Policy Number: UM-21-01
Manual Name: Utilization Management
Policy Name: Utilization Management
UMPC Approved: 11/2/2023, 11/7/2024
Last Revised: 10/24/2023, 11/6/2024

SMSO Policy Manual
Utilization Management

Executive Sponsor:	Chief Medical Officer
Issuing Department:	Clinical Management Department
Gate Keeper:	Director, Clinical Management

COMPLIANCE STATEMENT:

Enforcement: All members of the workforce are responsible for compliance with this policy. Failure to abide by the requirements of this policy may result in corrective action, up to and including termination. Workforce members are responsible for reporting any observed violations of this policy.

Review Schedule: This policy will be reviewed and updated as necessary and no less than every two years.

Monitoring and Auditing: The Issuing/Collaborating Department(s) is responsible for monitoring compliance with this policy.

Documentation: Documentation related to this policy must be maintained for a minimum of 10 years.

Applies to:

☒ SummaCare Apex
☒ Summa Management Service Organization (SMSO)
☒
☒ Summa Insurance Company

Line of Business:

- ☒ Commercial Groups
- ☐ Medicare Supplemental
- ☒ Off-Exchange Self-Funded
- ☒ Medicare On-Exchange
- ☒ Exchange

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1.0 Purpose:

1.1 To ensure members and providers have appropriate contacts to readily answer questions pertaining to the UM process and/or authorization of care.

1.2 To ensure that UM staff are supervised and that qualified licensed health professionals make decisions.

1.3 To ensure access to board-certified specialty physicians when clinical judgment requires a level of medical expertise not available within The Plan's medical staff.

1.4 To minimize disruption in the provision of health care.

1.5 To ensure that decisions are made in a fair, impartial, accurate, timely and consistent manner based on appropriate medical evidence.

1.6 To ensure that relevant information is gathered from appropriate providers when making UM decisions.

1.7 To ensure that practitioners and members receive timely information sufficient to understand the reason for a denial and to be able to make a decision about appealing the decision to deny service or coverage.

1.8 To provide a mechanism for provider and/or members to obtain the criteria used to support UM decisions.

1.9 To ensure members and providers that the Plan follows and adheres to all federal and state guidelines pertaining utilization and prior authorizations.

1.10 Ensure all policies/procedures are compliant with the Health Insurance Portability and Accountability Act (HIPPA) and that any data or information pertaining to the diagnosis, treatment, or health of any enrollee or applicant for enrollment that is obtained by the health insuring corporation from the enrollee or applicant, or from any health care facility or provider, shall be held in confidence.

2.0 Policy:

2.1 Access to UM Staff

2.1.1 SummaCare, Inc. (otherwise referred to as "The Plan" in this document) maintains an efficient and convenient method for members and providers to reach Utilization Management (UM), to seek information about UM processes and to request authorization for services. The Plan maintains records of all requests in an electronic authorization record. Either a member or a provider may request an organization determination by fax, online, or orally.

2.2 Affirmative Statement about Incentives

2.2.1 The Plan does not specifically reward delegates, practitioners, or other individuals conducting utilization review for issuing denials of coverage or service. UM decision-making is based only on the existence of coverage and the appropriateness of care and service. There are no financial incentives for UM decision makers to encourage denials of coverage or service.

2.2.2 The Plan is sensitive to the risks of underutilization of care and services, which include inappropriate and/or delayed treatment, preventable contraction of disease, extended duration and/or exacerbation of symptoms, undetected progression of disease, misdiagnosis, lowered quality of life, permanent loss of function, and preventable death. For this reason, The Plan annually distributes via the web a statement (to all members

and to all provider, providers and staff who make UM decisions) regarding its incentives to encourage appropriate utilization and discourage underutilization and of the need for special concern about the risks of underutilization and of the following:

2.2.2.1 UM decision-making is based on the appropriateness of the care planned, the services to be provided and the existence of member coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage.

2.2.2.2 Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

2.2.2.3 The Plan does not use incentives to encourage barriers to care and service

2.2.3 The Plan requires its employees and delegates who make UM decisions and those who supervise them to sign a statement affirming the foregoing.

2.3 **Appropriate Professionals**

2.3.1 Lines of authority and job descriptions ensure appropriate oversight of all UM decisions. The Medical Director is responsible for the clinical accuracy of all initial coverage decisions and appeals that involve medical necessity. The Medical Director must be a physician with a current and unrestricted license to practice medicine in State, Territory,
Commonwealth of the United States, or the District of Columbia. Licensed nurses and/or participating plan physicians supervise all clinical review processes. Licensed Pharmacists and Physicians supervise all clinical review processes regarding pharmacy prior authorizations and step therapy. Behavioral Health Licensed Specialists (Psychiatrists, Psychologists) supervise clinical processes for all inpatient and outpatient behavioral health care that is medically managed. Dentists supervise clinical decisions for dental

services. All supervisors are available to UM staff in person or by telephone. All clinical denials are reviewed by an appropriate physician.

2.3.2 Practitioners are required to have education, training or professional experience in medical or clinical practice, knowledge of Medicare coverage criteria, and a current license to practice in State, (Ohio) Territory, Commonwealth of the United States, or the District of Columbia, without restriction.

2.3.3 Authorization Coordinators (non-clinicians) collect data for pre-service review and make authorization approval decisions within defined parameters. Registered nurses and licensed practical nurses make authorization determinations and supervise non-clinicians involved in UM decisions and review all requests that fall outside of authorization parameters. A physician reviews all non-behavioral health medical necessity denials. A licensed psychiatrist reviews any behavioral health related medical necessity denials.

2.3.4 The Plan uses board-certified physician consultants from appropriate specialty areas, including behavioral health specialists, as appropriate, when making determinations of medical necessity. The Plan maintains a list of board certified consultants used for UM decisions. The Plan makes the final determination.

2.3.5 The Plan delegates initial decisions to EviCore for high-tech radiology, medical o n c o l o g y, radiation oncology, and genetic testing. EviCore will do appeals for all lines of business other than Medicare.

2.3.6 Determinations entered into the UM software are electronically date and time stamped with signatures. The Plan maintains controls on system access with password protection to insure accurate authentication of end users performing UM.

2.4 **Emergency Services**

2.4.1 The Plan facilitates all needed emergency services, including appropriate coverage of costs. Emergency services rendered to treat or stabilize an emergency medical condition are covered without prior approval where a **prudent** layperson, acting reasonably, would have believed that an emergency medical condition existed. The Plan's claim system is configured to pay all emergency department claims consistent with the member's eligibility and benefits (e.g., co-pays, deductibles, etc.).

2.5 **Investigational Items**

2.5.1 For utilization, requests for investigational items that are not excluded by the member's plan, a Physician, with assistance when needed of a Pharmacist, or Dentist, (as appropriate) performs a review for medical necessity.

2.6 **Clinical Criteria for UM Decisions**

2.6.1 The Plan Clinical Management and delegate staff based on medical necessity for medical and behavioral health coverage decisions on reasonable medical evidence or a consensus of relevant health care professionals.

2.6.2 For Medicare Advantage (MA) members, coverage decisions follow Medicare rules and regulations pertaining to MA plans, as well as federal and state regulations, and the member's evidence of coverage (EOC) document. When appropriate, relevant current clinical guidelines, SummaCare's internal policies/procedures and drug formularies may be utilized in the absence of Medicare guidance.

2.6.3 For non-Medicare members, coverage decisions follow appropriate federal and state requirements and the member's evidence of coverage (EOC) document. Additionally, SummaCare's internal policies/procedures, and drug formularies are followed when appropriate.

2.7 **Development and Approval of Criteria**

2.7.1 SummaCare utilizes industry standard criteria to assist in the decision-making process. Internally developed criteria supplement industry standard criteria as appropriate. Utilization management personnel draft internally developed guidelines based upon evidenced-based scientific data. Draft medical and behavioral guidelines are reviewed and approved by the Utilization Medical Policy Committee (UMPC). Pharmacy and Medical Drug Benefit evidence based pharmaceutical guidelines are reviewed and approved through a combination of the SummaCare Pharmacy and Therapeutics Committee, the Pharmaceutical Benefit Manager's Pharmacy and Therapeutics Committee, and the Centers for Medicare and Medicaid Services. Evidence-based clinical criteria are used to support appropriate care and foster optimal utilization of resources. The SummaCare Plan Utilization Medical Policy Committee (UMPC) develops or reviews, updates as necessary, and approves UM criteria annually. The Utilization Medical Policy Committee (UMPC) includes primary care and specialist providers who currently provide direct patient care. The Plan maintains at all times an active license for the most current version of industry standard criteria. The Chief Medical Officer and Director of Clinical Management are responsible for annually reviewing and updating criteria as needed. Plan providers have available 24/7 access via the SummaCare Provider web site indicates how to obtain medical necessity criteria for

care requiring prior authorization. Providers are also notified in writing at the time of determination notification of how to request a copy of the medical necessity criteria used in the determination.

2.7.2 Once approved, staff receives training on appropriate use and interpretation of clinical information collected to make decisions.

2.7.3 Clinical decisions about each request for service are based on the clinical features of the individual case including age, co-morbid conditions, response to treatment, including complications, and psychosocial factors, the medical necessity criteria, home environment and the resources/services available in the local delivery system and ability of the services to meet the member's specific needs, when criteria are applied.

2.7.4 The Plan approved criteria include, but are not limited to:

- 2.7.4.1 Centers for Medicare and Medicaid Services (CMS) Guidelines, NCD'S & LCD'S
- 2.7.4.2 Health Plan Benefits and Coverage Guidelines including Clinical Practice Guidelines and medical necessity criteria
- 2.7.4.3 Change Healthcare InterQual Imaging Guidelines
- 2.7.4.4 Change Healthcare InterQual Behavioral Health Guidelines
- 2.7.4.5 Change Healthcare InterQual Adult and Pediatric Procedures Criteria
- 2.7.4.6 Change Healthcare InterQual Level of Care Acute Adult and Pediatric Criteria (including acute care hospital, long-term acute care hospital, inpatient Rehabilitation, skilled nursing criteria)
- 2.7.4.7 Change Healthcare InterQual DME Criteria
- 2.7.4.8 Change Healthcare InterQual Home Care Criteria
- 2.7.4.9 Change Healthcare InterQual Medicare Behavioral Health
- 2.7.4.10 Change Healthcare InterQual Medicare Post-Acute & Durable Medical Equipment
- 2.7.4.11 Change Healthcare InterQual Medicare Procedures Criteria
- 2.7.4.12 EviCore Healthcare High Tech Radiology Criteria
- 2.7.4.13 Pharmacy and Therapeutics Committee
- 2.7.4.14 Peer Literature Review
- 2.7.4.15 Plan Developed Criteria
- 2.7.4.16 MCMC (managing care managing claims) review
- 2.7.4.17 Hayes, Inc. New Technology Criteria
- 2.7.4.18 EviCore High Tech Radiology and Oncology(Medical Oncology, Radiation Oncology, Lab/Genomic testing)

2.7.5 Annually, practitioners receive a provider newsletter with directions to The Plan's website that includes instructions for how to obtain UM criteria. The Plan sends a fax, email or mail a hard copy to a provider or member upon request. Letters of denial decisions include instructions on obtaining a copy of the criteria used to make the decision.

2.8 Consistency in Applying Criteria

2.8.1 The Director of Clinical Management oversees the assessment of consistency of the application of UM criteria. UM staff are evaluated on an annual basis to determine reliability and consistency of UM decisions. The goal is to identify inconsistencies and

to measure the UM staff understanding of the criteria and its application. Opportunities to improve consistency in criteria application/medical decision-making are identified and actions are taken if necessary.

2.8.2 Case studies are selected or created for all personnel involved in decision-making. Case studies reflect the types of decisions made by specific areas of job responsibilities. For example, UM Discharge planning nurses and RN Care Coordinator, Skilled Nursing evaluate concurrent review decisions, and physicians review a sampling of all cases. Utilization staff complete case studies specific to behavioral health utilization determinations. Cases are reviewed, at least annually, but may be reviewed throughout the year with audits occurring simultaneously to ensure appropriate application of criteria.

2.8.3 An annual report with the findings is prepared and reviewed by the Director of Clinical Management. The report includes methodology, goals, results, a barrier analysis and the action plan when opportunities are identified.

The Plan makes reasonable and diligent efforts to obtain all necessary medical records and other pertinent information within the required time limits. If the determination requires medical necessity review and there is not enough information provided to make a determination, no less than 1 attempt are made to obtain the necessary information. The Plan staff make at least 1 attempt to obtain the missing information from the appropriate provider(s) or to verify that the needed information is not available. When there is still lack of response, the Plan will contact the member, when appropriate, for records or assistance in reaching the provider. When efforts have been exhausted and a decision is required to meet timeliness, the determination will be made based on the information that is available to the reviewer and the member's available benefits.

2.8.4 Extensions are taken following the appropriate regulatory/accreditation guidelines if the member requests them

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2.8.5 Clinical Management staff obtains and considers all relevant clinical information to support UM decisions, including information from the treating provider, PCP, behavioral health specialists and other health care professionals and/or facilities as appropriate. In addition, Clinical Management staff considers previous claims history, CMS regulations and guidance, state, and other regulations and standards, the members Explanation of Benefits or Plan language, and drug formularies when appropriate, in making UM decisions.

2.8.6 Clinical Management staff consider the characteristics of the local delivery system that are available to a particular patient with regard to:

- 2.8.6.1 Availability of inpatient, outpatient, and transitional facilities
- 2.8.6.2 Availability of skilled nursing facilities, sub-acute care or home care to support the patient following hospital discharge;
- 2.8.6.3 Coverage of skilled, sub-acute and home care services;
- 2.8.6.4 Availability of outpatient services in lieu of inpatient services

2.8.6.5 Availability of highly specialized services (e.g. transplant facilities or cancer centers)

2.8.6.6 Ability of contract hospitals to provide all recommended services within an estimated length of stay.

2.8.7 To the extent that the local delivery system lacks sufficient alternatives to inpatient/outpatient care, the Medical Director develops a plan of care to meet patient needs.

2.8.8 Clinical Management posts the information necessary for Providers to create a complete request for service and to request a determination on the SummaCare.com website under the Providers tab. This information is listed on Prior Authorization Request Forms for various services and via a link to the EviCore criteria/information needed for a request/determination.

2.9 **Prior Authorization**

2.9.1 The Plan subjects certain pharmaceuticals, outpatient diagnostic, therapeutic, and elective procedures and surgeries to pre-service review to establish medical necessity and benefit coverage. The Plan maintains the SummaCare Provider Portal and a fax line available 24 hours a day, 7 days a week to receive authorization requests outside of normal business hours. The Plan also maintains on-call UM staff to process urgent UM electronic and faxed requests and to receive telephonic UM requests on weekends and holidays. Members or providers may make authorization requests, orally, or in writing. Providers may also submit requests electronically.

2.9.2 Services requiring authorization or prior authorization will be reviewed/approved no less than annually by the UPMC. Prior authorization list can be found on www.summacare.com

2.10 **Timeliness of UM Decisions**

2.10.1 UM staff make utilization decisions directly related to requests by members or by their authorized representatives for authorization or payment for healthcare services in a timely manner to accommodate the clinical urgency of the situation, and in accordance with applicable state and federal regulatory requirements and accreditation standards.

2.11 **Triage and Referral for Behavioral Healthcare**

2.11.1 The Plan does not require or have a centralized triage or referral process for members to obtain behavioral health care services.

3.0 Procedure:

3.1 **Communication Services**

3.1.1 The Health Services Management (HSM) department maintains a designated phone line with a toll-free number to receive inbound calls regarding UM issues. Providers and members may also contact the HSM department via fax or Internet through The Plan website Provider Services email address or through the Customer Service phone number located on member ID cards. Language assistance is available to UM staff through telephonic interpreters for those members needing to discuss UM issues. The Plan provides free language services to people whose primary language is not English,

such as qualified interpreters and information in other languages. Free aids and services are provided by The Plan to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). All HSM staff identify themselves with their name, title, and organization when receiving incoming calls when initiating or returning calls regarding UM issues.

HSM UM staff are responsible for staffing the designated line during normal business hours (Monday through Friday, 8:30am to 5:00pm) and are available to accept collect calls, authorization requests, benefit determination inquiries, and callers with questions about the UM process. During business and non-business hours, members and providers are offered the option of leaving a voice mail message. For callers leaving voicemail messages, the appropriate staff member speaks with the member or calls them back (outbound) within one business day during normal hours.

3.1.2 Providers are routinely educated on how to contact the HSM department (including the provision of a toll-free number) in regard to UM issues via the Provider Press newsletter, provider seminars, and provider manual and/or written/oral communication regarding authorization determinations.

3.1.3 Members are directed to contact The Plan Customer Service for any questions, concerns, or inquiries regarding their benefits or coverage, unless the member is requesting that a non-covered service be covered, and a decision be provided in writing. In this case, The Plan processes the request through the authorization process. Local, toll-free access and

TTY/TDD (for deaf, hard of hearing or speech-impaired members) numbers for Customer Service are located on the member's ID card. Members are also educated on how to reach Customer Service on a routine basis via member newsletters/updates, new member materials, and written/oral communication regarding authorization determinations. Customer Service Representatives direct calls regarding specific UM concerns to the HSM designated intake line, including those received by TDD/TTY.

4.0 Verification of Licensing and Responsibilities

4.1 Job descriptions are maintained, reviewed, and updated, as needed annually for all staff involved in UM decisions. Job descriptions include education, training or professional experience in medical or clinical practice, and require a current license to practice without restriction.

4.2 Upon hire, UM staff's nursing licenses are verified by the Human Resources Department. In addition, there is a bi-annual verification of licensure to follow the required state renewal of licensure. This is completed by the applicable Manager of the UM staff to verify that UM staff have valid unrestricted licenses. The date of original licensure, and date license was renewed and expires are documented by the manager or Human Resources in the Lawson system. Summa Health System Human Resources Department will email report monthly to all managers containing current information in the Lawson system for all employees. The report provides expired or expiring credentials at 30, 60, and 90 days listed by department.

4.3 The licenses of reviewing physicians making UM decisions are verified upon initial credentialing and during the re-credentialing process. All clinicians must maintain an active license without restriction.

5.0 Clinical Information for use in Making Utilization Management Decisions

5.1 The following information is collected as part of the UM decision making process, as appropriate to the service being requested:

5.1.1 Age.

5.1.2 Member's Benefit Plan

5.1.3 Diagnosis and co-morbid conditions.

5.1.4 History and physical assessment findings including, but not limited to, location, duration, description, cognitive function, length of time patient treated for condition, treatment progress, complications, family history, results of pertinent diagnostic tests including labs, X-ray, consultation findings, psychosocial history, home environment when applicable, information on consultations with treating provider, evaluations from other providers, and other individual needs of the member.

5.1.5 Demonstration of conservative treatment including medications, therapies, splints, etc.

5.1.6 Medical and Behavioral Health records and reports.

5.1.7 Provider plan of care.

5.1.8 Resources available in the local delivery system.

5.1.9 Any other information deemed necessary to facilitate the decision-making process.

In addition to the above, the following information is collected specific to behavioral health authorizations

5.1.10 Level of functioning including ability to perform activities of daily living.

5.1.11 Presence of suicidal or homicidal ideations

5.1.12 Presence of hallucinations

5.1.13 Participation in milieu

6.0 Timeliness of UM Decisions

6.1 UM Decisions are made in accordance with the time frames below. Extensions may be taken to obtain additional information needed to make the decision or for reasons beyond the control of The Plan. If there is not enough information to make a determination, The Plan notifies the requesting provider and/or the member/member's representative of what specific additional information is needed in order to make a determination. If The Plan extends the decision time frame due to matters outside of our control, we notify the member/member's representative of the extension, the reason, and the date we expect to make a decision.

6.2 The Plan subscribes to the National Committee on Quality Assurance (NCQA) standards regarding timeliness of decision-making and notification to ensure timely access to needed health care services (see standards below) unless government regulations (i.e., CMS, ODI) are more stringent. See Denial Determination Policy and Procedure for specific government regulations. The table below pertains to requests for Commercial/Marketplace and Medicare. UM decision-making and notification, including behavioral health and non-behavioral health requests.

Regulatory Body	Type of Request	Product Line	Notify Requestor within the following timeframe	Who must you notify	Required Communication Type	Miscellanous notes	Extension
Senate Bill 129	Urgent Preservice Decisions	Commercial and Exchange / Senate Bill 129 applies only to Commercial Insurance (Lg and Sm Groups) including Self Insured	48 hours via Portal and electronic	practitioner and member	Electronic or written notification of the decision		none.
Senate Bill 129	Nonurgent Preservice Decisions	Commercial	10 calendar days	practitioners and members	Electronic or written notification of the decision		none
Ohio Department of Insurance	Nonurgent Preservice Decisions	On & Off Marketplace	2 business days (48 hrs) when all necessary information has been obtained	practitioners and members	Electronic or written notification of the decision		none
Senate Bill 129	Postservice Decisions	Commercial	For denials, written notificaiton to provider within 30 calendar days of request.	practitioners always notified and members will only be notified if they are at financial risk.	Electronic or written notification of the decision		none
CMS	Urgent Preservice	Medicare	72 hrs	Practitioner and member	Verbal notification is required to the member, Electronic or written notification of the decision to the provider	If the member is notified by direct contact or a detailed VM is left for the member there is a 72hr extention on written notification	none
CMS	Nonurgent Preservice Decisions	Medicare	7 calendar days	Practitioner and member	Electronic or written notification of the decision		none
CMS	Postservice Decisions	Medicare	For denials, written notificaiton to provider within 30 calendar days of request.	practitioners always notified and members will only be notified if they are at financial risk.	Electronic or written notification of the decision		none
nate Bill 129 / Pharma	Urgent Preservice	Commercial and Exchange / Senate Bill 129 applies only to Commercial Insurance (Lg and Sm Groups) including Self Insured	48 hours via portal or electronic.	Practitioner and Member	Electronic or written notification of the decision		none
nate Bill 129 / Pharma	Non-Urgent Preservice	Commercial	10 Calendar days	Practitioner and Member	Electronic or written notification of the decision		none
Ohio Department of Insurance	Non-Urgent Preservice	On & Off Marketplace	2 business days (48 hrs) when all necessary information has been obtained	Practitioner and Member	Electronic or written notification of the decision		none
nate Bil 129 / Pharma	Post Service	Commercial LOB	30 Calendar days	Practitioner and member	Electronic or written notification of the decision		none
CMS / Pharmacy	**Medicare Part B** Standard Request	Medicare	72hrs	Practioner and member	Electronic or written notification of the decision	If the member is notified by direct contact or a detailed VM is left for the member there is a 72hr extention on written notification	none
CMS / Pharmacy	**Medicare Part B** Urgent Request	Medicare	24hrs	Practioner and member	Verbal notification is required to the member, Electronic or written notification of the decision to the provider	If the member is notified by direct contact or a detailed VM is left for the member there is a 72hr extention on written notification	None
Senate Bill 129	Urgent Concurrent Decisions: INPATIENT ONLY	Commercial and Exchange / Senate Bill 129 applies only to Commercial Insurance (Lg and Sm Groups)	48 hours via electronic or portal	Practitioner and member	Electronic or written notification of the decision		none
ERISA	Urgent Concurrent Decisions: INPATIENT ONLY	Self Insured	24 hours of receipt of request	practitioners and members	Electronic or written notification of the decision		none
Ohio Department of Insurance	Urgent Concurrent Decisions: INPATIENT ONLY	On & Off Marketplace	1 business day (24 hrs) once all necessary information has been obtained	practitioners and members	Electronic or written notification of the decision		none
NCQA	Urgent Concurrent Decisions: Service	Medicare	24 hours of receipt of request	practitioners and members	Verbal notification required to the member. Electronic or written notification of the decision	If the member is notified by direct contact or a detailed VM is left for the member there is a 72hr extention on written notification	Once, for 72 hrs. if request for additional information was made before the 24hrs had expired. This DOES NOT apply for service renewals. This extension is only used for IP hospitalizations.

The table above pertains to all other requests received by The Plan.

6.3 UM Decisions are made in accordance with the time frames above. Extensions may be taken to obtain additional information needed to make the decision or for reasons beyond the control of The Plan. If there is not enough information to make a determination, The Plan notifies the requesting provider and/or the member/member's representative of what specific additional information is needed in order to make a determination. If The Plan extends the decision time frame due to matters outside of our control, we notify the member/member's representative of the extension, the reason, and the date we expect to make a decision.

6.4 The Plan performs a monthly internal review of all authorizations in compliance with CMS guidelines in submitting the Universe files. Any authorizations that are out of compliance are reviewed internally and reported to Compliance.

7.0 Medicare Expedited Determinations

7.1 Although the Plan may notify the enrollee orally or in writing, the enrollee must be notified within the 24-hour time frame for medical benefit drug requests, or the 72-hour time frame for all other expedited requests. Mailing the determination within 24 or 72 hours respectively in and of itself is insufficient. The enrollee must receive the notice in the mail within the time frame. If The Plan first orally notifies an enrollee of an adverse expedited determination, the Medicare health plan must mail written confirmation to the enrollee within three calendar days of the oral notification.

8.0 Use of Criteria

8.1 Clinical Management staff applies criteria in the following order:

SummaCare Clinical Criteria for UM Decisions

Type of request	First Line Criteria	Second Line Criteria	Third Line Criteria
Inpatient medical services (Acute care hospital, long-term acute care hospital, rehabilitation, skilled nursing facility)	Change Healthcare InterQual Level of Acute Rehabilitation, Acute Long Term Care, Acute Adult, Acute Pediatric Criteria, Center for Medicare and Medicaid Criteria	Internally developed Clinical Practice Guidelines and medical necessity criteria	National Evidence-Based Peer Reviewed Medical Organization Recommendations and/or Peer Literature review
Diagnostic and therapeutic procedures, including elective surgeries	Change Healthcare InterQual Adult and Pediatric Procedures Criteria Centers for Medicare and Medicaid Criteria	Internally developed Clinical Practice Guidelines and medical necessity criteria	National Evidence-Based Peer Reviewed Medical Organization Recommendations and/or Peer Literature review
Medical Benefit Drugs	SummaCare P&T Committee Approved Criteria (Non-Oncology Drugs)	Internally developed Clinical Practice Guidelines and medical necessity criteria	National Medical Organization Recommendations and/or Peer Literature review

Type of request	First Line Criteria	Second Line Criteria	Third Line Criteria
	eviCore healthcare guidelines supported by National Comprehensive Cancer Network (NCCN) guidelines Centers for Medicare and Medicaid Criteria (Oncology Drugs)		
Behavioral health care	Change Healthcare InterQual Behavioral Health Guidelines and Acute Detox, Center for Medicare and Medicaid Criteria	Internally developed Clinical Practice Guidelines and medical necessity criteria	National Evidence-Based Peer Reviewed Medical Organization Recommendations and/or Peer Literature review
Neonatal Intensive Care	Change Healthcare InterQual Level of Care Pediatric Criteria	Internally developed Clinical Practice Guidelines and medical necessity criteria	National Evidence-Based Peer Reviewed Medical Organization Recommendations and/or Peer Literature review
High-tech Radiology procedures and tests	EviCore healthcare guidelines Centers for Medicare and Medicaid Criteria	Change Healthcare InterQual Adult and Pediatric Procedures Criteria	National Medical Organization Recommendations and/or Peer Literature review
Oncology: Medical, Radiology, and Lab/Genomic Testing	EviCore healthcare guidelines supported by National Comprehensive Cancer Network (NCCN) guidelines Centers for Medicare and Medicaid Criteria	Change Healthcare InterQual Adult and Pediatric Procedures Criteria	National Medical Organization Recommendations and/or Peer Literature review
Durable Medical Equipment	Change Healthcare InterQual DME Criteria Centers for Medicare and Medicaid Criteria	Internally developed Clinical Practice Guidelines and medical necessity criteria	National Evidence-Based Peer Reviewed Medical Organization Recommendations and/or Peer Literature review
Home Care	Change Healthcare InterQual Home Care Criteria	Internally developed Clinical Practice Guidelines and medical necessity criteria	National Evidence-Based Peer Reviewed Medical Organization Recommendations and/or Peer Literature review
Genetic Testing	National Medical Organization Recommendations, Peer Literature review and/or EviCore	MCMC, LLC. Review Services	Peer Literature review

New Technology	Hayes, Inc. McKesson Change Healthcare InterQual Medicare Procedures Centers for Medicare and Medicaid Criteria	Up To Date	National Evidence-Based Peer Reviewed Medical Organization Recommendations and/or Peer

	SummaCare Policies		Literature review

9.0 Authorization Process

9.1 The HSM Clinical Management Department processes and responds to all requests, organization determinations, notifications and communications in a thorough and timely manner in accordance with all applicable regulatory requirements and standards.

10.0 Responsibilities of Ordering Provider

10.1 Contact HSM through the SummaCare Provider Portal by, telephone, by mail or fax to request prior authorization no later than forty-eight (48) hours in advance of the test or procedure.

10.2 Provide pertinent clinical information as directed by the Prior Authorization List and the Pre-Certification Guidance Forms located on the summacare.com website/providers/Resources & Self Services

10.3 Submit medical records and any additional clinical information if requested by HSM staff.

10.4 Contract terms between The Plan and contracted providers properly incentivize contract providers to produce requested clinical records and other needed information in a timely manner.

11.0 Responsibilities of HSM UM Staff

11.1 Receive calls from ordering provider and collect pertinent clinical information.

11.2 Apply approved criteria or guidelines in accordance with The Plan policies and procedures.

11.3 HSM UM Reviewer will review request and will process a benefit determination if the request is specifically excluded from the member's benefit plan

11.4 Provide copies of criteria upon request.

11.5 If clinical information meets the approved criteria or guidelines, HSM staff approve the request and enter authorization into the claims system. Provide authorization number to the provider at time of notification of authorization.

11.6 Make reasonable and diligent efforts to obtain all necessary medical records and other pertinent information within the required time limits. If the determination requires medical necessity review and there is not enough information provided to make a determination, The Plan staff make at 1 attempt during normal business hours, when possible, in the provider's time zone to obtain the missing information from the appropriate provider(s) or to verify that the needed information is not available. The first outreach attempt for expedited/urgent requests is made upon receipt of the request. The first outreach attempt for standard requests occurs upon receipt of the coverage request. Outreach attempts are made using various methods which may include telephone, fax, email, and/or standard or overnight mail with certified return receipt. Subsequent outreach requests are timed in a manner that increases the likelihood of making contact with the provider and receiving the information. Situations where providers fail to provide needed clinical records, the Plan contacts the member for records or assistance in reaching the provider. When efforts have been exhausted and a decision is

required to meet timeliness, the determination is made according to the information available to the reviewer and the member's available benefits. The Plan has a system for tracking the contracted providers who do not submit clinical information in a timely manner. The Plan tracks outreach attempts for additional clinical information in the Care Manager system. Staff document in this system when clinical information is not received from a provider. A report of providers who have not sent clinical information in a timely manner is then generated and sent monthly to Provider Services so that they can educate the provider on why clinicals are needed and so they can review contract requirements for timely submission of clinical information with the provider.

11.7 If clinical information submitted does not meet approved medical necessity criteria, request is submitted to the Medical Director or physician designee for review.

11.8 The Physician Reviewer reviews requests sent by HSM staff and either:

11.8.1 Consults with requesting provider.

11.8.2 Requests additional information in written form.

11.8.3 Refers the case to an appropriate board-certified consultant who has expertise in the discipline related to the request. In addition to board-certified physician, pharmacists or dentists may also be consulted for additional information and/or expertise. The Consultant completes the review and documents his/her findings and recommendations. The Medical Director reviews consultant findings and makes a final determination.

11.8.4 Denies the request. If the physician denies the request, he/she documents the clinical reason (s) for the denial and the date of the determination. If the reviewer is handling the review telephonically, then the nurse who calls and discusses the case with the reviewer documents the date and time of the conversation, and the determination made by the reviewer.

11.9 Notify the member of the decision by phone, as appropriate, depending on the type and urgency of the request. A voice mail may be used if it is stated it is a confidential voicemail or a voicemail may be left to notify the member to contact The Plan for outcome. Note: All The Plan determinations are provided electronically to the member via Plan Central online.

11.10 Notify and ask the member for an extension if applicable.

11.11 Process denial determination letters. The Plan staff written notification of denial to the requesting provider and member including:

11.11.1 The specific reason for the denial;

11.11.2 A reference to the benefit provision, guidelines, protocol or other similar criterion on which the denial decision is based.

11.11.3 Notification that the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision is based upon request;

11.11.4 The availability of a physician reviewer or other appropriate reviewer to discuss with the ordering provider the denial decision, and how to contact the reviewer;

11.11.5 At the time of notification, the ordering physician is offered the opportunity to speak to a physician reviewer or designee about a denial determination to provide additional information or discuss alternatives to care.

11.11.6 Description of appeal rights including the right to submit written comments, documents or other information relevant to the appeal;

11.11.7 Explanation of the appeal process including the right to member representation and time frames for deciding appeals;

11.11.8 A description of the expedited appeal process for urgent pre-service or urgent concurrent denial decisions, and for urgent care, that external concurrent expedited appeal is available.

11.12 For Medicare denials, CMS requires the use of OMB approved Integrated Denial Notice for non-inpatient Medicare service denial determination letters.

11.13 For telephonic notification, if a busy signal is reached when notifying providers of a denial, additional attempts are made including the next day and are documented in the authorization remarks.

12.0 Documentation of UM Decisions

12.1 Documentation pertaining to UM decisions includes the following:

12.1.1 Date the initial request was received.

12.1.2 Name of the requesting provider or member/member representative.

12.1.3 Type of service requested.

12.1.4 Date of any request or outreach for additional information and specific information about who was contacted, what was discussed/requested, and what information was obtained.

12.1.5 Reference to criteria used in making the determination.

12.1.6 Reason for denial, if denied.

12.1.7 Name and date of all reviewers.

12.1.8 Date and content of any member and/or provider notification of the determination. Any denial communication to the member must include a denial reason explained in layperson terms as well as all information delineated above.

12.1.9 For oral notifications, the name and phone number of who was reached.

12.1.10 Upon request by a provider or member, The Plan staff print or photocopy the appropriate criteria and fax or mail a copy of the criteria as requested.

12.1.11 Denials, including documentation, are electronically available for review.

13.0 Utilization Monitoring and Reporting Timeliness of UM Decisions

13.1 Utilization monitoring reports are reviewed at least quarterly to determine trends suggestive of over or under utilization of services. Truven and/or other industry standard benchmarks may be used when available for comparison. Utilization trending may include but not be limited to provider/procedure/service type utilization (i.e. cardiac cath, skilled nursing facility, IV infusions), location of services (inpatient, outpatient, inpatient, emergency room, etc.), or other utilization trends such as length of stay using claims data. If a sustained (greater than 6 months) negative trend is identified, further trending and investigation will be done up to and including the implementation of a performance improvement plan when appropriate.

13.2 Clinical Management will monitor the timeliness of decision making and of notification for all requests, including Non-Behavioral Health, Behavioral Health and Pharmacy requests. Reports will calculate the percentage of decisions that adhere to the timeframes as specified in the regulatory standards (Medicare, NCQA, and Marketplace) using at least 6 months of data. Minimally, the timeliness report will calculate the rates of adherence to time frames for each category of request (urgent concurrent, urgent pre-service, non-urgent pre-service, and post service for Non-Behavioral Health, Behavioral Health and Pharmacy requests. It is noted that Medicare does not recognize post service prior authorization reviews; the plan monitors all lines of business.

14.0 Records:

14.1 Utilization authorizations are stored within Health Edge.

15.0 References:

15.1 NCQA UM Standards **(UM 1, UM 2, UM 3, UM 4, UM 5, UM 6, UM 7);** ORC§3923.041; 42 C.F.R. § 422.562 to 422.626; CMS Chapters 4, ODAG/CDAG manual chapter, formerly Chapter 13"

16.0 Definitions:

For purposes of this policy:

Authorized Representative: For urgent pre-service and urgent concurrent situations where the member is in an inpatient setting, The Plan considers the health care practitioner with knowledge of the member's medical condition or the Facility personnel to be the member's authorized representative(s) for communication of requests and determinations. In addition, those holding durable power of attorney for the member are considered to be authorized representatives in all situations.

Provider: A practitioner or physician who provides health care services.
Coverage based on Medical necessity is an item or service in which coverage under the plan depends on required conditions, symptoms, or treatment plans to be present.

Pre-service Medical Necessity Review is the process of determining the medical necessity of a proposed procedure, surgery, or treatment (including pharmacological intervention) or service relative to approved criteria. It takes into consideration the appropriateness of location, frequency, intensity and scope of care and service. This process may be carried out telephonically, electronically, or in-person.

A Benefit Determination: is an approval or denial of a requested service that is specifically excluded from a member's benefit plan, which the plan is not required to cover under any circumstances. Benefit determinations include decisions about services that are limited by number, duration or frequency in the member's benefit plan, denials for extension of treatments beyond the specific

limitations and restrictions imposed in the member's benefit plan, and decisions about care that do not depend on any circumstances, such as the member's medical need or a practitioner's order.

A Pre-service Organization Decision is any case or service that the organization must approve, in whole or in part, in advance of the member obtaining medical care or services. Preauthorization and precertification are preservice decisions.

Emergency Care: Emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency services are defined as covered inpatient or outpatient services or medical transportation that is needed to evaluate or stabilize an emergency medical condition as defined above. Emergency services are provided and covered twenty-four hours a day, seven (7) days a week without requiring prior authorization. Emergency room services include emergency services provided both in-network and out-of network of a member's plan.

Expedited or urgent requests for care is any request for medical care or treatment with respect to which the application of the time periods for making non-urgent or non-expedited care determinations could result in the following circumstances:

Could seriously jeopardize the life or health of the member of 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 subject of the request.

A concurrent review is a review conducted when there is a medical need to extend the LOS or treatment course beyond what has already been authorized. Concurrent review may include those members currently inpatient or those receiving ongoing ambulatory care. A member or provider may submit such requests orally or in writing for consideration with the inclusion of clinical information from providers. In addition to clinical information received from the providers, continued utilization of services is considered along with industry norms such as CMS's geometric length of stay (GMLOS) and discharge readiness (using industry approved screening criteria) when making a concurrent review decision.

Routine request for care is defined as a request for routine care that is not urgent or emergent. If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization does not meet the definition of "urgent care," the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., preservice or post-service). Medicare calls this a standard request.

A Post-service decision is any review for care or services that have already been received (e.g., retrospective review). A request for coverage of care that was provided by an out-of-network practitioner and for which the required prior authorization was not obtained is a post-service decision.

17.0 Key Words or Aliases (Optional):

17.1 None

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