## Section Contents

## UTILIZATION MANAGEMENT PROGRAM

### Purpose and Scope

The Utilization Management (UM) Program is designed to monitor, evaluate, and manage the quality and cost of healthcare services delivered to all members of the IPA. The utilization management structures and process are clearly defined and responsibility is assigned to the appropriate individuals.

This section outlines the UM Program structure and accountability. Its description includes the scope of the program and the processes and information sources used to make determination of benefit coverage and medical appropriateness.

The program will ensure that:

- Services are medically necessary and are delivered at appropriate levels of care.
- Medical services are provided by the IPA contracted providers and practitioners unless authorized by the EXCEL MSO, LLC (EXCEL) Chief Medical Officer, the IPA UM Committee, or the IPA Clinical Medical Director.
- Services are not over utilized or under utilized.
- High quality medical care is offered in a timely manner with consideration to the urgency and emergency of the situation.
- Services are authorized timely and efficiently with consideration to the urgency of the situation.
- Costs of services are monitored, evaluated, and determined to be appropriate.

- Guidelines, standards, and criteria set by governmental and other regulatory agencies are adhered to, as appropriate.

- IPA will maintain regulatory compliance with respect to various health plans in general and also specific contracted member populations, (e.g. Commercial, Medicare, and Medi-Cal.)

- IPA utilizes standard criteria and informational resources to determine the appropriateness of healthcare services.

- The utilization management team of physicians, licensed staff, and unlicensed staff carry out the responsibilities designated for their level of expertise.

- Compensation plans for the IPA physicians do not include incentives, direct or indirect, for making inappropriate review decisions.

- The Utilization Management Program will be reviewed and approved at least on an annual basis by the Utilization Management Committee and Board of Directors. Supporting policies and procedures will be reviewed and approved at least annually by the UM Committee.

- The Utilization Management Program will be integrated with the Quality Management Program to ensure continuous quality improvement.

## Utilization Management (UM) Program

### Goals/Objectives

The UM Program goals are:

- To provide medically necessary health care services that are quality focused, cost efficient, and outcome oriented.
- To ensure continued compliance with the regulation set forth by the regulatory organizations and California legislature.

The Utilization Management Program objectives are designed to meet the goals of the program by ensuring the following:

- Provide access to the most appropriate and cost efficient health care services.
- Ensure that authorized services are covered under the member's health plan benefits.
- Develop a mechanism to evaluate and determine that services provided are consistent with accepted standards of medical practice.
- Collaboration and cooperation with the peer review process, when necessary.
- Coordinate thorough and timely investigations and responses to member and provider issues that are associated with utilization management, and when appropriate, initiate corrective actions to prevent problematic situations in the future.
- Ensure that services delivered are medically necessary, criteria based, and are consistent with the member's diagnosis and level of care requirements.
- Facilitate communications and develop positive relationships between members, practitioners, and health plans by providing education related to appropriate utilization.

- Evaluate and monitor health care services provided by IPA practitioners by tracking and trending data on a regular basis.
- Continually monitor continuity and coordination of care.
- Identify areas of overutilization and underutilization of services by means of a continuous process of evaluating utilization patterns.
- Enhance the delivery of care by recognizing physicians and providers for sound utilization practices and exceptional quality of service.
- Identify "high risk" members and ensure that appropriate care is delivered by accessing the most efficient resources.
- Reduce overall health care expenditures by developing / adopting and implementing effective health promotion and disease management programs.
- Use and provide utilization management data in the process of evaluating practitioner performance and re-credentialing.
- Identify potential quality of care and service issues and refer to Quality Management for full investigation.
- Continually monitor utilization services by maintaining Bed Days/1000, Admits/1000 and average length of stays, referral patterns across all providers.
- To monitor utilization of non-contracted providers and report findings to the Utilization Management Committee and Credentialing Committee for identifying network needs.
- Develop, adopt, and implement clinical practice guidelines to provide high quality and evidence based medical care.
- Continuously monitor, evaluate, and improve the Utilization Management Program.

## UTILIZATION MANAGEMENT POLICIES

1. The authorization request determinations made by the professional utilization management reviewers at EXCEL MSO, LLC (EXCEL) are based only on the appropriateness of care and service. EXCEL does not compensate the physician or the nurse reviewers who conduct utilization review for any denials of coverage or service. There are no financial incentives in the organizations that encourage inappropriate denials of service.

2. All medically necessary decision determinations are based on sound clinical evidence and are criteria based. The criteria are updated, reviewed and revised (as appropriate) and approved on an annual basis by the Utilization Management Committee. The EXCEL Chief Medical Officer, a senior physician with substantial involvement in the implementation of the UM Program will over see the criteria development and application process. Participating IPA practitioners outside the Utilization Management Committee are available to assist in the review, revision, or acceptance of criteria as necessary.

3. The criteria are available to all practitioners upon request. Procedures are in place for the following:

    - A mechanism for checking the accuracy and consistency of application of the criteria for physician reviewers and non-physician reviewers.
    - Application of the criteria that justifies the appropriateness of services is clearly documented and considers individual patients and the characteristics of the local health care delivery system.
    - The process for practitioners to follow when requesting copies of criteria is in place.

4. Emergency services, necessary to screen and stabilize members, will be authorized without prior notification in cases where a prudent layperson acting reasonably would have believed that an emergency medical condition existed.

5. Efforts are made to obtain all necessary information, including pertinent clinical information, and documented phone conversations with the treating physician, as appropriate, for the purpose of reviewing all authorization requests.

6. Referral/authorization process and associated timeframes for decisions, notification, and confirmation are implemented and monitored to comply with the regulatory and NCQA standards.

7. Preauthorization, concurrent review and case management decisions and processes are supervised by qualified licensed medical professionals. Physician consultants are utilized to review cases as appropriate from specialty areas of medicine and surgery, and behavioral health.

8. Only the Chief Medical Officer or his/her physician designee can make the decision to deny service after conducting a review for medical appropriateness. Reasons for denial are clearly documented and available to the member and requesting physician. Notification to the member and requesting physician of a denial includes appeal process information and instructions regarding the process for expedited appeal. Notification to the requesting physician includes information of the Chief Medical Officer's availability to discuss the case. These processes are detailed in the supporting policies and procedures located at the IPA's (EXCEL, MSO, LLC's) office.

9. Utilization management determinations are made in a timely manner. The urgency of the situation is always considered to ensure that the request is processed appropriately and according to established timeliness standards in compliance with regulatory and NCQA standards. Timeliness is monitored on a regular basis and corrective action measures are implemented as appropriate.

10. The IPA measures member satisfaction and practitioner satisfaction at least every two years with a focus on the ease of getting requested services approved and obtaining authorizations. Any areas of dissatisfaction are subject to corrective action and re-measurement for achieving and demonstrating performance improvement.

11. Utilization data is tracked and trended on a regular basis. The data reports are submitted to the Utilization Management Committee Board of Directors and to the contracted health plans on a quarterly basis. The analysis of the data focuses on outcomes related to over/under utilization and acceptable expected rates established for the population served. The UM Committee will make recommendations for improvement when necessary. A re-measurement process will determine improvements or whether further analysis and actions are required.

12. Quality of care and quality of service issues are referred to the Quality Management Department and to the Quality Management Committee for investigation and determination. The UM Committee and the QM Committee work collaboratively to resolve any cross related issues or problems.

13. The Utilization Management Program will include the effective processing of prospective, concurrent, and retrospective review determinations by qualified personnel. The areas of review will include:

    - Emergency Department authorizations
    - Inpatient hospitalizations (Acute, Rehab and Skilled Nursing)
    - Outpatient surgeries (all procedures done outside of the practitioner's office)
    - Selected outpatient services
    - Selected ancillary services
    - Home Health services
    - Selected physician office services
    - Out-of-network services
    - Specialist to specialist referrals
    - Specialist referring to him/her self

14. Provider and member appeals will be efficiently processed according to the IPA/health plan appeals policy and procedure

15. The Case Management Program will clinically and administratively identify, coordinate, and evaluate services delivered to those members that require close management of care. The Case Management Program will work in conjunction with disease management programs approved by the Utilization Management Committee.

16. The UM Program, supporting policies and procedures will be reviewed, revised as necessary and approved on at least an annual basis by the UM Committee and the IPA Board of Directors.

17. The UM Program will be submitted to the contracted health plans. Other UM reports will be submitted to the health plans according to contractual agreements.

18. Timely encounter data reporting to the Health Plans will be as required by contract.

## ORGANIZATION AND RESPONSIBILITIES

The IPA Board of Directors reviews, revises and approves the Utilization Management Program on an annual basis or as needed. The IPA Board of Directors has a contractual agreement with EXCEL MSO, LLC (EXCEL), a Managed Services Organization for the operational implementation of the UM Program with its supporting policies and procedures.

The EXCEL Chief Medical Officer, the designated senior physician, and the IPA Medical Director have the responsibility for overseeing the management and implementation of the UM Program with a focus on the program's financial viability, the allocation of resources and staffing, and the overall effectiveness of the UM Program. The Chief Medical Officer in conjunction with the Clinical Medical Director of IPA reports to the IPA UM Committee and Board of Directors.

### Chief Medical Officer (EXCEL)

The Chief Medical Officer in conjunction with the Clinical Medical Director of the IPA is responsible for the overall oversight and implementation of the UM Program that includes the prospective, concurrent and retrospective review process for services provided by the UM Program. Other responsibilities include:

- The review process for medical necessity of service requests.
- The denial of all medical necessity services requests that are not medically appropriate according to established approved criteria.
- Participation and reporting to the IPA Utilization Management Committee and Board of Directors.

The Chief Medical Officer or his/her designee is available at all times to the Utilization Management Staff and to the IPA practitioners.

## IPA Clinical Medical Director

The IPA Clinical Medical Director acts as the liaison between the IPA practitioners and the IPA Utilization Management and Quality Management Committees, the Board of Directors and EXCEL. The IPA Clinical Medical Director, in conjunction with the EXCEL Chief Medical Officer, report to the UM Committee and IPA Board of Directors. Other responsibilities include:

- The review of hospital inpatient cases, as necessary, in order to assure the care is medically necessary, high quality, and provided at the most appropriate level of care.
- The discussion of cases as necessary with the attending physicians and/or the primary care physician.
- Participation on the UM Committee and reporting to the IPA Board of Directors.

## Chief Executive Officer (EXCEL)

The Chief Executive Officer is responsible for the overall planning development and monitoring of operations in the areas of Utilization Management, Quality Management, Provider Relations and Contracting, Credentialing, and Customer Service. The Chief Executive Officer, an executive of EXCEL reports to the IPA Board of Directors.

## Manager, Utilization Management (EXCEL)

The UM Manager is responsible for overseeing the daily operations of the UM Department and acts as support to the EXCEL Chief Medical Officer, IPA Clinical Medical Director, and to the IPA UM Committee. The UM Manager is a Registered Nurse and reports to the Chief Medical Officer.

The Utilization Management Department consists of licensed nurses and non-licensed support staff. Under the auspices of the EXCEL Chief Medical Officer, the licensed nursing staff is responsible for the prospective, concurrent, and retrospective review of service requests. The licensed nursing staff acts as support to the IPA UM Committee and the EXCEL Chief Medical Officer. The non-licensed staff is responsible for the confirmation of benefits and eligibility of the members and for the data entry and other functions unrelated to the review of service requests. All Utilization Management nursing and support staff report to the UM Manager.

The Utilization Management Department utilizes a computer program for authorization tracking and documenting authorizations, referral requests and pertinent clinical information. Other software is utilized for reports, letters, and committee minutes.

## IPA Board of Directors

The IPA Board of Directors has the ultimate responsibility for the oversight and implementation of the UM Program. The Board of Directors revises, makes recommendations and approves the UM Program on a yearly basis. In addition to the UM Program, the Board of Directors approves the annual UM Evaluation, the annual UM Work Plan, and the UM quarterly reports. The Board of Directors provides the oversight for the administrative functions conducted by EXCEL that pertain to the IPA.

## IPA Utilization Management Committee

The Utilization Management Committee is a standing committee for the IPA, and is accountable to IPA Board of Directors. The UM Committee Chairperson is appointed by the Board of Directors. The UM Committee members are comprised of IPA physicians selected by the Committee Chairperson and approved by the Board of Directors in accordance with the IPA bylaws. Committee Members are rotated annually to assure broad representation and may be re-appointed.

The UM Committee has been given the authority from the IPA Board of Directors for the implementation and oversight of the UM Program. The committee performs data analysis from UM activities, reviews and evaluates the outcomes of UM services and revises and recommends policy decisions. The UM Committee reports to the Board of Directors (at least) on a quarterly basis.

The UM Committee establishes and maintains solid avenues of communication and networking between the participating practitioners, EXCEL UM staff, facility providers and health plans. When requested by the UM Committee, physician consultants from appropriate specialty areas of medicine and surgery are available to review cases pertaining to their specialty. The UM committee evaluates the quality of services and identifies issues that are forwarded to the Quality Management Committee.

The UM Committee conducts monthly meetings on the 3rd Wednesday of each month. To comply with oversight obligations, representatives from health plans may attend the Utilization Management Committee Meeting with prior arrangements. A confidentiality statement is signed and filed in the EXCEL UM Department. The UM Committee maintains meeting minutes that are contemporaneous, dated and signed by the UM Committee Chairperson and include:

- Agenda and supporting documents
- Attendance of the members and non-voting members
- Active discussion, actions and follow-up for UM issues
- Analysis of UM data
- Review, revisions and approval of policies and procedures, programs, reports, criteria and guidelines used for UM decisions.

Only the physicians on the committee have voting rights. No committee member shall vote on any case in which he/she is personally involved. A quorum of the committee shall consist of three physician members.

**UM Committee Chairperson**

The UM Committee Chairperson, is an IPA physician appointed by the Board of Directors. The UM Committee Chairperson in collaboration with the EXCEL Chief Medical Officer plans and facilitates the UM Committee meetings. Other responsibilities may include program implementation, and reporting to the Board of Directors on a quarterly basis.

## Confidentiality

All information involving the medical care of members shall be treated with the highest level of confidentiality to protect both the member's rights and the IPA's legal requirements that include the protection of peer review information.

- All members of the Utilization Management Committee, EXCEL staff members, and guests are required to sign a confidentiality statement on an annual basis, or as necessary to preserve member and provider confidentiality.

State law (SB480) regulates disclosure or acquisition of medical information by a requestor, and except as otherwise provided requires appropriate authorization by a member or a member representative. All records and proceedings of the UM Committee are confidential and protected from discovery according to State statute.

## UTILIZATION MANAGEMENT PROCESS

### UM Program Effectiveness and Review

The effectiveness of the Utilization Management Program will be evaluated annually by the UM Committee. The Chairperson reports the evaluation results to the Board of Directors.

To ensure the appropriateness of medical services, active participation by all practitioners and providers affiliated with IPA are encouraged. Detailed utilization management activities that include active communication between the EXCEL staff and IPA representatives, practitioners, affiliating hospital and ancillary care providers are utilized. The different review methods used include:

- **Prospective Review**: A process of reviewing and authorizing elective service requests, both inpatient and outpatient, that meet established criteria and are medically appropriate for the individual factors of the patient and local delivery system of care.

- **Concurrent Review:** A process of reviewing and authorizing all current care of patients receiving inpatient services that meet the intensity and severity criteria requirements and are medically appropriate and delivered at the appropriate level and setting.

- **Retrospective Review:** A process used for the review of medical services that have previously been provided without prior authorization to determine urgency, emergency, and medical appropriateness.

## Prospective Review Process

The primary care physician coordinates all care that is being rendered to the IPA members. The primary care physician initiates a referral request by submitting a referral request form to EXCEL MSO Utilization Management Department.

All referral requests must be reviewed by the EXCEL Chief Medical Officer or by his/her designee. All relevant clinical information is gathered in order to make an appropriate decision. Consultation with the treating physician and/or designated Board Certified specialists occurs at the discretion of the Chief Medical Officer/designee. All review decisions are made within the regulatory and NCQA timeframes, but remain sufficiently flexible to accommodate urgent situations. Referral requests that do not meet established criteria will be further evaluated using UM Committee review and/or specialty review.

Requesting physicians are notified of the review decision according to the regulatory and NCQA time frames. Notification to the requesting physician for denied services include the availability of the EXCEL Chief Medical Officer for discussing the case.

Effective January 1, 1999, female members may self-refer to any contracted gynecological provider.

## Concurrent Review Process

All non-urgent hospital admissions require prior authorization. The estimated length of stay using the Milliman and Robertson Healthcare Guidelines for Inpatient and Surgical Care, is used only as a guideline to assist the inpatient concurrent reviewer. There is no set pre-authorized length of stay determinations for any surgical procedure including mastectomy and lymph node dissection. All authorized length of stay decisions are based on medical necessity determinations made in the concurrent review process.

All urgent/emergent admissions will be reviewed within 1 working day of notification of the admission. IPA affiliated hospitals notify the EXCEL Utilization Management Department of the admission. The IPA concurrent review nurse performs initial reviews on site or telephonically. If the medical necessity for the admission is not evident, the case is referred to the IPA Clinical Medical Director for review. The Chief Medical Officer/designee will discuss the case with the attending physician and/or PCP to determine medical necessity.

The Inpatient Concurrent Review nurse reviews and facilitates efforts to move IPA patients through the health care system efficiently from admission to discharge. He/she identifies and evaluates all inpatients on the date of admission or next business day for concurrent management and discharge planning according to accepted guidelines. The Concurrent Review nurse works with the practitioners, the IPA Clinical Medical Director, hospital staff, ancillary providers, patient and families and contracted health plans to ensure that the inpatient stay is medically appropriate.

## Discharge Planning

The Concurrent Review nurse facilitates access to other services in timely manner in order to discharge patients from acute care facilities to a lower level of care. In addition, the Concurrent Review nurse is available to assist patients and family members in establishing plans for post hospital care. The Chief Medical Officer of EXCEL reviews inpatient cases with the Concurrent Review Nurse on a daily basis and is available to discuss discharge plans with the attending and primary practitioners on an as needed basis. The Concurrent Review nurse refers patients with complex medical and/or social needs to Large Case Management as necessary. The Concurrent Review nurse reports inpatient information to the health plans per contractual obligations. The Concurrent Review nurse attends the IPA UM Committee meeting to report on hospital utilization and individual complex cases as needed.

## Retrospective Review

Retrospective review is performed when medical services were obtained without prior authorization. Retro-authorization requests will be considered for authorization under certain circumstances. Retrospective review also includes the review of referral patterns, appropriateness of referrals and procedures. The data is collected and analyzed on regular basis, at least annually. Retrospective review may lead to focus review on a prospective basis to determine the appropriateness and medical necessity of requested services.

## LARGE CASE MANAGEMENT

The goals of the Large Case Management Program are to enable members requiring complex medical interventions to achieve high quality health outcomes that are resource efficient and cost effective. The Large Case Management process is intended to assess care needs across the continuum of care and analyze and measure the effectiveness of interventions in meeting the established goals.

All cases referred to the Large Case Management nurse are reviewed and screened to determine if the case is appropriate for case management. Large Case Management referrals are generated from multiple sources that are appropriate for identifying individuals that are at risk including but not limited to the inpatient concurrent review nurse, the referral authorization nurse, the quality management nurse, medical directors, providers, hospitals and health plans. The Large Case Management nurse performs the following key functions:

- Provides assessment of care needs and establishes treatment goals
- Develops a treatment plan in conjunction with the patient's PCP and/or specialist, the patient, and designated caregiver
- Facilitates the implementation of necessary health services in an organized manner
- Evaluates the treatment plan in relationship to the desired patient outcomes
- Evaluates the care management interventions designed to promote quality of care and quality of service, and appraises the effectiveness of interventions to the desired outcomes.
- Documents the clinical course of the case on an ongoing basis.
- Consults with the EXCEL Chief Medical Officer on a regular basis.
- Documents case closure when appropriate after the medical problems that caused entry into case management is resolved and independence is reasonable achieved.

## UM DECISION TIMELINESS AND NOTIFICATION

UM decisions are made in a timely manner after all relevant information is obtained and are respectful to the urgency of the member's situation. Timeframes for pre-certification, concurrent and retrospective decisions are made according to the health plan, regulatory and NCQA standards.

Initial notification timeframe requirements are according to the established NCQA standards. For denied services, the physician reviewer's availability to discuss the case is indicated on the initial notification to the requesting provider.

To confirm the UM decision, letters are sent to the member within the established regulatory and NCQA standard timeframes for written confirmation.

### Denials and Appeals

A licensed physician reviews all denials based on medical appropriateness. Services denied for lack of benefit may be reviewed by the UM nurse. All written confirmation letters to members and providers for denied decisions include the reason for the denial, instructions regarding the appeal process and expedited appeal process. All denials and appeals are logged and tracked. Denial and appeal rates are reported to the UM Committee, QM Committee and Board of Directors and if required, contracted health plans.

### Clinical Data Tracking

Data is tracked and monitored on a regular basis. Data is collected by a variety of mechanisms and is reviewed, analyzed and reported to the UM Committee, QM Committee and Board of Directors. Opportunities for improvement are identified with appropriate corrective action plans for implementation and follow-up. Utilization data reports are reviewed for over and under utilization and reports are provided to the health plans according to the contractual requirements.

## CONTINUITY OF CARE

It is the expectation of the IPA for all contracted specialists and Primary Care Physicians to cooperate with the continuity of care efforts that promote high quality effective care. Behavioral Health Specialists, with written consent from the member will collaborate with Primary Care Physicians for the purpose of ensuring that a patient receives safe appropriate healthcare.

The IPA and EXCEL will support members with specific conditions requiring continuing care from a terminated provider of the IPA for a period of time after the termination, or until a safe transfer to a new IPA provider can be arranged.

## CALIFORNIA CHILDREN SERVICES (CCS)

### Overview of CCS

The California Children's Services (CCS) program is a state-funded program that provides services to children with serious medical conditions which can be cured, improved, or stabilized. Eligible conditions include birth defects, chronic illness, genetic diseases, handicaps which are present at birth or develop later, and injuries due to accident or violence. Through a network of CCS participating specialty and sub-specialty providers and special care centers, CCS provides comprehensive medical case management services as well as prescribed medical therapy services which are delivered at medical therapy units located in public schools.

This program is available to those children who have medically eligible conditions and are enrolled in either Medi-Cal or the Healthy Families Program. Children with other commercial insurance may also be eligible if they meet other specific requirements. (e.g. financial requirements)

### Goal of CCS

The primary goal of CCS is to assure that children with physically handicapping conditions receive necessary and appropriate health care to treat their eligible conditions at the appropriate time and place by CCS-paneled health care practitioners. The program performs these assurance functions by defining those handicapping conditions requiring multi-specialty, multidisciplinary care, and by determining program eligibility.

The program performs other services which include:

- Assessing the qualifications of and selecting the most appropriate providers and sites for care
- Case management activities
- Determining the appropriateness of treatment plans
- Authorizing the funding for services

## CCS (continued)

Frequently, families and children with multiple problems need extended service in the home and coordination with other community agencies.

In order for ay medical service to be covered under CCS, the eligibility of the child and medical condition(s) must be determined by CCS prior to the service(s) being rendered. The UM Department will assist the members and providers to submit information and follow-up with CCS for eligibility determination.

Once the child has been determined to be CCS eligible, as case number will be provided by CCS to the IPA and the member. All claims for CCS approved services provided to this child must be sent to CCS.

The UM Department may initially authorize a CCS eligible medical service while the child is awaiting CCS eligibility determination. If CCS subsequently approves the medical services for the child, CCS will be responsible for reimbursement for the services. The IPA will notify the provider and cancel the authorization as "carved out" to CCS. If CCS denies the medical service(s) or eligibility, the IPA will be financially responsible.

In order for medical service(s) to be covered by CCS:

1. The child and family must meet financial requirements. Children under Medi-Cal have already fulfilled this requirement.

2. Child has medical condition which has been pre-determined by CCS as medically eligible.

3. Medical service has been pre-approved by CCS and provided by as CCS provider.

Claims Submissions: All claims for services where the diagnosis is qualified as a CCS eligible condition must first be submitted to CCS.

- Claims submitted to the IPA for reimbursement must include the denial letter from CCS.

- The IPA (EXCEL) Case Management staff can assist physicians with the identification of possible candidates for additional services available through CCS.