under medical benefits, including dental care or services associated with procedures that occur within or adjacent to the oral cavity or sinuses
  - Pharmaceuticals covered under the medical or pharmacy benefit
- Services whose coverage depends on specific circumstances
- Dental services that are covered under the medical benefit
- Out of network services that are only covered in clinically appropriate situations
- Prior authorizations for pharmaceuticals that requiring a prerequisite drug or step therapy program
- Experimental/investigational requests covered by the organization

The following decisions do not require medical necessity review:

- Services in the member's benefit plan that are limited by number, duration, or frequency
- Services whose coverage does not depend on any circumstances
- Extension of services beyond the limitations or restrictions imposed by the member's benefit plan
- Experimental/investigational services that are always excluded and never deemed medically necessary under any circumstance
- Requests for personal care services, such as cooking, grooming, transportation, cleaning and assistance with other activities of daily living (ADL)

Medical Necessity Review of Requests for Out-of-Network Coverage

All Out-of-network requests that are not deemed to be urgent/emergent require prior authorization and are reviewed for medical necessity. If the service is determined to be a benefit according to the member's policy, then it will be reviewed according to criteria to determine if it is medically necessary. If services are available in network and the network provider can meet the member's needs according to GHC's access and availability standards, then the request would be denied as out-of-network.

GHC compared strategies, processes, evidentiary standards and source information used in determining coverage through the prior authorization process of OON services for mental health/substance use disorder. In compliance with Mental Health Parity and Equity Act, processes and criteria used to evaluate and determine whether OON mental health/substance use disorder services are approved and covered are comparable to, and applied no more stringently, than the processes used to evaluate and determine whether medical/surgical services are covered OON. The plan uses the same definitions for OON services for both mental health/substance use disorders and medical/surgical services as defined in plan documents. OON Mental health/substance use disorder coverage determinations are not made any differently than medical/surgical coverage determinations. Policies and criteria based on evidence based clinical practice guidelines are used for both mental health/substance use disorder coverage decisions and medical/surgical coverage decisions. Clinic policies related to coverage determinations are developed with the same standards and not applied any more stringently to mental health/substance use disorder services.

Information sources used to determine benefit coverage and medical necessity

The review process not only utilizes the resources and national recognized clinical practice guidelines to guide decisions but also includes a number of other information sources in making determinations. UM staff and Advisor Reviewers evaluate the member's current symptoms, impact on functioning, and the member's support system. A review typically includes member medical records, diagnosis and procedure codes, a claims review when applicable, and may include a conversation with the member's providers, a discussion with the member, member's caregiver, or a discussion with the vendor of the requested service.

Nationally recognized clinical practice guidelines that are used in the review process include but are not limited to InterQual, Hayes, GHC's policy and procedures, specialty society clinical practice guidelines, Member Handbook, Certificate of Coverage, SOBs, CMS NCDs and LCDs, Forward Health Updates, and Wisconsin Administrative Code. InterQual Guidelines and national clinical practice guidelines, or CMS Coverage Determinations are used to determine place of service and levels of care for both medical and behavioral health determinations.

According to WI Administrative Code medically necessary means a service that is required to treat a member's illness, injury or disability and meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;

2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

3. Is appropriate with regard to generally accepted standards of medical practice;

4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;

5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;

6. Is not duplicative with respect to other services being provided to the recipient;

7. Is not solely for the convenience of the recipient, the recipient's family or a provider;

8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and

9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Information sources used are documented in the electronic care management system. The criteria used to make a denial determination are outlined in a nonburdensome manner and included in the denial letter to member and provider.

Development and Selection of Medical Necessity Criteria

Nationally recognized, evidence-based standards and decision support tools/criteria sets, and clinical practice guidelines are used to maintain quality of care, eliminate unnecessary care, and improve patient safety. The guidelines serve as a foundation and guide for ensuring the member's needs are being met according to evidence based guidelines and that medical necessity

determinations are being made consistently and fairly according to national evidence-based practice standards. GHC uses two nationally recognized criteria sets, Hayes, Inc and InterQual Guidelines for the foundation of our prior authorization review process. These were chosen because they are used by many of our in-network providers and have extensive criteria sets to cover a wide range of services that we review.

GHC also develops internal policies and procedures when Hayes, Inc., InterQual Guidelines, or National or Local Coverage Determinations do not exist for a service or are incongruent with coverage outlined by the benefit plan/contract.

For DNSP determinations, National and Local Coverage Determinations are used when available and Forward Health Updates are used when available for the Medicaid membership. When there is no National Coverage Determination (NCD) or Local Coverage Determination (LCD) for DNSP, then GHC internal policies or InterQual are used. When WI administrative code or a WI Forward Health Update is not available, the GHC internal policies or InterQual are used.

InterQual Guidelines and national clinical practice guidelines, or CMS Coverage Determinations are used to determine place of service and levels of care for both medical and behavioral health determinations.

The WI DME index, Commercial Member Handbooks and Certificates of Coverage, National and Local Coverage Determinations are used to determine medical necessity approval frequency for DME items for the respective product line.

GHC compared strategies, processes, evidentiary standards and source information used in determining medical necessity coverage of outpatient and inpatient services for mental health/substance use disorder. In compliance with Mental Health Parity and Equity Act, processes and criteria used to evaluate and determine whether mental health/substance use disorder services are medically necessary are comparable to, and applied no more stringently, than the processes used to evaluate and determine whether outpatient and inpatient medical/surgical services are medically necessary. The plan uses the same definition of medical necessity for both mental health/substance use disorders and medical/surgical services as defined in plan documents. Mental health/substance use disorder medical necessity coverage determinations are not made any differently than medical/surgical coverage determinations. Policies and criteria based on evidence based clinical practice guidelines are used for both mental health/substance use disorder coverage decisions and medical/surgical coverage decisions. Clinic policies related to coverage determinations are

developed with the same standards and not applied any more stringently to mental health/substance use disorder services.

Clinical Criteria for UM Decisions

UM Criteria

Written UM Decision-Making Criteria

To ensure consistency in applying criteria in the UM review process, GHS uses written criteria to make utilization decisions, and specifies procedures for appropriately applying the criteria. There are specific written criteria to determine the medical necessity and clinical appropriateness of medical, behavioral healthcare, and pharmaceutical services. The UM decision making criteria are objective and follow evidence based nationally recognized clinical practice guidelines and criteria.

The criteria that are used to support decision making in the utilization management process include but are not limited to the following:

- InterQual medical necessity criteria sets and LOS data.
  These protocols are used to review selected procedures, DME, high end imaging, medical and behavioral health hospital admissions, AODA admissions, and subacute and rehabilitation admissions. InterQual criteria sets are reviewed annually.

- Hayes Technologies for services that are experimental/investigational. Hayes has a knowledgeable team of physicians and doctor level staff which complete a comprehensive review and analysis of the research behind emerging technologies and develop a comprehensive assessment related to the respective technology. Hayes assessments are reviewed annually.

- Other national evidence-based clinical practice guidelines that are used include but are not limited to the National Comprehensive Cancer Network, American College of Radiology Criteria sets, United States Preventive Services Task Force, JNC 8, NHLBI asthma guidelines, ACA-AHA guidelines, ADA guidelines American College of Obstetricians and Gynecologists, American Academy of Pediatrics, and American Academy of Family Practice.

- GHC Policy and Procedures are developed when there is no InterQual criteria set or Hayes recommendation for a service that is a covered benefit and there needs to be a medical necessity determination. These internal policies are developed based on nationally recognized evidence

based clinical practice guidelines, other insurer coverage policies including CMS and WI Administrative Code or Forward Health Updates, and Up-to-Date. The policies are reviewed against current clinical and medical evidence and are updated as appropriate. These are reviewed at least annually by the QI Committee.

- The Certificate of Coverage, SOBs, SBCs, Member Handbooks

- Forward Health Updates, Medicare National and Local Coverage Determinations, and WI Administrative code are also used in coverage determinations for the respective membership.

To ensure UM staff are appropriately applying the criteria, GHC does interrater reliability, extensive training for new hires, and reviews criteria sets and how to apply them to specific clinical situations weekly with staff.

Consideration of Member's Individual Needs
When applying criteria to the individual member, GHC also considers the individual and unique needs and circumstances of the member which includes but is not limited to age, comorbidities, complications, treatment progress, psychosocial factors, and home environment or living circumstances. The individual factors above are incorporated into the UM criteria sets and UM policies and procedures that are used in making determinations.

Assessment of the Local Delivery System
There is also an assessment of the local delivery system and the accessibility of the service and the various levels of care to meet the member's specific health care needs. This assessment includes evaluating the availability of the following:

1. inpatient, outpatient, and transitional facilities
2. outpatient services in lieu of inpatient services
3. specialized services such as transplant, cancer care centers, and infusion centers
4. skilled nursing facilities or home care to support the member after discharge
5. local hospitals' ability to provide all recommended services within the estimated LOS

When member's with complications or the delivery system does not have a sufficient alternative to a medically necessary level of care, the UM staff would approve the next higher level of care for that member. These UM cases would also be discussed through individual discussions with the advisor reviewer and/or in the weekly UM meetings where individual cases are discussed.

Practitioner involvement

The UM criteria and procedures for medical and behavioral health services are reviewed against current clinical and medical evidence with practitioner involvement. GHC includes appropriate network practitioners (both medical and behavioral health with clinical expertise in the area being reviewed) in the development, adoption, and review of UM criteria and on instructions for applying the criteria. Network providers sit on the QI Committee where all UM criteria are reviewed. Behavioral health policies and procedures used in the prior authorization review process are also reviewed by our designated network behavioral health consultant at the Behavioral Health UM/QI meetings. The member's provider has the opportunity to discuss criteria used during the review process through a peer-to-peer discussion

Reviewing and Updating Criteria

Clinical practice guidelines and UM policies and procedures that outline medical necessity criteria are revised based on feedback from our network providers through the utilization management process, QI committee meetings, Behavioral Health UM meetings, peer-to-peer discussions, Forward Health Updates from the WI DHS, CMS NCDs and LCDs, Hayes Updates, FDA updates, and case management interventions. Guidelines and evidence-based criteria sets are reviewed at least annually but revisions may occur more frequently when new evidence or research supports a change to criteria.

UM criteria are shared with our providers and members upon request, in denial letters, and during peer-to-peer discussions. GHC policies and procedures related to UM criteria are available to the public on our website.

Availability of Criteria

1. GHC makes UM criteria available upon request which is outlined in the denial letter.
2. Practitioners can obtain UM criteria by requesting the criteria from the UM department.
3. Criteria are shared by the provider's preferred method and can be distributed telephonically, in person, by fax, email, or mail.
4. GHC policies and procedures are available on our website.
5. Criteria used in the denial determination are listed in the denial letter.

Consistency in Applying UM Criteria for Medical and Behavioral Health

1. GHC evaluates the consistency with which physicians and nonphysician UM staff apply UM criteria using hypothetical UM test cases every 4 months using InterQual interrater. See Interrater Policy and Procedure.

2. Interrater results are reviewed and analyzed every 4 months to identify opportunities to improve consistency. Identified opportunities are reviewed during the weekly Inpatient UM and Outpatient UM meetings.

Communication Services

GHC UM and Member Services staff are available for members and providers to discuss UM processes including prior authorizations of care.

Access to staff

1. GHC staff are available for inbound collect and toll-free calls from members and providers seeking information about the UM processes, prior authorization requests, and UM issues from 7 am to 6 pm Monday through Friday.
2. Inbound communication regarding UM issues can be received outside of normal business hours and occurs via email, fax and telephone and are responded to on the same business day if received after midnight on Monday through Friday or the next business day on other days.
3. Staff identify themselves by name, title, and organizational name when initiating or returning calls related to UM issues.
4. For members with hearing or speech difficulties TDD/TTY is used to facilitate communication and meet the communication needs of these members. GHC uses the 711 Relay Service. The Member Handbook and member letters include this information as a resource.
5. For all members who request language services, free of charge language interpreter services through a contracted language service are used to communicate with the member. The Member Handbook and member letters include this information as a resource.

Appropriate Licensed Professionals

Supervision of UM Activities

All UM activities are supervised by licensed professionals. The UM Manager (RN) and the CMO (MD):

1. Provide day to day supervision of assigned UM staff: The UM Manager is an RN and directly oversees the inpatient and outpatient UM specialists. The CMO is an MD and directly oversees the advisor reviewers who are physicians and a PharmD.
2. Participate in staff training.
3. Monitor for consistent application of UM criteria by UM staff for each level and type of UM decisions.
4. Monitor documentation for adequacy.
5. Are available to UM staff on site or by telephone.

As outlined above, a licensed behavioral health provider is involved in the behavioral health aspect of the UM program.

Personnel Responsible for Each Level of UM Decision Making
UM decisions that require clinical judgement are made by UM staff that are licensed health care professionals. If a non-licensed UM staff is reviewing a request that requires clinical review, the request will be sent to the advisor reviewer. The following UM staff may approve services:

1. Licensed health care professionals
2. Non-licensed health care professionals who are under the supervision of a licensed health care professional are able to approve services when there is explicit UM criteria and no clinical judgement is required.

Initial clinical review: The utilization management staff (Outpatient and Inpatient UM Specialists) do the initial review of the requested service using the criteria and processes outlined in this policy. If the requested service meets explicit UM criteria, requires no clinical judgement (medical necessity determination), and is a covered benefit according to the member's policy, the request can be approved. If the UM specialist has questions related to the requested service, it would be reviewed by a physician or a pharmacist (advisor reviewer) depending on the request.

Secondary clinical review: All medical necessity determinations and denials require secondary review by an advisor reviewer (physician or pharmacist) according to NCQA, CMS, and State of Wisconsin standards. All requests that require clinical judgement and that were reviewed by a non-licensed UM staff, require secondary review by an advisor reviewer. Non-pharmaceutical medical necessity determinations and denials are made by physicians and medical necessity pharmaceutical determinations and denials are made by a PharmD or a physician. GHC's standards for the advisor reviewers who review medical necessity determinations include the following:

- Sufficient medical and other expertise
- Knowledge of the coverage criteria for all product lines including Medicare
- A current and unrestricted license to practice within the scope of their profession

See Staff Structure above.

Education, Training or Professional Experience, Licensure of Practitioners Making UM Decisions
To ensure qualified practitioners are reviewing medical necessity determinations and denials, GHC has written job descriptions with the necessary qualifications. See written job descriptions for Assistant Medical Director and Clinical Pharmacist. Advisor reviewers are expected to have

education, training or professional experience in medical or clinical practice and to have a current clinical license to practice. See respective job descriptions and HR file for license verification.

The types of practitioners (advisor reviewers) who review denials of care based on medical necessity for GHC include physicians and a pharmacist. See Staff Structure section above. The specified UM denial decisions are made as outlined below:
Physicians: Medical, behavioral healthcare, pharmaceutical, dental, chiropractic and vision denials.
Pharmacist: Pharmaceutical denials.

Practitioner Review of Nonbehavioral Healthcare, Behavioral Healthcare and Pharmacy Denials

See Staff Structure above.
The UM denial file that is located in the electronic care management system includes documentation on the UM staff doing the initial clinical review and the Advisor Reviewer who made the determination including all medical necessity denials. The advisor reviewer's name which is their unique identifier is notated in the denial file. In rare cases, a denial determination may be documented by the UM staff. In this case, the UM staff will notate in the UM file the advisor reviewer's name who reviewed and decided the case.

Use of Board-Certified Consultants

GHC has a written policy for using board-certified consultants to assist in making medical necessity determinations. See Use of Board-Certified Consultants Policy and Procedure

Timeliness of UM Decisions

GHC makes UM decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Please refer to the respective policies below that outline our processes related to Timeliness of UM Decisions.

When a Request is Considered Received by the Plan

GHC accepts prior authorization requests 24 hours a day, 7 days a week (including holidays) through dedicated fax lines. Requests are deemed "received" on the date and time:

- The plan initially stamps a document received by regular mail (i.e., U.S. Postal Service)
- A delivery service that can track when a shipment is delivered (e.g., U.S. Postal Service, UPS, FedEx, or DHL) delivers the document
- A faxed document is successfully transmitted to the plan, as indicated on the fax transmission report

- A verbal request is made by telephone with a customer service representative
- GHC does not utilize a voicemail system or website to accept requests or supporting statements

For standard requests, the processing timeframe begins when the plan, any unit in the plan, or a delegated entity (including a delegated entity that is not responsible for processing) receives a prior authorization request.

For expedited requests, the processing timeframe begins when the UM Department receives the request. Plan materials clearly state where pre- and post-service requests should be sent to ensure requests are received at the correct location to allow the greatest amount of time to process the request. Prior authorization requests that are received in an incorrect location are sent to the correct location as expeditiously as possible. Faxes received at an incorrect location are routed to the UM fax folder. Mailed requests received at the wrong location are date stamped and scanned into the HM Scanning folder. If a request was emailed, the email would be forwarded to the UM department shared email.

Notification of Nonbehavioral Decisions See Timeliness of UM Decisions Policy and Procedure
Notification of Behavioral Health Decisions See Timeliness of UM Decisions Policy and Procedure
Notification of Pharmacy Decisions See Timeliness of UM Decisions Policy and Procedure

UM Timeliness Report
Behavioral, non-behavioral, and pharmaceutical UM determination timelines are monitored and the percentage of decisions that adhere to time frames related to urgent concurrent, urgent pre-service, non-urgent pre-service, and post-service categories are calculated and tracked at least annually.

Clinical Information

Relevant Information for Non-Behavioral Healthcare Decisions
Relevant Information for Behavioral Healthcare Decisions
Relevant Information for Pharmacy Decisions

GHC obtains and reviews relevant clinical information when making non-behavioral health, behavioral health, and pharmaceutical medical necessity determinations. The UM staff will consult with the treating practitioner to obtain additional information when applicable. Clinical information used in reviewing prior authorization requests is documented in the electronic care management

system. All information relevant to a member's care is used and is considered in light of criteria used in making determinations. If additional clinical information is needed to make a determination, it is requested, and the attempt is documented in the denial file. Clinical information used in determining coverage may include but is not limited to the following:

- Medical records including history of presenting problem, treatment plans, consultant notes, psychosocial history, and progress notes
- Physical examination results
- Diagnosis codes
- Claims
- Diagnostic testing results
- Operative and pathological reports
- Copy of criteria related to the request
- Hayes Technology reviews
- Images
- Member's policy or certificate of coverage
- Patient demographics
- Information from informal supports
- Information regarding local delivery system and network
- Information from providers including pharmacist or other county health care providers

Outreach for Additional Information to Support Coverage Decisions

If there is not enough information to make an approval decision on an item, service, or drug request, GHC will make reasonable and diligent efforts to obtain all necessary information.
In instances when outreach is necessary to make a coverage or appeal decision, a minimum of one attempt will be made to obtain additional information. If GHC does not receive any additional information, the decision will be made based on the information available within the required adjudication timeframes. All requests for information are documented within the case file in the electronic case management system. If an adverse decision due to the inability to obtain clinical information needed to approve coverage, the written denial notice would clearly identify that basis and the necessary information that was missing.

Part C Only (Applicable only to DSNP)
For expedited organization determination and reconsideration requests, if medical information is needed from a non-contract provider, GHC will request the necessary information within 24 hours of receipt of the request.

Approval Notices

For favorable decisions on a request for an item, service, or Part B drug, notice is provided in writing to the requesting party. The written notice explains the conditions of the approval including the requested service, frequency of the service if applicable, and the duration of the approval. If a practitioner submits the request, a written notice is also sent to the member or the member representative if applicable. GHC notifies the member as well as the treating or attending practitioner of its determination. For urgent concurrent decisions, GHC informs the hospital Utilization Review (UR) department staff who informs the attending practitioner. When the member's representative submits a request, the representative will be notified in lieu of the member.

Denial Notices

GHC documents and communicates the reasons for a denial. Members and practitioners receive enough information in the denial notice to help them understand a decision to deny care or coverage and to decide whether to appeal the decision. GHC documents all behavioral and nonbehavioral healthcare denial reasons in the electronic care management system and the time and date of the notification, the UM staff who reviewed the case and made the determination, the treating practitioner who was sent the denial notification, and how the denial notification occurred (written/verbal) to the member and the provider. Communication of the denial notification includes sending a written notification to both provider and member. The denial notification also outlines all denial reasons and the criteria used to make the determination and that criterion are available upon request.

Opportunity to Discuss Denials with a Reviewer

For all behavioral and nonbehavioral medical necessity denials, providers are given the opportunity to discuss denial decisions with an advisor reviewer (physician or clinical pharmacist). The process for discussing the denial is outlined in the denial notification or in some instances a verbal notification. In the event of a verbal notification by telephone, GHC documents the name of the UM staff who notified the treating practitioner, and the date and time of the notification and outlines the process for discussing the denial with a reviewer.

Peer to Peer Reviews

Any provider may request a peer-to-peer review to advocate on behalf of the member with a GHC physician or pharmacist (Advisor Reviewer) who has made the determination. During this review, medical necessity criteria or the clinical practice guideline that was used in the review process is shared. This process is also used to obtain feedback on the criteria and obtain any new guideline

recommendations or research studies that support the requested service. Our criteria and policies are updated (including services considered experimental/investigational) if the provider submits documentation that is evidence based and is supported in a nationally recognized clinical practice guidelines. Providers also can participate in the grievance process at the member's request to advocate for them. Peer to peer reviews are documented in the electronic care management system in the UM case file.

Written Notification of Nonbehavioral Healthcare Denials and Behavioral Healthcare Denials and Notice of Appeal Rights/Process

Standardized written notifications are used based on the respective product line. Denial notifications are sent when determinations are partially or fully adverse to the member. When applicable, a specific explanation about what information is needed to approve coverage will be included. The denial outlines in terms specific to the member's condition or request so the member and provider understand why the organization denied the request and have enough information to file an appeal. The written notification includes a complete explanation of the grounds for the denial, in language that a layperson would understand, and does not include abbreviations, acronyms or health care procedure codes that a layperson would not understand. For denials resulting from medical necessity review of out-of-network requests, the reason for the denial will explicitly address the reason for the request (e.g., if the request is related to accessibility issues, that may be impacted by the clinical urgency of the situation, the denial will address whether or not the requested service can be obtained within GHC's accessibility standards). A denial notice is not sent to the member if there is no member liability.

Written denial notifications to members and providers include the following:

1. The specific denial reasons and a detailed explanation for why the medical service was denied
2. A specific explanation about what information is needed to approve coverage
3. A list of the criterion such as the applicable policy, coverage rule, benefit provision, or guideline that was used to make the determination
4. A statement that member and provider can obtain a copy of the criterion used in making the denial determination.
5. The process for the provider or member to obtain the criterion on which the denial decision was based.
6. Information regarding the member's right to appeal and a statement that the member may be represented by anyone they want including a provider or attorney and has the right to appoint a representative to file an appeal on the member's behalf. Provides contact information for the respective contact at the state level or federal level whichever is applicable to the product line

7. A description of both the standard and expedited appeal processes, including the specific department or address for reconsideration requests and a description of conditions for obtaining a standard or expedited reconsideration, the timeframes for each, information to include in the appeal, GHC's time frame for deciding standard or expedited appeals, and other elements of the appeals process.
8. The member's right to submit additional evidence such as comments, documents, or additional information in writing or in person.
9. Notification that expedited external review can occur concurrently with the internal appeals process for urgent requests. This is N/A for Medicare and Medicaid.
10. When applicable, an explanation of a provider's refusal to furnish an item, service, or Part B drug.

GHC will provide written communications and notices in alternate formats and languages when applicable to ensure members with limited English proficiency are able to communicate in a culturally and linguistically equitable manner with the plan regarding initial determinations, appeals, and grievances. The member will receive the same level of access to information as an individual not requesting information in an alternate format. GHC will take into account the additional time that may be needed to provide the instructions in the alternate format when a timeline is involved.

When Notification is Considered Delivered by the Plan
Written notification is considered delivered on the date (and time, if applicable) the notice has left the possession of the plan or delegated entity. For mailed notifications, this occurs when the notice has been deposited into the courier drop box or external outgoing mail receptacle (e.g., U.S. Postal Service or FedEx bin) and for electronic delivery of required materials, it is the date the plan sends the materials to the member or provider. Placement into the plan or delegated entity's internal outgoing mail receptacle is not considered delivered.

Verbal Notification
Verbal notification does not replace electronic or written notification of denial decisions, but when provided, GHC may extend the time frame for written notification for commercial and Medicare members only. For Medicaid decisions, providing verbal notification does not extend the written notification time frame. Verbal notification requires:

1. Communication with a live person; the organization may not leave a voicemail, and
2. GHC records the time and date of the notification and the staff member who spoke with the practitioner or member, and

3. GHC provides verbal notification within the time frames specified for an urgent concurrent or urgent preservice request, and
4. Written notification is delivered within 3 calendar days.

Verbal notification is considered delivered on the date (and time, if applicable) GHC speaks directly to the member or the member's representative.

Reference to UM Criterion

The denial notification references the specific criterion used to make the denial decision. The criterion used and referenced is specific to the member's condition or to the requested services. The criterion referenced is identifiable by name and is specific to an organization or source. When benefit documents are referenced, members are directed to the information using the section title or page number. For denials resulting from medical necessity review of out-of-network requests, criteria may be excerpted from benefit documents that govern out-of-network coverage. The references cited specifically support the rationale for the decision and must relate to the reason for the request.

Availability of Criterion

The denial notification informs the member, and the practitioner acting as the member's authorized representative, that the criterion used to make the decision is available upon request. The criterion used in making the coverage decision is included in the denial notice.

Failure to Follow Filing Procedures

If the member (or the member's authorized representative) does not follow GHC's reasonable filing procedures for requesting preservice or urgent concurrent coverage, GHC notifies the member (or the member's authorized representative) of the failure and informs them of the proper procedures to follow when requesting coverage.
For urgent preservice and concurrent decisions, GHC notifies the member or practitioner (member's authorized representative) within 24 hours of receiving the request. Notification may be verbal, unless the member or practitioner requests written notification.
For nonurgent preservice decisions, GHC notifies the member or the member's authorized representative within 5 calendar days of receiving the request.
GHC does not deny nonurgent preservice, urgent preservice or urgent concurrent requests that require medical necessity review for failure to follow filing procedures.

Discussing a Pharmacy Denial with a Reviewer

Delegated

Written Notification of Pharmacy Denials
Delegated
Pharmacy Notice of Appeal Rights/Process
Delegated

Evaluation of New Technology
See policy

UM Information Integrity
UM denial information integrity refers to maintaining and safeguarding information used in UM denial decision process. GHC is committed to protecting the integrity of UM information used in in the processing of UM denials and UM appeals. 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.

See UM Denial and Appeals System Controls policy
See UM Information Integrity policy

Monitoring of Over and Under Utilization

Group Health Cooperative of Eau Claire monitors over and under-utilization through our utilization management and QI processes. Risk Manager, an NCQA certified tool that uses HEDIS technical specifications, is used to identify noncompliant members who have gaps in care related to chronic health conditions, preventive screenings, medication adherence, and follow up care. Risk Manager is used to identify members who have gaps in care so that member outreach can occur. It also allows us to identify providers who are outliers with respect to utilization patterns. Risk Manager is also used to track HEDIS/Quality metrics compliance monthly. Behavioral health counseling visits are tracked from claims. The following table outlines the over- and under- utilization initiatives.

Over Utilization Initiatives
Behavioral health counseling greater than 1 time per week
Under Utilization Initiatives
Diabetics missing an HbA1C
Childhood and adolescent immunizations
Colon cancer screening
Cervical cancer screening

Breast cancer screening

Also, through the utilization management prior authorization process, we monitor for under- and over-utilization patterns during the utilization review process. When the outliers are identified, the Group Health Cooperative of Eau Claire management team does a thorough medical record and claims review and decides on interventions to address the issue. A meeting with the provider and facility management will occur to address and rectify identified concerns.

Concerns related to over and under-utilization are also identified through our adverse event process, our SIU committee, and through our HEDIS medical review process.

APPROVED: Michele Bauer MD DATE: 11/17/2024

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
01/05/2020	Michele Bauer, MD, CMO	New policy
01/22/2021	Michele Bauer, MD, CMO	No revisions
08/04/2021	Michele Bauer, MD, CMO	Add section of UM Controls and removed information on assistant medical director role
03/23/2022	Michele Bauer, MD, CMO	Added assistant medical director role, updated manager title, clarified nonmedical criteria used in reviews.
06/15/2022	Michele Bauer, MD, CMO	Updated documentation of clinical information sources, updated senior level physician involvement, updated peer to peer section and how network providers provide feedback on criteria and clinical practice guidelines
11/15/2022	Michele Bauer, MD, CMO	Added over and underutilization initiatives, updated board-certified consultant section, updated responsibilities of the senior-level physician, updated the UM systems control section which will be incorporated into the UM Denial and Appeals Systems Control policy. Updated UM's role in the QI program and updated behavioral healthcare aspects of the UM program.
11/08/2023	Michele Bauer, MD, CMO	Reviewed. No changes.
04/18/2024	Michele Bauer, MD, CMO	Updated UM staff section, behavioral healthcare aspects of the program, updated over and underutilization section, communication services, how medical necessity criteria are updated, and interrater process.

05/01/2024	Michele Bauer, MD, CMO	Added updated DNSP processes
11/17/2024	Michele Bauer, MD, CMO	Updated to reflect 2025 NCQA Standards and mental health parity language.